Readiness Assessment for transition and sustainability planning for Sri Lanka's AIDS response

Transition Readiness Assessment report

8 October 2020

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with funding support from UNAIDS

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List of Acronyms

ADB	Asia Development Bank	GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
AEM	Asia Epidemic Model	GIS	Geographic Information System
AG	Auditor General	GNI	Gross National Income
AIDS	Acquired Immunodeficiency Syndrome	GOSL	Government of Sri Lanka
ART	Antiretroviral Therapy	HAQ	Healthcare Access and Quality
ARV	Antiretroviral	HDI	Human Development Index
BB	Beach Boys	HIV	Human Immunodeficiency Virus
CBO	Community Based Organizations	HMIS	Health Management Information Systems
CCM	Country Coordinating Mechanism	HR	Human resources
CDC	The Centers for Disease Control and Prevention	HRH	Human Resource for Health
CFM	Case Finder Model	HSS	Health Systems Strengthening
CHE	Current Health Expenditure	HTS	HIV Testing Services
CIGAS	Computerized Integrated Government Accounting System	IBBS	Integrated Biological and Behavioural Study
CSO	Civil Society Organizations	ICASL	Institute of Chartered Accountants of Sri Lanka
DGHS	Director General of Health Services	ICU	Intensive Care Units
DHE	Domestic Health Expenditure	IDU	People who Inject Drugs
DIC	Drop-In Centre	IP	Implementation Period
DMA	Department of Management Audit	ITMIS	Integrated Treasury Management Information Systems
DNB	Department of National Budget	KII	Key Informant Interviews
EIMS	Electronic Information Management System	KP	Key Population
EMTCT	Elimination of Mother to Child Transmission	LFU	Loss to Follow-Up
FBO	Faith-based Organization	M&E	Monitoring and Evaluation
FPA	Sri Lanka Family Planning Association	MA	Management Assistant
FS	Field Supervisor	MOH	Ministry of Health
FSW	Female Sex Worker	MSD	Medical Supply Division
GAM	Global AIDS Monitoring (UNAIDS)	MSM	Men who have Sex with Men
GDP	Gross Domestic Product	MSW	Male Sex workers

NAC	National AIDS Committee
NARI	National AIDS Research Institute
NASA	National AIDS Spending Assessment
NFM	New Funding Model
NMRA	National Medical Regulatory Authority
NSACP	The National STD/AIDS Control Programme
NSP	National HIV/STI Strategic Plan
OPE	Out of Pocket Expenditure
PDHS	Provincial Director of Health Services
PE	Peer Educators
PEM	Peer Educator Model
PFM	Public Financial Management
PHC	Primary Healthcare
PHI	Public Health Inspector
PIU	Project Implementation Unit
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSM	Procurement and Supply Chain Management
PUDR	Programme Update and Disbursement Request (GF)
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RDHS	Regional Directors of Health Services
RDT	Rapid Diagnostic Tests
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goal
SHP	Sexual Health Package
SLESP	Sri Lanka Essential Services Package
SLPSAS	Sri Lanka Public Sector Accounting Standards
SPC	State Pharmaceutical Corporation
SR	Sub Recipients
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TG	Transgender
TGW	Trans Gender Women
TOR	Terms of Reference
TRA	Transition Readiness Assessment
TSP	Tourism Service Providers
TWG	Technical Working Group on HIV Transition Readiness and Sustainability Planning
UHC	Universal Health Coverage
UIC	Unique Identifier Code
UMI	Upper-Middle-Income
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	The United Nations Population Fund
WHO	World Health Organization

Executive Summary

Introduction

Sri Lanka is classified as a low-level epidemic country and the total number of people living with HIV is estimated at 3 600 with most infections concentrated amongst key populations. The HIV/AIDS response has benefited from significant support and contributions from government through the National STD / AIDS Control Programme, local Civil Society Organizations (CSOs) and through funding and technical support from development partners, mainly the Global Fund. The domestic contribution to the HIV response was estimated at $6.5 million in 2019. The total value for the signed grants for the 2019-2021 implementation period is $6.9 million. Whilst significant achievements have been made in the fight against HIV, challenges remain and ambitious targets may not be reached.

Sri Lanka has been included in the list of countries which must prepare for transitioning from GF support due to rapid economic growth and the concentrated epidemic. The NSACP is not unaware of the inevitable transition, and the GF Technical Review Panel specifically asked for the completion of a Transition Readiness Assessment (TRA). The NSACP, through the ministry of health, requested UNAIDS to support the preparation of a TRA report. A TRA makes a valuable contribution to a more sustainable response by identifying key areas of risk and vulnerability to declining external support and developing suitable responses to mitigate against these risks.

The approach to the TRA was guided by the ACESO / APMG transition readiness assessment tool but was adapted to focus on the different service delivery modalities for KP services implemented by CSOs and through STD centres. Data collection was conducted mainly in four districts: Colombo, Matara, Kurunegala and Kalutara. Work included an initial scoping visit to Sri Lanka, followed by a data collection phase including virtual, key informant interviews and an electronic survey. COVID-19 restrictions prevented further country visits by international consultants. Three virtual workshops were held to seek input on the identified risks, recommendations and mitigating next steps.

Background

The National Strategic Plan, 2018 to 2022, recommends expanding and scaling up prevention activities, increasing accessibility to prophylaxis and advanced testing options, close monitoring of diagnosed HIV positive persons and access to ‘free’ antiretroviral therapy (ART) and a comprehensive care package.

At the end of 2019, of the estimated 3 600 HIV positive persons living in the community, 2 302 (64%) knew their HIV status and 1 845 (51%) registered for treatment, indicating a substantial number (estimated at 10-20%) are lost or significantly delay initiating HIV care and treatment after the they know their HIV status.

The HIV epidemic is concentrated amongst key populations (KPs). The highest prevalence of HIV is among men who have sex with men (MSM) at 1.5%. HIV prevalence is also reported among trans-gender women (TGW), female sex workers (FSW), beach boys (BB) and injecting drug users (PWID). Other high-risk groups include prisoners, drug users and migrant workers. HIV prevalence is low in the general population at less than 0.02%. Sri Lanka is fortunate in that the absolute numbers of new infections is extremely low; estimated to be approximately 100 per annum.

The HIV prevention programmes have reached approximately 25% of the estimated KP populations and KP coverage must increase substantially to end AIDS by 2025. The GF supported KP intervention programme is delivered via 2 models, the Peer Educator Model and the Case Finder Model in urban areas and high prevalence districts. Services include providing outreach prevention services and escorting people to STD centres for HIV tests. These two interventions are currently implemented in partnership with CSOs in the allocated districts via GF resources available to the MOH (Principle Recipient 1) and the Family Planning Association (FPA, Principle Recipient 2).

In addition, community drop-in centres in Colombo district provide services to injecting drug users, transgender people and FSWs. These KP interventions are delivered via peer educators, outreach workers and field supervisors. STD centre staff and the NSACP managed program are not currently formally linked to community based or community led organizations that provide psychosocial or financial support services to PLHIV.

Stigma and discrimination by health care workers and other service providers and legal, human rights related barriers prevents many KP members from reaching out to HIV prevention and care services provided by STD centres and those provided via KP intervention groups. A large proportion of some KP populations (estimated at 65% of MSMs and 70% of FSWs) do not disclose their KP status or if positive for HIV status to their family and/or the community and are therefore 'hidden' and "unreached" by HIV services provided by STD centres or KP-led or KP-focused CSOs.

Transition risks and high-level recommendations

The TRA resulted in the identification of 16 transition risks and vulnerabilities that need to be addressed to improve preparedness for transitioning from GF support over the medium term. Each risk is described together with high level recommendations and next steps. Most 'next steps' described below must be investigated further and unpacked into operational-level plans for implementation. Implementation of these will contribute to achieving Sri Lanka's end AIDS target by 2025 while facilitating a managed transition from GF support to domestic funding.

Governance and leadership

Risk 1. Multi-sectoral governance and accountability mechanism

There is a risk that a governance and multi-sectoral coordination mechanism will not have been established and capacitated to oversee the implementation of the multi-sectoral response both at national and sub-national levels when GF funding ends. Civil society organizations and members of key populations may lose their ability to participate in oversight and decision-making related to KP programmes.

The National AIDS Council has not been active for several years and at this level, there is no demonstrated support for the response and there is no common vision for the governance and coordination of the response post the GF. The capacity and effectiveness of the provincial AIDS committees varies and coordination between the Regional Directors of Health Services and STD centres is not satisfactory in some districts. Civil Society network organizations, representing a national, key population constituency have not been established. A clear pathway for establishing a capacitated, national governance and coordination structure for the long-term management of HIV response has not been documented. Failure to develop a common vision for the response and a multi-sectoral governance and coordination mechanism will erode the effectiveness and efficient implementation of the response.

High level recommendation:

- Initiate and implement a process to develop a common vision for a multi-sectoral governance mechanism where all parties have a voice, to oversee the implementation of the national HIV response.

Proposed actions for implementing the recommendation include: 1) Conduct a comprehensive mid-term review of the HIV programme. 2) Establish a committee to develop the vision and mission of a sustainable HIV programme including its multi-sectoral governance and coordination mechanisms which provide for representation from civil society organisations. 3) Conduct a review of available HIV governance and coordination structures to assess capacity and 'fit for purpose' as mechanisms for efficient coordination of the response. 4) Develop a strategy to capacitate and operationalization the coordinating mechanism and secure resources to fund the mechanism.

Service delivery

Risk 2. Stigma and discrimination.

There is a risk that deep-rooted stigma and discrimination toward members of key populations will persist in Sri Lanka. The impact of the combined KP-related and HIV-related stigma and discrimination on members of key populations and People Living with HIV (PLHIV) is wide-ranging, including effects on their health-seeking behaviours, risk perceptions and risk behaviours, mental health, family relationships, employment, access to housing and access to legal services. Stigma and discrimination also contributes to members of KP groups remaining hidden and/or unreachable, which directly effects their willingness and ability to access vital HIV-related services. In addition, the systemic stigma and discrimination can influence policy and programme decisions at all levels of the HIV response.

The surveys of beneficiaries, frontline workers and CSOs conducted by the TRA reinforced the concerns about stigma and discrimination shared by various key informants. Nearly two-thirds of beneficiaries (62%) reported facing some level of stigma and discrimination from health care workers and more than half (57%) reported the same from family members. 43% of frontline workers felt KPs faced high levels of stigma and discrimination in the general community and 37% felt they faced high levels in the healthcare setting; 60% of frontline workers also felt they faced stigma or discrimination because of their work with key populations. 30% of CSOs reported high levels of KP-related stigma and discrimination in health care settings compared to 75% reporting high levels in the general population. The pervasiveness of KP-related stigma and discrimination is supported by the fact that 0% of respondents reported low levels in healthcare settings or in the general population

The deep-rooted and persistent nature of stigma and discrimination against key populations could easily undermine political support for public funds to be used directly (e.g., through government-implemented programs and activities) or indirectly (e.g., through CSO-implemented programs and activities supported by government resources) for HIV-related activities for these populations.

High-level recommendations:

- Reducing wide-spread and long-standing stigma and discrimination towards members of key populations is a massive task that is beyond the capacity of the HIV response. However, it should be possible to focus on specific actions to reduce the barriers that limit or prevent the use of essential HIV services by key populations; for example, an ongoing activity to reduce stigma and discrimination in health facilities. It is particularly important

to think about the barriers that limit or prevent use of services by hidden or unreached populations.
- There is a parallel opportunity to look at ways to address other aspects of systemic stigma and discrimination (e.g., criminalized behaviors, police harassment, sexual violence) that negatively affect the ability of key populations to have greater control over the HIV risks that they face.

Proposed actions to address the recommendations include: 1) Work closely with members of different key populations at national and sub-national levels to better understand where and how stigma and discrimination has the most serious effects on their HIV risk and their access to and use of HIV-related services. 2) Provide regular training and mentoring on stigma and discrimination for health care workers. 3) Develop formal mechanisms to ensure quick and strong actions on complaints related to stigma and discrimination in the health sector.

Risk 3. Coverage of KP services

There is a risk that the coverage of services for key populations will continue to be limited and fail to reach the majority of key population members, many of whom are hidden in the general population. If interventions fail to reach a large proportion of key populations, fewer new infections will be averted and fewer undiagnosed cases will be found at an earlier point of disease progression which may result in an increase in incidence.

Given Sri Lanka's concentrated epidemic, it is critical to achieve adequate coverage of key and vulnerable population groups, especially MSM where incidence is highest, with a minimum package of relevant services including prevention information, counselling and commodities, HIV and STI testing and care and treatment. Evidence shows that coverage of KP populations, based on recent size estimations, is approximately 20% -25% (coverage varies between KP groups). Significantly higher coverage is required if the goal of ending AIDS by 2035 is to be achieved and sustained.

High level recommendation:

- Develop and implement a comprehensive, *national* KP intervention programme to achieve a minimum of 80% coverage by 2025. A full range of HIV-related services should be widely available and readily accessible to key populations at scale, using STD centres and/or community-based programs (e.g., outreach activities and drop-in centres).
- Increasing coverage will require rethinking on how to deliver HIV services in geographic areas that cannot support a full KP program due to small numbers of KPs living in the district. Providing essential HIV services to hidden and unreached members of key populations will require a similar rethinking. (See below.)

Risk 4. Hidden populations not receiving services

Existing KP programmes are not able to reach "hidden" members of the different key populations. In addition, there has not been sufficient thinking and/or planning about how to connect with these sub-groups. This contributes to the low coverage of KP populations with required services; coverage which is too low to reach ambitious goals. A continued inability to provide prevention and testing services to hidden and/or unreached members of key populations has the potential to undermine effective work with these populations in other areas, making it more difficult to reach epidemic control in Sri Lanka.

High level recommendation:

- Factor hidden and unreached populations into the goals, objectives and targets of KP programmes and approaches to implementation of services.

Risk 5. HIV testing yield

The yield from the two main HIV testing approaches focusing on key populations is consistently low and the cost per case identified is high. Given the nature of the epidemic, undiagnosed HIV cases will be increasingly difficult to find and increasingly expensive on a per-case-identified basis. Policy makers and planners may raise questions about the value of the investment in these approaches, which could lead to a reduction in the availability and uptake of HIV prevention and testing services overall.

Low testing yield is generally seen as a serious shortcoming of a testing approach and a sign that a new or different approach is warranted. In a concentrated, low-prevalence HIV epidemic like the one in Sri Lanka, low yield can be an inevitable consequence of a declining number of undiagnosed cases and the fact that undiagnosed PLHIV are hidden and harder to convince to test. In Sri Lanka's case, it may be time to develop and pilot other approaches to either supplement or replace existing approaches.

High level recommendation:

- New HIV cases will be harder and more expensive to find as the total number of undiagnosed cases declines. It is important to balance testing yield with the value of the prevention component of outreach programs. However, it is equally important to explore other approaches to testing, both to improve yield and reach people who are not currently being reached, including expanded community testing (i.e., rapid testing done by outreach workers), rapid testing in all settings to reduce lost-to-follow-up, provider-initiated testing and self-testing.
- Explore opportunities to improve public perceptions and increase usage of the network of STD centres by repositioning them as positive and supportive providers (e.g., sexual health centres as opposed to STD centres); leverage the link to sexual health to increase HIV testing and strengthen prevention programs.

The links between Risks 3, 4 and 5 create an opportunity to address them through a set of integrated and/or related actions, including: 1**)** Establish a representative working group with a small oversight/steering committee to develop a comprehensive national KP intervention program that will guide the strengthening and scaling-up of KP services in the country, including a strategy to engage with hidden and unreached members of key populations; the working group should include qualified representatives from government, civil society and the KP community and it should be supported by local and international experts as needed. 2) Increase opportunities and locations to have an HIV test (e.g., expanded community testing, private clinics, provider-initiated testing, self-testing). 3) Expand the availability/reach of HIV testing to other populations with higher risk behaviours (e.g., remand prisoners, returning migrant workers). 4) Consider ways to reposition and rebrand the STD centres to reduce the negative perceptions (e.g., Room 33) and make them more appealing to clients, including key populations. 5) Provide space for CSOs in STD centres for their activities as a way to contribute to their sustainability and to better connect their outreach work with the services delivered at the facility.

Risk 6. Slow adoption of innovations

There is a risk that Sri Lanka continues to slow or prevent the adoption of innovative and/or alternative approaches to activities that could improve the performance and effectiveness of the key-population programs (e.g., PrEP, self-testing). The lack of innovation limits the ability of Sri Lanka to develop and implement the adaptable KP programs that it needs for effective and sustained HIV prevention, testing and treatment.

The National HIV/STI Strategic Plan (NSP) for 2018-2022 cites the importance of innovation as a way to improve the HIV response. The importance of innovation was also highlighted in the

2014/15 and 2018 IBBS reports. However, there appears to be limited progress in implementing innovations, including approaches well-established in many countries around the world.

High level recommendation:

- Build on local knowledge and experience, including the direct and sustained involvement of representatives from the KP communities, to identify, develop and test alternative approaches to engage key populations with essential HIV services, including prevention, testing and treatment. Relevant international approaches (e.g., informal peer networks, expanded community-based services, consistent outreach, flexible/customizable activities by location and/or population) should be factored into the process, but they should be assessed — and adapted, as needed — in light of Sri Lanka's national and sub-national contexts and realities.

Proposed actions to address the recommendations include: 1) Set up a cross-cutting working group to consult with stakeholders and develop the strategy and corresponding protocols and/or standard operating procedures for the testing, approval, introduction and scaling up of innovations. 2) Establish a small *ad hoc* advisory group of qualified representatives from government, civil society and KP communities as well as local/international experts to provide support as needed to NSACP about relevant innovations**.** 3) Support a dialogue among key stakeholders to identify innovations that could be piloted and potentially implemented in Sri Lanka.

Support systems

Risk 7. Procurement processes

There is a risk that the protracted and complex procurement processes and the procurement of small quantities may result in stock-outs of required ARVs, and quality condoms and lubricants and other related commodities at STD centres.

The NSACP Annual reports for 2018 and 2019 noted the long time it took for the procurement process to unfold. Other issues include difficulties with estimating the mix of ARV regimen quantities, multiple agencies involved in procurement, small quantities and resulting poor response rate by international suppliers to tenders, barriers to participation by local vendors, examples of poor quality non-pharmaceutical products and a shortage of adequate, suitable storage space at national and STD centre levels. Although the risk of stockouts seems to have been reduced, the procurement of ARVs, health products and laboratory supplies remains cumbersome and protracted, and efforts to streamline the process would be beneficial and prevent potential disruption to service delivery.

High level recommendation:

- Streamline the procurement process for ARVs and other health commodities and develop mechanisms for the urgent procurement of small quantities of ARVs through local suppliers and reduce barriers to participation.

Proposed actions to address the recommendation include: 1) Evaluate and streamline existing procurement processes to reduce lead times and provide for input from all relevant stakeholders. 2) Explore the possibility of partnering with other countries for the supply of ARVs and other commodities. 3) Assess the value of using pooled procurement mechanisms to secure a timely supply of ARVs at an acceptable price. 4) Develop an accurate multi-year procurement plan.

Risk 8. Health Information Management Systems
There is a risk that a decline in external support may constrain the ongoing efforts to refine and scale up the NSACP-led Electronic Patient Management Information System (EIMS) to all districts, develop and implement the prevention information management system and diligently maintain these system.

The NSACP initiated development of an EIMS during 2017 with the support of the GF. The development of the EIMS, is still in progress and certain modules are not complete. The Global Fund continues to provide significant support for the development of information systems at the NSACP, including a standard M&E system for the KP program, and contributes to the maintenance and refinement of systems at FPA. NSACP does not currently have a dedicated M&E team to oversee implementation and conduct data validation visits and checks. There is currently no funding for the replacement of hardware and limited funding for systems-related training and supporting the on-line training platform. If a fully functioning HIMS is not established and maintained the effectiveness and efficiency of HIV response will be impacted.

High level recommendation:

- Use the current grant funding to ensure that the EIMS and the prevention information management system are fully installed and operationalized in all districts including training of key individuals in the districts.
- Motivate for the inclusion of adequate funding for ongoing maintenance of HIMS and training of staff in budget submissions to the MOH and ensure inclusion of the resource need in the business plan submission by MOH to the treasury to secure domestic funding.

The proposed actions to address the recommendations include: 1) Develop a plan to accelerate the implementation of the outstanding components of the EIMS, the prevention information management system and establishing inter-operability between these systems and the national health information systems. This may include the possible recruitment of TA to support the current service provider. 2) Secure sufficient domestic funding to maintain HIV-related HIMS systems. 3) Expand the capacity within NSACP, with suitably qualified HIMS systems support staff to reduce the dependency on externally funded service providers.

Risk 9. Research and evaluation activities
Essential, ongoing operational research and program evaluations and reviews are curtailed as external funding declines.

The current GF budget includes provisions for operational research, the mid-term HIV program review and developing geographical density maps to track intervention coverage and distribution of commodities. Other development partners, mainly UNAIDS and WHO, make valuable contributions by funding TA and research studies on an ad hoc basis such as this TRA study. The lack of accurate updates on data about key populations, KP services and progress against outcome and impact indicators impacts on NSACP's and other stakeholder's ability to plan and manage the response to achieve targets.

High level recommendation:

- Motivate for the inclusion of adequate funding in the MOH budget request to implement an agreed country HIV research, monitoring and surveillance agenda.

Proposed actions to address the recommendations include: 1) Consult with all relevant stakeholders to establish a comprehensive, multi-year research agenda listing required research, surveys and reviews to support monitoring, evaluation and planning for the HIV response. 2) Include an adequate provision for related funding in the MOH budget request and related business planning. 3) Develop strategies to build local capacity for research and evaluation activities.

Risk 10. Capacity to manage a complex KP-services program

NSACP does not have the capacity to manage, support and monitor the provision of HIV-related services to key populations by multiple CSOs and CBOs. Building this capacity within government may result in an expensive and bureaucratic approach to providing the oversight and support to the CSOs and CBOs implementing a KP-services program.

The lack of capacity within NSACP to provide oversight and support to multiple CSOs/CBOs, particularly smaller, KP-led or KP-focused organizations with their own capacity constraints, could undermine the partnership between government and civil society and reduce the effectiveness of the program. Without a robust and flexible system in place to support partner CSOs/CBOs, the ability of these organizations to provide vital services to key populations could be compromised.

High level recommendation:

- Government and civil society should develop and agree on a practical strategy and fully resourced operating plan for the management and oversight of CSOs and CBOs providing HIV-related services to key populations, which builds on the relative strengths of the involved organizations.
    - Proposed actions to address the recommendation include: 1) Use a qualified intermediary CSO to coordinate and manage the different CSOs and CBOs working on the HIV response with key populations (see Risks 12 and 15). 2)
    - Build the capacity of NSACP to handle direct oversight of an intermediary CSO and broad oversight over the full KP-services program, including key activities during the transition from GF funding to domestic funding and ongoing monitoring and evaluation activities (e.g., via a dedicated M&E team.).
    - Establish links between government and civil society partners to improve the understanding of respective roles and responsibilities and build a system of mutual accountability.

Risk 11. Understanding of the funding gap

There is a risk that a poor understanding of the total resources required to implement the HIV response makes it difficult to motivate for increased domestic (or external) funding to close the gap between current and expected funding levels and the total resource need.

Although a costing of the NSP was carried out, this was done as part of the preparatory work for the previous GF funding request and is not comprehensive. Many costing assumptions need to be updated mainly due to changes in KP service-delivery modalities, the need to increase coverage of KP services and improve case detection and the adoption of new and innovative interventions. Failure to develop an accurate estimate of the total cost of implementing the NSP may lead to resource mobilisation efforts which understate the funding requirement and funding gap. Insufficient resources for the HIV-response will have wide-ranging implications on the coverage and quality of services and may ultimately impact on the country's ability to sustain gains made and achieve NSP targets.

High level recommendation:

- Based on a refined HIV programme, which may include innovations, technical efficiencies and revised targets, estimate the total resource need and likely funding gap over the medium term.

Proposed actions to address the recommendation include: 1) Conduct a comprehensive costing of the HIV response based on a refined HIV programme. 2) Estimate the total, annual

funding gap over the medium term. 3) Motivate for increased domestic funding to cover the funding gap to secure stable and predictable funding for the HIV programme (see also Risk 14 below).

Civil Society Organisations

Risk 12. Funding mechanism for CSOs

An efficient financing and procurement mechanism for social contracting of CSOs to deliver HIV prevention services, including the timely transfer of funds, does not exist and may take an extended period of time to develop, approve and implement, assuming it moves forward at all. When external funding declines, it is possible prevention and treatment support services, which are implemented by CSOs and funded externally, will be scaled down or in a worst case discontinued, resulting in increased infections.

The Ministry of Finance has explored how to design, build and operate a CSO funding mechanism. While there are supporters of CSO funding in government, it is unclear if, how, when, in what amount and for how long these funds will be widely available as the transition from Global Fund to domestic financing moves forward. One of the most fundamental questions about the provision of public funds to CSOs for HIV-related work with KPs is the sustainability of those funds; see Risk 14.

High level recommendations:

- When external resources are reduced or are no longer available, the government will need to provide funding to CSOs for them to continue to play an integral role in the HIV response. In order for these funds to flow efficiently to CSOs, there needs to be a practical mechanism in place that meets the needs of both government and the recipient CSOs.
- Consider the use of a qualified intermediary CSO as the primary recipient of government funds, which it would then redirect to implementing CSOs. The intermediary CSO would also play a role in monitoring accountability of the use of funds; see Risks 10 and 15.
- Establish a small oversight board, including representatives from the Ministry of Finance, the Ministry of Health, NSACP and CSOs to monitor the operation and accountabilities of the funding mechanism

Proposed actions to address the recommendation include: 1) Explore different mechanisms that can be put in place to ensure the efficient and sustained flow of government funds to CSOs implementing HIV-related activities with key populations, including the use of an intermediary CSO; the mechanism should include reasonable accountability policies and procedures. 2) Consider developing criteria (e.g., minimum standards) that CSOs would need to meet to join the pool of organizations eligible to receive government funds; these criteria/standards must make reasonable allowances for small and/or nascent CSOs (e.g., KP-led organizations), which typically have lower capacity, to ensure they are not excluded from the pool. 3) Ensure government and civil society discuss the strengths and weaknesses of a proposed mechanism to make sure it is workable and sustainable.

Risk 13. Capacity of CSOs

CSOs have limited capacity at multiple levels of their operations, including governance, management, technical, implementation, accountability, resource mobilization and M&E. The limited capacity of these organizations has direct implications on their ability to function effectively, including undermining their ability to provide their clients with HIV services and to be reliable and accountable partners of government. The issue of limited capacity is particularly acute among KP-led organizations.

The limited capacity of CSOs working on HIV also raises questions about the effectiveness of capacity-building programs for these organizations and their leadership/staff. For example, there are complaints that capacity building focuses on trainings, not on longer-term approaches (e.g., mentoring, recurrent TA) that can make a more meaningful and sustainable contribution to CSO capacity across their operations.

High level recommendations:

- Develop and implement a comprehensive plan to strengthen the capacity of CSOs working with key populations on the HIV response.
- CSOs must be mindful of their responsibility to improve and maintain the quality of their performance in all aspects of their operations, including their accountability to both funders and clients.

Proposed actions to address the recommendation include: 1) Conduct a comprehensive capacity and capacity building needs assessment for qualifying CSOs. 2) Launch a collaborative initiative involving government, civil society, external funders and members of key populations to define and develop an effective and responsive capacity-building programs for CSOs working with key populations on the HIV response. 3) Review, redesign and implement tailored capacity-building activities to meet the needs of CSOs, including their ability to provide services and support to key populations. Capacity-building activities should focus on longitudinal support, not one-off activities; they should also consider the longer-term viability and sustainability of the participating CSOs. 4) Use robust self-assessment tools to monitor CSO performance, demonstrate their commitment and ability to strengthen their capacity and prove their accountability.

Risk 14. Predictable and sustained funding

Government may not be able to provide sufficient and sustained funding to civil society organizations for HIV-related work with key populations. With the decline in external resources allocated for CSOs to do HIV-related work with key populations, a lack of or limits on the availability of government funds for these activities could cripple the response for these populations.

Without predictable and sustained funding, CSOs with the expertise to work with KPs, including both KP-led and KP-focused CSOs, struggle to maintain the staff and infrastructure to provide consistent and effective services. Developing a sustainable, long-term approach to CSO funding is an important opportunity and outcome of a shift to the use of domestic resources for these activities.

High level recommendations:

- There must be a commitment by government to provide predictable and sustained funding to support CSOs working on the HIV response, including for continued HIV case detection and for effective, long-term prevention.
- Stakeholders in the HIV response for key populations should be strong advocates for long-term government funding for the comprehensive programs serving these populations needed to ensure Sri Lanka meets and maintains its 2025 HIV goal.

Proposed actions to address the recommendation include: 1) Identify and act on opportunities to advocate for sustained funding for CSOs implementing KP programs; where and when possible, these opportunities should be done as formal or informal collaboration between stakeholders. 2) Include specific lines for CSOs implementation of KP activities, including prevention, in annual budgets and the next NSP response resource estimate.

Risk 15. Relationships between government and smaller CSOs and CBOs

Government wariness about CSOs and CBOs, including their motives and lack of capacity, may adversely affect government's willingness to work with these organizations. In general, a trusting relationship between government and smaller civil society organizations has not been well established as part of the HIV response. This complicates discussions about the role of CSOs in the response as well as the government's readiness to provide funding for these organizations and its willingness to integrate CSO activities (e.g., peer-based programs) with their programs.

Trust — particularly in the areas of finance and accountability — is essential to a thriving CSO sector and any betrayal of that trust, even by a small number of organizations, can undermine the critical role that CSOs can and should play in the HIV response.

High level recommendations:

- The long-term effectiveness of the HIV response for key populations depends on a productive and mutually trusting relationship between government and the CSOs/CBOs implementing HIV activities. Consequently, steps should be taken to identify and address any issues that have the potential to undermine this relationship.
- Consider the use of a qualified intermediary CSO to coordinate and manage the different CSOs working on the HIV response with key populations; see Risks 10 and 12.

Proposed actions to address the recommendation include: 1) Develop a practical framework for building and maintaining a productive partnership between government and civil society that will ensure the delivery of relevant, high-quality HIV-related services to key populations; the framework should also be the basis for the necessary policies, procedures, systems and structures to manage and implement the partnership. 2) Establish links between government and civil society partners to improve the understanding of respective roles and responsibilities and build a system of mutual accountability; this same action is proposed under Risk 10.

Risk 16. KP-led organisations and networks

A shortage of KP-led and/or KP-focused organizations in the country complicates efforts to connect with these populations. For example, the lack of viable national networks and/or umbrella organizations for CSOs working with key populations is problematic as is the absence of KP-led and/or KP-focused CSOs in some parts of the country. KP-led and KP-focused organizations generally provided key populations with a stronger, more representative voice in broader discussions about priorities and resources in both government and civil society circles. Without these organizations, the engagement of key populations is diminished, which is particularly problematic in a country with pervasive stigma and discrimination towards these populations. The effectiveness of KP programs will be reduced.

High level recommendation:

- Develop and implement a strategy to increase the number and capacity of KP-led and KP-focused CSOs with the capacity to meet the criteria to receive government funds and to play significant roles in the HIV response, including networks for KP organizations.
- Identify one or more established and effective CSOs in Sri Lanka with experience working with key populations to lead the initiative to develop and implement the strategy to increase the number of KP-led and KP-focused CSOs; wherever possible, the priority should be to add KP-led organizations.

Proposed actions to address the recommendation include: 1) Assess the scale and scope of the need for KP-led and KP-focused organizations to determine the priorities for addressing the shortage (e.g., by type (organization, network), by population, by location, by demand for

services/support); this assessment should directly involve members of key populations to understand their needs and perspectives. 2) Work with credible and accountable members of key populations to build support within the population to help catalyse and nurture the development of new organizations and networks. 3) Conduct an independent assessment of the performance (i.e., strengths and weaknesses) of existing KP-led and KP-focused organizations to learn from their experience. 4) Establish a set of criteria to ensure that qualifying KP-focused organizations have the requisite attitude, knowledge and skills to provide appropriate services and support to key populations; their ability to connect with a key population in open, non-stigmatizing ways is essential.

Conclusion

Significant support has been provided by the government and development partners, but the largest ongoing *external* contribution has been provided by the Global Fund to support the CSO-led HIV interventions over many years. The country's progression to middle income status (temporarily halted as a result of the COVID-19 pandemic), means that support from the Global Fund will be phased out and responsibility for funding the HIV response will transition to the government of Sri Lanka.

The absolute number of new infections is extremely low. It is important to sustain prevention services, best delivered through innovative interventions and partnerships between community organisations and government services to protect gains made and prevent an increase in incidence.

The transition readiness assessment examined the HIV response and support systems to identify areas of vulnerability or risk, which if not addressed, will pose obstacles to transitioning and will likely erode gains made. The TRA identified 16 important risk areas which need to be addressed to facilitate transitioning over the next 5 years. These risks were categorized into four main groups being governance and leadership, service provision, support systems and participation of civil society organisations.

Work on implementing the proposed actions for all risks and recommendations should commence as soon as possible, given that these need to be investigated and unpacked further, proposed solutions and mechanism need to be developed and tested, an enabling environment established (e.g. regulations and SOPs) and then fully 'bedded down' before the next GF implementation period ends at the end of 2024. Rapid implementation will also improve chances of achieving the ending AIDS goal by 2025. The National STD/AIDS Control Programme is ideally positioned and is mandated to drive the implementation of the actions in close collaboration with the multi-sectoral sustainability working group and with the support of all stakeholders.

1 Background

Sri Lanka is an island with approximately 21.4 million people[1] and is located south east of the Indian sub-continent. Sri Lanka has shown steady growth over the last decade although key macroeconomic challenges persist. Until recently, Sri Lanka was a middle-income country with a GDP per capita of USD 4,102 (2018)[2] but was reclassified as a lower middle-income country on 1 July 2020, largely due to the economic impacts of the response to COVID-19. Sri Lanka's economy grew at an average 5.6% during the period of 2010-2018, although growth has slowed down in the last few years to ~3.2%. The economy is transitioning from a predominantly rural-based economy towards a more urbanized economy oriented around manufacturing and services.

Sri Lanka is classified as a low-level epidemic country and the total number of people living with HIV is estimated at 3 600[3] with most infections concentrated amongst key populations. Total adult prevalence (15-49 years) is less than 0.1%[4]. Sri Lanka has adopted the sustainable development goal (SDG) target of "End AIDS by 2030" and has accepted the challenge of achieving this target five years before the rest of the world, i.e. by 2025. The National STD/AIDS Control Programme (NSACP) is a government institution in the Ministry of Health, (MOH) and is responsible for leadership and guiding the national response to HIV and achieving its ambitious goals.

Significant achievements have been made in the fight against HIV but a review of the epidemiology (see below in section 3) shows that there is a need to find the missing cases (64% of the estimated people living with HIV know their status) and there is room for improvement in linking people with HIV to treatment and care which was reported at 51% in the 2019 Annual report of the NSACP. The Government of Sri Lanka (GOSL) has led the HIV/AIDS response in the country with significant support and contributions from local Civil Society Organizations (CSOs) and through funding and technical support from development partners (see section 3.5 below). The costing of the National HIV/STI Strategic Plan, Sri Lanka. 2018-2022 (NSP) estimates the total resource requirement for implementing the plan at approximately $11million to $12million per annum ($59.9 million in total over 5 years) of which $13 million has been allocated to 'Prevention'; between $2 million and $ 3.7 million per annum. According to the data from NSACP, domestic funding for the AIDS response has increased from $1,6 million in 2016 to $4 million in 2018. Importantly, the GOSL is the sole supplier of ART (including procurement of all ARVs) and treatment of co-infections and has borne a major portion of the costs of STI screening, diagnosis and treatment.

International funding for the HIV response comprises significant contributions by the Global Fund to fight HIV, TB and Malaria (GF), whilst technical support for improving the laboratory, strategic information & capacity building of the community-based organizations was supported by FHI 360 (with US government funding) and CDC India during 2018-2019. Funding from the Global Fund has declined over the years and this trend is likely to continue until the final transition grant.

[1] United Nations Population Data (www.data.un.org)
[2] https://www.worldbank.org/en/country/srilanka/overview; in 2020 per capita income was $ 4 020
[3] NSACP Annul Report 2019, Chapter 3
[4] NSACP Update Quarter 3, 2019

Due to rapid and sustained economic growth, Sri Lanka's reached upper-middle-income (UMI) status in 2019 but was re-classified to lower-middle-income status in July 2020[5]. This transformation together with a concentrated epidemic has resulted in Sri Lanka being included in the list of countries which must prepare for transitioning from GF support[6]. The total value for the signed grants for the 2019-2021 implementation period (period II) is $6.9 million, a more than 30% decline from the previous implementation period (2016-2018) that reflected grant confirmation values of $10.8 million[7]. The allocation for the next funding cycle (2020-2022) reflects an envelope of $6.4 million for HIV. The GOSL is not unaware of the inevitable transition, and in its current GF proposal for 2019-2021, included transition planning for key population (KP) interventions, showing the district activities which will gradually be transitioned to the GOSL each year. Planning for transitioning from Global Fund (GF) funding support is also a priority and the GF Technical Review Panel specifically asked for the completion of a Transition Readiness Assessment (TRA). In response, the NSACP, through the MOH, requested UNAIDS to support this process and the preparation of a TRA report.

Given that the ART program is largely funded from domestic sources, declining international financing poses a risk mainly for sustained and uninterrupted case finding, prevention interventions aimed at key populations, strengthening of laboratory services for detection and management, monitoring of PLHIV on ART and for managing the complex surveys and other data related interventions. There is a need to plan for transitioning from external funding to mitigate this risk. To steer the HIV response towards a smooth transition, the NSACP established the Technical Working Group on HIV Transition Readiness and Sustainability Planning (TWG) to guide Sri Lanka's transition to full domestic funding. This includes oversight of the current "Transition Readiness Assessment" assignment and the development of a roadmap of corrective actions which will respond to transition risks and contribute to the establishment of a sustainable HIV response.

1.1 Purpose of assignment

This assignment seeks to contribute to a broader initiative to improve and ultimately establish the sustainability of the HIV response in Sri Lanka. As noted above, a transition readiness assessment makes a valuable contribution to this process by identifying key areas of risk and vulnerability of the HIV response to declining external support. Importantly, the identification if these risks focuses the attention on developing suitable responses to mitigate against these risks to facilitate a smooth transition from external support. The purpose of the assignment as described in the terms of reference is to:

- Conduct a transition readiness assessment (TRA) to support Sri Lanka in preparing for transition. The TRA will be done in consultation with the Government (NSACP and Ministry of Finance), Global Fund and other donors and technical partners (UNAIDS, UNFPA, WHO), civil society, and other stakeholders. The TRA will be guided by the multisectoral, multi-stakeholder Technical Working Group on Transition and Sustainability
- Based on the findings of the assessment, develop a set of priority actions to address and / or mitigate the major risks and vulnerabilities towards a smooth transition and sustainable AIDS response

[5] Sri Lanka was downgraded to Lower middle-income country on July 1, 2020 by the World Bank. https://datahelpdesk.worldbank.org/knowledgebase/topics/19280-country-classification. It is not clear how this will impact on the list of transitioning countries.

[6] GF STC Policy guidance, 2019

[7] For the implementation period I, the signed grant amounts reflected on the GF website are in total $8.7 million. The *confirmed* grant values have been used above as an indication of available resource.

- Conduct comprehensive cost-effectiveness analysis of the three different services delivery models to meaningfully inform the transition readiness assessment and the related roadmap and activities

1.2 Expected deliverables and results

The deliverable and results for the TRA assignment comprise the following:

- An inception report,
- Final transition readiness assessment report that identifies the gaps and challenges, potential risks (system, financial, program management & service delivery capacity, governance, etc.) and opportunities in sustaining the AIDS response in Sri Lanka with recommendations on risk mitigation measures, and a
- Transition and sustainability roadmap with details on how transition risks identified during the assessment will be addressed or mitigated and what steps are needed for this.

The TRA report outlines the process of assessment, methods used, and provides clear and tangible actions for risk mitigation. The structure of the report is based on the TRA guidance modules as described in the ACESO / APMG transition risk assessment tool[8] but will be refined to reflect the focus areas of this assignment and facilitate a logical and understandable flow.

It is further noted in the TOR that recommendations from the TRA will help GOSL to maximize the use of existing skills, resources and assets to specifically implement efficient and effective service delivery modalities to key populations and other risk populations, strengthen and expand quality and coverage of HIV treatment to newly detected HIV positive people to achieve Sri Lanka's Ending AIDS Targets by 2025. The assignment will explore available modalities that can be introduced to create social contracting frameworks and / or partnerships with CSOs and CBOs for providing services for key populations and PLHIV including a comment on "public utility" status for CSOs / CBOs.

The TRA will ultimately support the country in the scaling up the prevention and treatment continuum in a sustainable manner and will help inform investment decisions and efforts to improve the quality, efficiency and sustainability of the HIV response beyond Global Fund financing.

1.3 Structure of this report

This structure of this report was developed to reflect the guidance provided by the ACESO / APMG transition readiness assessment tool. Section 1 provides some contextual background while Section 2 briefly describes the methodology. The methodology is comprehensively described in the inception report. Section 3 provides country context including a brief overview of the health system, the HIV epidemiology, the NSP interventions and external support for the HIV response.

Section 4 provides a detailed description of HIV services with a focus on the modalities for providing KP-related services but also describes other HIV services and support systems. Although not a focus of this report Section 5 provides information on the macro-economic indicators and total health expenditure and the public financial management system. Section 6 describes civil society involvement in the HIV response and related issues.

This report has identified transition risks and high-level responses and presented these in three grouped risk tables: 1) governance and response coordination at the end of that section,

[8] Guidance for the Analysis of Country Readiness for Global Fund Transition.

2) Health services and support systems at the end of Section 4 and 3) civil society related risks at the end of Section 6. Section 7 provides a short conclusion.

Detailed information on stakeholders consulted, a breakdown of the current GF grant, a detailed description of the epidemiology, selected survey data and contextual tables for the four focus districts are included in the annexes.

2 Methodology

Given the context of the Sri Lanka HIV response and discussions with stakeholders, a focused approach was adopted and not every element of readiness was examined in detail. The scope of the assessment was also guided by the ACESO / APMG transition readiness assessment tool[9] and the Diagnostic Tool on Public Financing of CSOs (Social Contracting Tool). These tools provide valuable guidance and accommodate a more focused approach. Notwithstanding the change in approach necessitated by the COVID-19 travel restrictions as described in the inception report and summarised below, this assignment continued to focus on the different service delivery modalities for KP services. The TRA developed a good understanding of the known service delivery modalities for KPs services as described in section 6 and assessed the cost efficiency and effectiveness of each through a case study approach and compared the advantages and disadvantages of each in a given context. Closely related to this assessment, possible operational arrangements between government and CSOs were considered. In addition, work included a review of the institutional arrangements and governance and leadership structures. Throughout the assignment, every effort was made to implement a process that facilitated the participation of all relevant stakeholder, despite the travel restrictions imposed by the COVID_19 response.

The assignment methodology provides for three phases. These are depicted in the figure below and comprise the following:

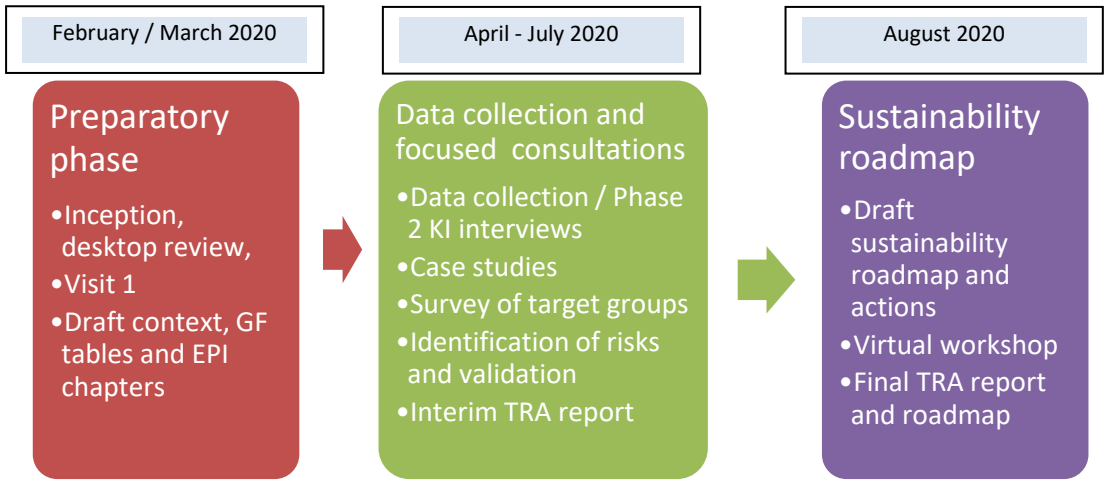
- **Phase I:** A preparatory phase which included a country visit, a detailed desk-top review of existing research materials, progress reports, financial reports and published literature, a task which continued throughout the assignment. Key informant interviews were conducted with numerous stakeholders (see Annex 1),
- **Phase II:** A data collection and analysis phase which in the absence of a second visit (see below), included virtual key informant interviews, case studies in four districts and a virtual survey of civil society organisations (CSO), managers and front-line workers in government and civil society and beneficiaries and a detailed interrogation of expenditure reports. Key objectives of this phase were to describe existing risks (immediate and long-term) to a sustainable HIV response in Sri Lanka and make recommendations[10] with respect to appropriateness of prevention and case finding service delivery models.
- **Phase III:** This phase provides for the ranking of risks in terms of their impact and the development of next steps in line with high-level recommendations, which if implemented, will mitigate for the risk and will improve the countries readiness to transition from Global Fund and other partner support. This phase initially included a third country visit and provided for a workshop with stakeholders, which was not possible. Three virtual workshops were conducted with government and civil society stakeholders to discuss the risk, recommendations and next steps.

[9] Guidance for the Analysis of Country Readiness for Global Fund Transition.
[10] Adapted from the original terms of reference

The rapid response by many countries to the COVID19 pandemic resulted in extensive travel restrictions and in Sri Lanka, include a 'Stay-at-home' policy for all citizens. This made the originally proposed 'Visit 2' impossible. In addition, many health workers and officials were focused on preventing and managing the expansion of COVID-19 infections and patients. Visiting health facilities and holding group meetings was not be possible. The COVID context also limited the ability of country stakeholders to fully engage in consultations as many of the key stakeholders, responsible for overseeing the HIV response, were charged with tackling additional challenges brought on by COVID-19.

The second phase of data collection was implemented **entirely through remote interviews** with key informants at all levels of the health system and the implementation of an electronic survey for four target groups. The surveys were developed and adapted for use on mobile devices and provided mainly qualitative responses. It is important to note that the survey was not designed to generate a representative sample of results but to replace the interviews and group sessions that would have been held, had the second country visit materialised. Nevertheless, the surveys provided valuable insights and corroborating evidence for opinions expressed in KII and the findings of research reports.

Figure 2-1: Transition readiness assessment – process overview



As part of Phase II, the TRA undertook case studies in four districts to explore the integrated dynamics of the HIV programmes. These case studies looked at the programmes from the perspective of the facility management, the implementing organizations (i.e., government and civil society) and clients. This work informed the answers to two overarching questions:

1. Do any of the models meet the needs of the KPs given a specific context?
2. What is the overall cost to support KP prevention and treatment support services?[11]

The district context considered 1) the different HIV-related services available to clients (e.g. prevention, testing, treatment, quality) and related implementation structures; 2) the demographics and number/percentage of clients accessing services, 3) availability of output and financial data and 4.) the distribution/use of commodities (e.g., condoms, test kits, ARVs).

[11] As noted above, our work did not answer this question fully but provided useful input for our analysis and a full costing should be carried out as a separate costing study if deemed beneficial.

Within this context, and guided by relevant sections of the social contracting tool, key informant interviews and a review of available documents were used to develop a detailed understanding of:

- The level of planning, coordination and effort by the implementing organizations providing services to KP target groups, with a focus on the frontline staff who are actively providing services to clients
- General spending data (e.g., institutional overheads, human resource costs, commodities) and sources of funding for KP services. Where sufficient data is available unit cost indicators will be calculated specific to that district and its implementers.
- The KP service delivery modality (e.g., the case-finder model in use in Colombo) in the local context and where possible, compare approaches and activities, especially in districts where government and civil society are both implementing programmes,
- As the STD centre burden has increased with community-based prevention programmes for KPs, surveys included questions to help understand the impact of patient burden, identify the risks related to quality and coverage of services provided by the STD centres.

Case studies are indicative and not definitive. For example, government expenditure records do not provide activity specific data and it will not be possible to provide detailed, comprehensive cost-effectiveness data (using full economic costs), but interviews and surveys provided a useful perspective on how resource commitments contribute to outcomes.

The final selection of districts was done in collaboration with UNAIDS, the GF and NSACP representatives. Districts were included which allow us to cover both service delivery modalities and to create opportunities for comparisons by selecting districts in which both PRs were active during 2019. These criteria limited the districts that the could use for the case studies. Given the criteria the following four districts were selected:

1) **Colombo**, where civil society (FPA) implements the case-finder model to provide services to MSM, FSW, PWID and TG populations,
2) **Matara**, where FPA works with FSW and government works with tourism service providers (Beach Boys) and both use the refined peer educator model,
3) **Kurunegala**, where government works with MSM and FPA worked with FSW during 2019 also using the peer educator model,
4) **Kalutara**, where the case finding model was first piloted in implemented during 2018 but where Government NSACP currently implements the Peer Educator model for MSMs while FPA implements peer educator model for FSWs and BB.

3 Country context

3.1 Brief overview of the health system

Sri Lanka has made impressive gains in health outcomes and in ensuring access to health services for all, compared to most low and lower-middle-income countries. This section provides a brief overview of the health context in Sri Lanka

Table 3-1: Basic Statistics related to health of Sri Lanka and selected countries[12]

Indicator	Sri Lanka	Maldives	Banglad esh	Vietnam	Thailand	Malaysia	Australia
Income Group (WHO categorization)	LM	UM	LM	LM	UM	UM	HI
HDI ranking	76	101	136	116	83	57	3
Population (million)	21.7	0.56	161.4	95.5	69.4	31.5	25.0
GNI per capita (Atlas Method)	4 060	9 280	1 750	2 360	6 610	10 590	53 230
Life Expectancy at Birth	77	78	72	75	77	75	82
Total CHE on Health as a % of GDP (2017)	3.8	9.0	2.3	5.5	3.7	3.9	9.2
Per Capita Current expend. on Health (USD)	160	1007	36	130	247	384	5332
OPE expenditure (% of total exp. on health) (2014)	42.1	18.3	67.0	36.8	11.3	35.3	18.8
UHC Index[13]	66	62	48	75	80	73	87
HAQ Index (from 1990 to 2016)[14]	71	72	133	108	76	84	5

The life expectancy of females is 78.6 years while that of men is 72.0 years in 2011 to 2013 with a male-female life expectancy gap of 6.6 years in 2011[15]. The Total Fertility Rate (TFR) is

[12] HDI Rankings obtained from http://hdr.undp.org/en/composite/HDI and other data from http://data.worldbank.org

[13] UHC service coverage Index is defined as 'Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. The tracer indicators are as follows, organized by four components of service coverage: 1. Reproductive, maternal, new born and child health 2. Infectious diseases 3. Noncommunicable diseases 4. Service capacity and access [See the WHO UHC 2019 monitoring report (https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf) for the tracer indicator within each component]'. Accessed on May 15, 2020 from https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4834

[14] *GBD 2016 Healthcare Access and Quality Collaborators,* Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016; The LANCET, Vol 391 June 2, 2018 (2236-2271); www.thelancet.com. Accessed on March 30, 2020 from https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2930994-2. The Healthcare Access and Quality (HAQ) Index provides a summary measure of healthcare access and quality for a given location. This measure is based on risk-standardized mortality rates or mortality-to-incidence ratios from causes that, in the presence of quality healthcare, should not result in death – also known as amenable mortality. HAQ is reported on a scale of 0–100, with 0 representing the worst levels observed from 1990 to 2016, and 100 reflecting the best during that time.

[15] Sri Lanka Life Expectancy Tables, 2011-2013, Census and Statistics Department. http://www.statistics.gov.lk/PopHouSat/CPH2011/Pages/Activities/Reports/FinalReport/LifeTables.pdf.

at 2.2 children per woman[16]. The maternal and infant mortality has reduced to 25.7 per 100 000 live births and 8.5 per 1 000 live births, respectively. Most of the vaccine preventable diseases are at near elimination stage with immunization coverage at more than 99%[17]. malaria, filaria, poliomyelitis, maternal and neonatal tetanus were certified by WHO as eliminated diseases in Sri Lanka in 2016. The Universal Health Coverage (UHC) index is 66% and the Healthcare Access and Quality (HAQ) index is at 71%. This may be reflective of the much lower per capita current health expenditure (in neighbouring UM income countries) rather than gaps and inadequacies in the system and the institutional structure that is in place in Sri Lanka.

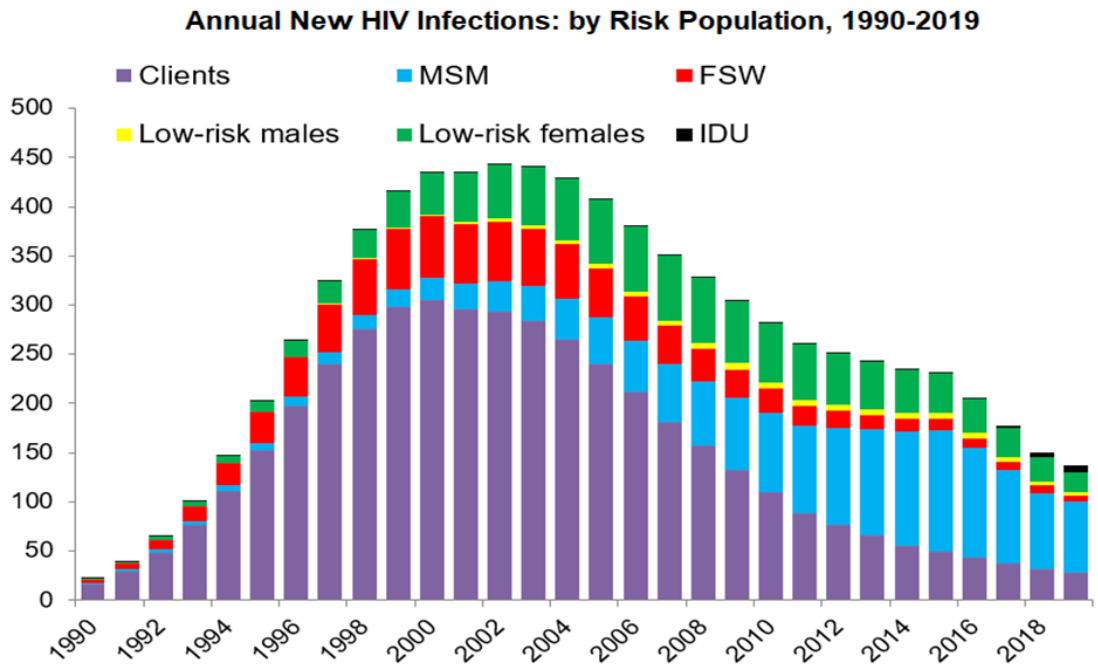
3.2 Summary of HIV epidemiology in Sri Lanka

3.2.1 Current and projected burden of disease

Sri Lanka has a low HIV prevalence at 0.02 HIV positive people per 100 000 population (0.01 per 100 000 blood donors and 0.003 among pregnant women). The HIV epidemic is concentrated among some KP groups. The prevalence of HIV amongst men having sex with men (MSMs) and trans gender women (TGW) is at 1.5% and 1.4% respectively. The prevalence amongst female sex workers (FSWs) is at 0.1 per 100 000 population.

In 2019, 20 years since the first HIV positive person was detected, it is estimated that there are approximately 3 600 (range 3200 to 4200)[18] persons living with HIV (PLHIV).

Figure 3-1: Current HIV burden by risk groups in Sri Lanka 1990 to 2019 (AEM estimates)

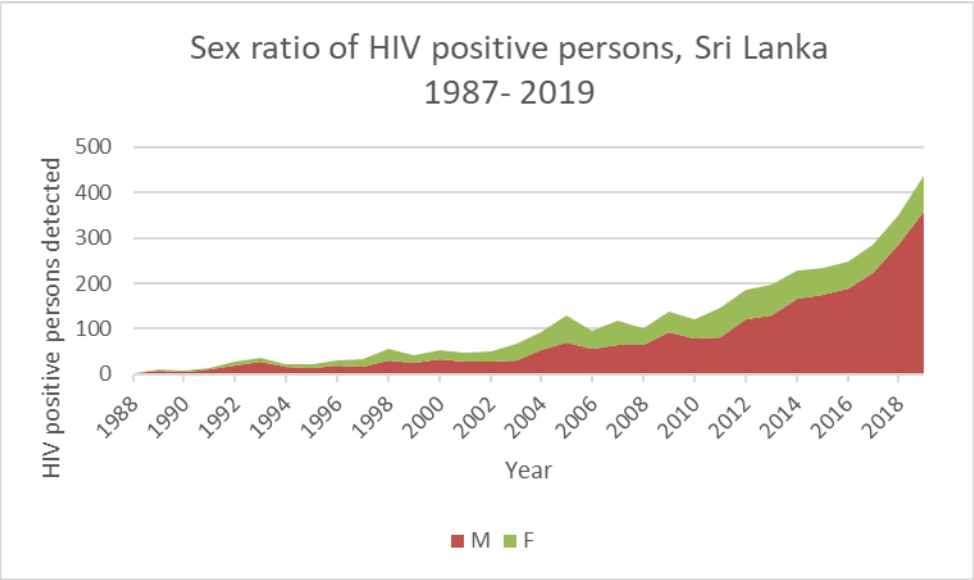


[16] Demographic and Health Survey, Sri Lanka 2016, Department of Census and Statistics and Ministry of Health, 2017

[17] Annual Health Bulletin 2017. Medical Statistics Unit. Ministry of Health, Colombo, Sri Lanka.

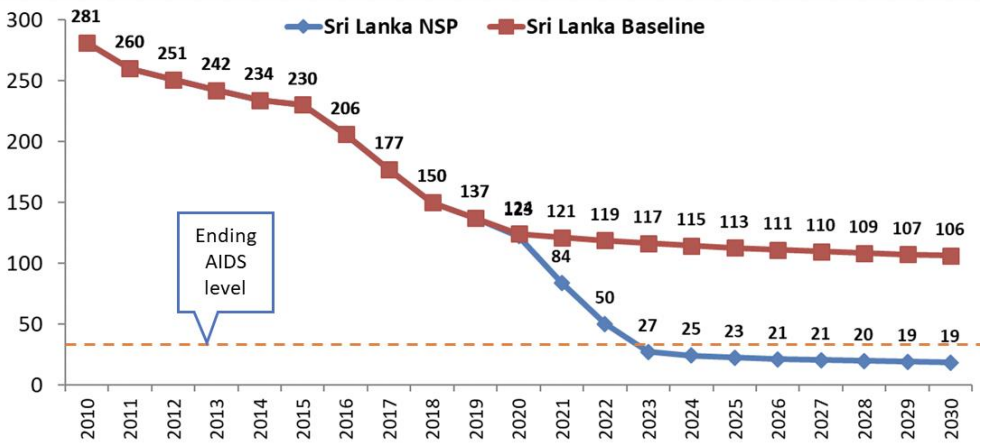
[18] The latest AEM estimates indicate that this has increased to 3600. Technical Report on HIV estimates in Sri Lanka, March 2020. Accessed from https://www.aidscontrol.gov.lk/images/pdfs/publications/other_doc/AEM-HIV-Estimation-Report-SriLanka-2019.pdf

Figure 3-2: Current HIV burden by sex 1987 to 2019 (actual numbers)



It is postulated that the HIV epidemic peaked in the 2000 to 2004 period and is currently on a downward trend. The epidemic is concentrated amongst men (Figure 3-2) and specifically amongst men having sex with men (MSM) (Figure 3.1). New infections amongst female sex workers (FSWs) and their clients and low risk males and females are reducing and are currently extremely low (Figure 3.1).

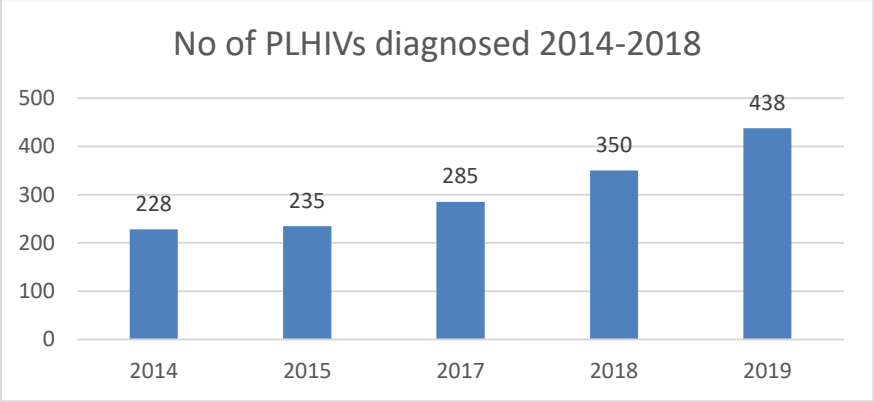
Figure 3-3 Projected trend in new infections – actual vs NSP target



Note: the dotted line represents a value of 28

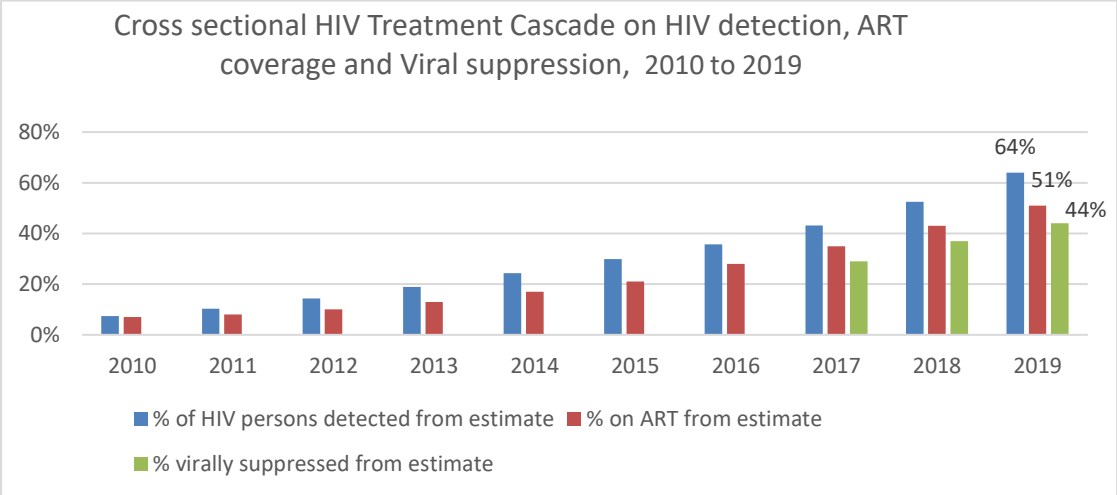
It is projected that the HIV burden will continue to increase and the case load will remain in the range of 110 new infections each year from 2019 onwards. As shown in the figure above, if the interventions are not changed to significantly reduce the number of new infections to levels targeted in the National Strategic Plan 2018 to 2022, Sri Lanka will not be able to meet the ending AIDs goal in 2025 or even by 2030

Figure 3-4: Number of new HIV cases detected (2014-2019)



Of the 3 600 estimated HIV persons living in Sri Lanka, 2 302 persons (64%) know their HIV status and approximately 1 298 persons (36%[19]) are estimated to be living in the community without knowing their HIV status. Of the 2 302 who know their status, 1 845 persons (51%) are under care and treatment, and it is estimated that as many as 1 755 people (49%) are not on HIV treatment and care and only 1 587 persons (44%) are virally suppressed. Cumulatively, a total of 516 AIDS deaths were reported during this 20-year period up to end of 2019. Significant progress is therefore required to achieve the three 90s target by 2025 and the 95-95-95 target by 2030. The number of PLHIV who do not know their status is of concern and indicates that there is an undiagnosed, undetected proportion of people, most likely belonging to key population groups, hidden (intermingled) within the general population. One of the main challenges for the programme is to find these undiagnosed HV positive persons form the community.

Figure 3-5: HIV Treatment Cascade Trend on HIV detection, ART coverage and Viral suppression, 2010 to 2019



Note: Percentage values refer to % of total population of PLHIV

It is evident that Sri Lanka has been able to increase the proportion of detected HIV positive persons who know their status from a low of 35% in 2016 to 64% in 2019. Approximately 80%

[19] All percentages calculated as a percentage of the total estimate of people with HIV.

of the detected PLHIVs (which is only 51% of the estimated PLHIVs in the country) are enrolled on ART. This indicates that, even though Sri Lanka has been able increase the detections of HIV positive persons to 64% of all estimated PLHIV, a significant proportion are never registered for ART, have died from AIDS or another illness or are lost to follow up.

The cohort analysis of the treatment cascade, introduced to monitor this progress since 2013, shows that in the last 5 years, major improvements in meeting the 90 -90-90 targets have been made. Of the 2018 cohort of 350 PLHIVs who were detected, 334 (95%) persons were registering in the HIV clinics (know their status) and among them, 302 (90%) had started on ART and 270 (81%) were virally suppressed at the end 2019. One person stopped therapy within that year. There were 16 people (4.7%) lost to follow up and did not register at the centre while another 15 (4.5%) persons had died during the year of diagnosis. The 2017 Cohort reflects similar trends.

The longitudinal data of the annual cohorts indicate that deaths due to AIDS is in the range of 4-5% of the number detected for that year and that a similar proportion of 4-5% of the new detections are lost to follow up in the first year of care. This indicates that the HIV programme may have achieved the 90-90-90 target for specific cohorts in recent years. Given that more than 50% of annual new detections have low CD4 counts, the proportion of deaths (referred to above) may be underestimated when using cross sectional data.

3.2.1.1 HIV new case detection

The NSACP, the National Blood Transfusion services, private sector laboratories, and other partners carry out HIV screening service in Sri Lanka. HIV confirmation is carried out only at the National Reference Laboratory of the NSACP. The STD centre sample data indicates that approximately 30 000 (16%) of STD centre samples were from KP groups. By far the majority of tests are carried out using the ELISA test and the use of rapid diagnostic tests (RDT) is largely limited to testing KPs during outreach, testing at drop-in centers and the screening of hospital patients.

Table 3-2: No of HIV tests and positivity rates, 2019, Sri Lanka

Category of sample tested for HIV (excludes Private Sector data)	Type of Test used most often	No of Tests (%)	No Positive for HIV (% from total Positive)	% HIV Positivity Rate
Blood donor screening	ELISA	444 915 (41%)	43 (9.8%)	0.01%
Antenatal mothers screening	ELISA	333 964 (30.8%)	10 (2.3%)	0.00%
STD Clinic Samples*	ELISA and Rapid Tests	193 247 (17.8)	198 (45.2%)	0.10%
Private Hospitals, Laboratories, Jayawardenapura GH,	ELISA and Rapid Tests	Data not Available	102 (23.3%)	Data not available
Tri Forces personnel screening	ELISA	63 946 (5.9%)	7 (1.6%)	0.01%
Screening suspected hospital patients (Rapid tests are used)	Rapid Tests	22 625 (2.1%)	56 (12.8%)	0.25%
Screening prisoners via HIV testing programme	ELISA	17 024 (1.6%)	11 (2.5%)	0.06%

Screening TB patients (at TB Clinics) (ELISA is used)	ELISA	7 690 (0.7%)	10 (2.3%)	0.13%
Drop-in centres (Rapid Tests are used)	Rapid Tests	722 (0.1%)	0	0.00%
TOTAL		**1 084 133 (100%)**	**437 (100%)**	**0.03%****

* STD clinic samples include clinic attendees, pre employment screening, outreach samples, and testing of contacts.
**Positivity rate excludes private sector data as the total number of samples done in the private sector is not available.

The number of HIV screening tests carried out among suspected hospital admitted patients, key population groups, higher risk and the general population (blood donors, antenatal mothers) have increased to more than 1 million tests each year. Of the STD centre samples, only 16% (30,598 samples) were from KP populations and more than 50% of these were from prison inmates. The newly identified HIV positive persons increased 75% (from 249 cases in 2016 to 438 in 2019) (Figure 3.1) (Annual Report NSACP 2019). As many as 54% of the newly detected HIV positive cases had a CD4 cell count below 350, indicating that a significant proportion of the newly detected PLHIVs are not new infections. Approximately 32% (140 persons) of all 438 newly detected had a CD 4 count below 200 indicating that as many as one third of new detections in 2019 have presented with AIDS.

The increasing trend of detecting more HIV positive persons each year (Figure 3-1), with the majority having low CD 4 counts, is most likely due to the increased case detection through intensified HIV testing rather than an actual increase in HIV incidence[20]. It is also important to note that most of the new cases are men and most are members of the MSM population. New case detections and modelling seem to suggest that this trend will continue with most new cases being recorded in the MSM population[21].

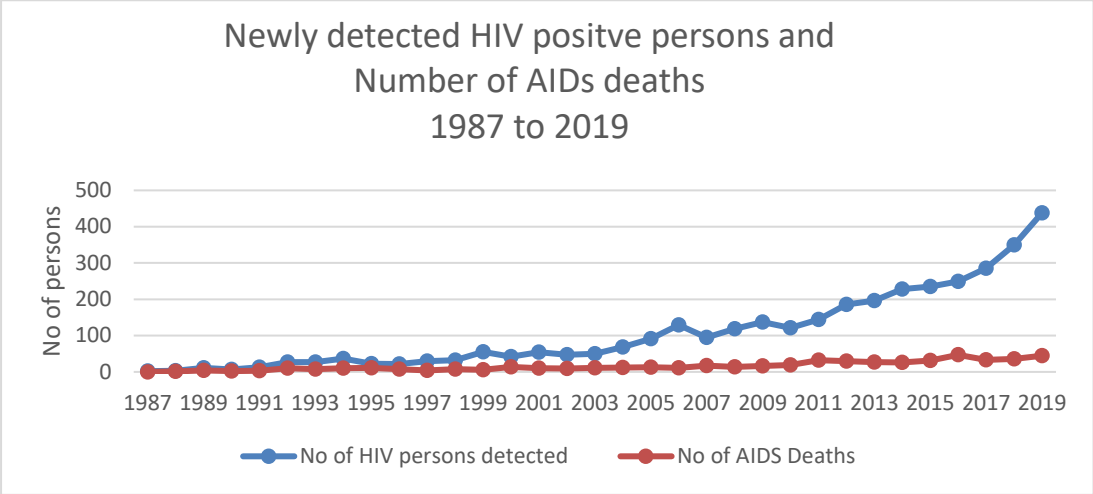
It is important to note that no new cases of mother to child transmission were reported after 2017. This is due to the introduction of the elimination of the mother to child transmission programme (EMTCT) in 2016 with more than 90% screening for HIV of all pregnant women at an early stage of the pregnancy and by ensuring that 100% of the HIV positive mothers are benefitting from treatment and care.

The number of AIDS deaths has remained static. It is likely that some AIDS related deaths were misclassified under other causes of death. It is also possible that the AIDS related deaths have reduced with increased management coverage and access to care and treatment for HIV positive persons. Some of the reasons for misclassification of AIDS deaths could include the stigma associated with the disease and low coverage of country-wide cause of death data classification.

[20] NSP External Review Report 2017

[21] We are not able to obtain a detailed breakdown of actual annual and cumulative new cases by population groups.

Figure 3-6: No of HIV persons detected and AIDS deaths in Sri Lanka (1987 - 2019 per annum)



(Data Source: Annual Reports-NSACP from 1987 to 2018 and 2019 data from NSACP Epidemiology unit).

3.2.1.2 Key population groups for HIV in Sri Lanka

The key populations (KPs), identified by the National HIV/STI Strategic Plan, Sri Lanka, 2018-2022, are men who have sex with men (MSM), transgender (TG) persons, female sex workers (FSW), people who use drugs (PWUD) /people who inject drugs (PWID), beach boys (BBs) and prisoners[22]. In Sri Lanka, the defined key populations and their estimated population sizes are given in the table below.

Table 3-3: Sri Lanka key population size estimates and coverage of KPs in 2018/2019

Key Population Groups	Estimated population size (2018)	Estimated Reachable / Hidden Population[23]	Range (Number of people)	Number of people tested in 2019 (coverage)
Female Sex workers (FSW)	30 000	30% / 70%	20 000-35 000	4 893 (25%-14%)
Male Sex workers (MSW)	6 000	75%/25%	4 000-8 400	NA[24]
Men who have Sex with Men (MSM)	40 000	35%/65%	30 000-50 000	5 746 (19% -12%)
People who Inject Drugs (IDU)	900	70%/30%	650-1 200	135[25] (21% - 11%)
Trans Gender Women (TGW)	2 200	55%/45%	2 000-3 500	581 (29% to 17%)
Tourism Service Providers (Beach Boys) (BB /TSP)	4 500	65%/35%	3 000-6 000	819 (27% to 14%)
All KPs	83 600	55%/45%	59 650 –104 100	12 039 (20% to 12%)

(Data source: Report on Key Population Estimates for Sri Lanka June 2018, Integrated Bio Behavioural Surveillance 2017/2018 and NSACP Annual Report 2019)

[22] National STD AIDS Control Program, National HIV/STI Strategic Plan Sri Lanka 2018 – 2022, 2017

[23] Key Population size estimation Report, NSACP, July 2018. Accessed from http://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Final-draft-report-Key-Population-Size-Estimation--2018July.pdf

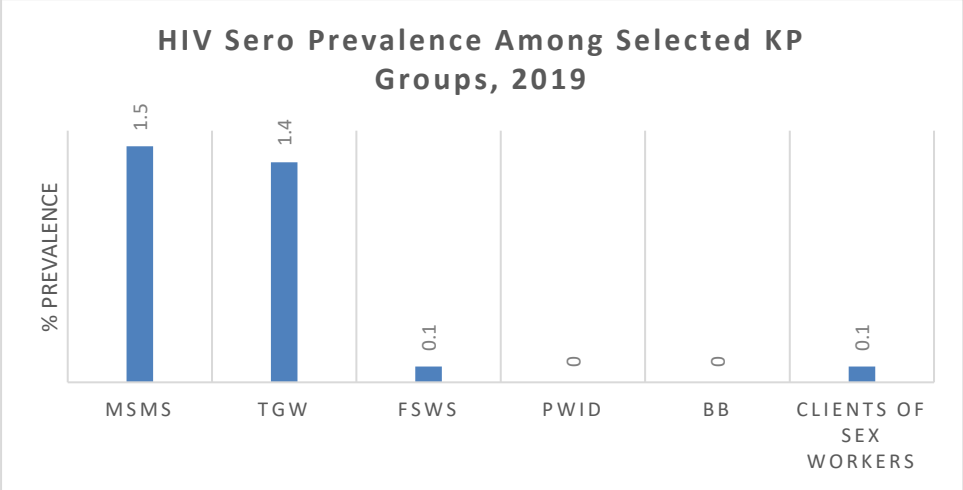
[24] MSW's are included in MSM numbers

[25] FPA tested 135 PWIDS and reached 530 PWIDs.

The HIV prevalence among key population groups is less than 5% in Sri Lanka. The prevalence rates, as seen from the HIV sero-prevalence survey 2019 among MSMs and TGW are the highest at 1.5% and 1.4% respectively in 2019. But the FSW and the clients of sex workers prevalence rates have decreased to 0.1%.

In addition to the KPs defined above, prisoners are considered a high-risk group while a few other population groups are defined as 'vulnerable' population groups. These include clients of sex workers, migrant workers, military staff and garment factory workers.

Figure 3-7: HIV prevalence amongst key population groups - % of total population



Source: HIV Sero Prevalence data from the NSCP Annual Report, 2019

Given that the HIV epidemic is concentrated among mainly KPs and specifically among the MSMs, interventions should be adjusted to mainly target MSMs and other key population groups. But, due to various reasons including widespread self, family, societal and health care worker stigma and discrimination, it is estimated that on average approximately 45% of key populations are 'difficult to reach' via key population interventions. 65%[26] of MSMs are 'unreachable via MSM groups' as they do not disclose their status to anyone and 70% of the FSWs are difficult to reach via FSW KP interventions. To curtail the epidemic and reach end AIDS by 2025, interventions need to reach the majority of MSMs and other KPs via both direct and indirect interventions in order to achieve 80% coverage of the MSMs and other KP groups. At the same time, interventions targeting the general and higher-risk populations are essential to address stigma and discrimination while scaling up testing, treatment and care to reach the 95-95-95 targets defined by UNAIDS. Quality improvements to support these initiatives with better data management, improved laboratory services, client and especially KP friendly services, infrastructure and adequate human resources will be instrumental in curtailing the HIV epidemic in Sri Lanka.

3.2.1.3 Geographical distribution of people living with HIV in Sri Lanka

When the rates of newly reported HIV infections are disaggregated by their district of residence, it becomes apparent that the rate of increase has been significant in many districts in the years 2017 to 2019. It is evident that all districts (except Trincomalee district) have a higher rate of newly detected cases per 100 000 in 2016/2018 and 2019 compared to 2013/15 and only Mannar district did not report new detections. The highest HIV prevalence was

[26] Key Population size estimation Report, NSACP, July 2018. Accessed from http://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/Final-draft-report-Key-Population-Size-Estimation--2018July.pdf

observed in Colombo District with a rate of 4.4 per 100 000 population. The overall prevalence is also highest in Colombo, Gampaha and Puttalam districts (Table 3.3 in Annex 5).

This increasing in detection of new HIV cases reflects the scaling-up of and combination of interventions which have reached all districts. This includes the expanded screening of STD centre clients, TB clients, antenatal mothers, military personnel, blood donors supported by the NSACP via the regional STD centres along with prevention programmes on at-risk groups and the FPA led interventions on KPs in selected districts.

The highest male HIV prevalence is seen in Colombo, Gampaha, Kalutara, Galle, Matale, Puttalam and Vavuniya districts at rates over 2.5 per 100 000 male population. This is supporting the hypothesis of increasing male to male transmission of HIV and the increased prevalence of HIV amongst MSM groups (both reachable ad difficult to reach groups) in these districts. Among females, most districts reflect low prevalence which is most likely due to the low transmission observed amongst FSW and their clients. However, Polonnaruwa district reported an increased prevalence in 2016/18 of 1.8 per 100 000 female population.

3.2.1.4 Concluding remarks

In conclusion the HIV Prevalence in Sri Lanka has remained very low since the reporting of the first HIV positive person. The epidemic continues to be concentrated in the KPs but the prevalence rates among the MSM and TG populations has increased over the last five years. The prevalence rates of HIV among males has increased in all districts while female prevalence rates have decreased in most of the districts. Western province districts are home to most people living with HIV across all KP groups.

What is of concern is that based on the estimated number of people living with HIV, only 51% are under care. There is a large proportion of HIV positive population **who are not under care yet**. This is due to both a large proportion of missing cases (assuming the estimates of the total population of PLHIV is correct) as well as poor linkage to care in certain settings.

Reported program coverage is relatively low at approximately 20% across KP groups when comparing both achievements and targets with estimated KP population size. A large proportion of the KPs do not receive targeted prevention programmes, access to testing and care and condoms. Given that a large portion of the estimated KP populations are considered unreachable, combined with a very low prevalence rate makes finding missing cases a very challenging task. However, in the recent 3 years 2017 to 2019, the programme has reported an average of 350 case detections per annum. The AEM estimates that there are approximately 140 new infections annually. If Sri Lanka is to come to an end AIDS state by 2025, as many as 400 new detections should be reached each year for the next 5 years. Therefore, the programme needs to scale up the ongoing KP interventions and implement discreet interventions to reach 'KPs intermingled in the general population'. Interventions related to self-assessment / testing opportunities, social media led interventions and interventions to address stigma and discrimination towards KPs, interventions to encourage early detection and to reduce loss to follow up of detected positive persons will need to be in place to increase the likelihood of reaching the end AIDS target.

3.2.2 Gains in Access to Services

Major gains are noted over the last 10 years in Sri Lanka's HIV response. This includes improvements in access to HIV prevention and care services, coverage of KP groups, access to testing and better quality monitoring mechanisms, accessibility to condoms and lubricants, accessibility to HIV drugs free of charge, mechanisms for convenient testing with the use of HIV Rapid Tests.

KP Services: Improvements in access to services for STI and HIV

In 2011, the only intervention focused on KPs was to carry out a few advocacy meetings where 1 246 KPs were trained on HIV knowledge. The establishment and implementation of the GF financed PE and CFMs have facilitated the increase in the number of people from KP groups attending clinics, either escorted or alone, in some of the HIV high prevalence and/or higher KP prevalence districts from 2018. Interventions for KP groups via partnerships with non-governmental organizations were in place from 2011 via GF funding. In 2019, the programme tested 8 000 KPs and reached about 18 000 KPs with prevention services. However, the coverage of services is still relatively low at approximately 25% of the KP population.

The NSACP via the USAID Linkages project, in 2017/18 was able to introduce, for the first time, a web-based application to reach MSMs. The application facilitates a self, risk- assessment and provides virtual support through two permanently employed peer educators based at the NSACP. The application had 39 000 hits and was instrumental in getting 81 MSMs to walk into STD centres to test for HIV discreetly. Overall, this *Know4sure* app has helped to reach some of the 'difficult to reach' MSM populations.

Treatment and care services

The NSACP, its field network of STD centres and its partners (FPA and the smaller community based and non-government organizations), with the support of the Global Fund, have been able to increase detection of HIV positive persons and enhanced the care and treatment package to the positive persons substantially since 2008. Care and treatment services for HIV clients are currently (in 2019) available in more than 26 of the 35 STD centres located across the country. Major improvements in the quality of care provided to HIV positive persons is noted in the last 5 years. The availability of adequate numbers of CD4 machines and viral load testing facilities have markedly improved the quality of care of HIV positive persons. As described in the previous section, the linkage to care in the last two years (2017 and 2018 cohorts) has been relatively good with few losses along the cascade of care.

Improvements in comprehensiveness and data quality

Monitoring of the HIV response has also improved significantly since 2010. The reporting formats from the regional STD centres have been revised to facilitate better data reporting. In addition, the electronic management information system is expected to be operational soon while a new KP information management system is also being developed with the introduction of a unique identification number. (See section 4.4 for more detail).

CSO Capacity

One significant achievement of the response over the last 10 years has been the building of capacity and empowerment of CBOs and CSOs to work with the National Programme to support the delivery of KP services. Although concerns about the capacity of CSOs and CBOs remain, a foundational layer of capacity has been established and represents a significant investment, mainly by the GF, to provide not only HIV-related services but also other social services to communities which may be required as part of other development programmes.

3.3 Current strategy and programs to prevent, treat, and manage HIV

In October 2017, NASCP published the National HIV/STI Strategic Plan (NSP) for 2018-2022. The NSP set an ambitious goal to end AIDS in Sri Lanka by 2025, which is five years earlier than the global goal of ending AIDS by 2030. To achieve its 2025 goal, Sri Lanka must maintain the strengths of its existing HIV response while also leveraging them to further expand its programmes and continue to improve their performance. A smooth transition to domestic resources, specifically to sustain key populations prevention interventions and service

delivery models — financially and technically — is imperative if the 2025 goal is going to be reached.

The development of the NSP included inputs from relevant stakeholders from DGHS, NSACP, officials from peripheral STD centres, community-based organizations, nongovernment organizations, networks of People Living with HIV and representatives of key populations. The process also considered challenges identified during the implementation of the previous NSP (2012-2017). These challenges included limits on access to services by key populations because they are hidden, marginalized and stigmatized; insufficient knowledge and information about the social networks of key populations; inadequate reach and uptake of prevention services; and greater decentralization and simplification of HIV testing services.

Strengths and Weaknesses

The core objectives and strategic directions in the NSP are aligned with well-established principles for addressing a low-prevalence HIV epidemic. The focus on key populations matches the epidemiology of the situation in Sri Lanka as does the emphasis on accessible prevention, testing and treatment. The linking of HIV prevention and testing to broader STI prevention and testing is also a strong component of the overall strategy; the provision of STI services can be an effective way to engage with key populations, many of whom may have a higher risk of sexually transmitted infections.

The commitment to collect and use quality data to both monitor and improve performance is a clear strength of the NSP, but it will require significant improvements in existing data practices and systems. The commitment to address legal, social and cultural barriers facing the key populations who are most affected by HIV in the country is certainly vital if activities are going to be effective and sustainable. However, historical efforts to lower these barriers have had limited impact. In addition, citing innovation as a way to improve the reach of prevention programmes is positive — the importance of innovation was also highlighted in the 2014/15 and 2018 IBBS reports — but there appears to be limited commitment and little progress in this area.

A potential weakness of the NSP is the extent to which the strategic directions can be translated into practical programmes and interventions that meet the needs of the affected populations facing the KP-related and HIV-related stigma and discrimination that is widely reported by key informants. For example, CSOs currently play a central role in ensuring members of the different key populations are able to access the necessary programmes and interventions. As is the case in HIV responses in many countries around the world, the peer educators and/or outreach workers employed by the CSOs have an ability to establish a rapport with KP clients that can be leveraged to promote and support HIV prevention and testing. It is a rapport that can be difficult for government workers to build with KP communities and clients because they don't have the same personal connection as a peer.

In addition, it is unclear if the programmes for key populations can/will be adequately funded with domestic funds (i.e., without external resources such as the targeted support from the Global Fund). It is also unclear if an equivalent body to the externally-mandated oversight group (i.e., the Country Coordinating Mechanism), which provides an important seat at the table for key populations and civil society, will be operational in a way that includes and values the perspective of KPs and CSOs in the decision-making processes.

Another potential weakness of the NSP is the ability to shift from a "commitment to a supportive environment" to ensuring this environment actually exists for key populations. For example, the deep-rooted and persistent stigma and discrimination cited by multiple sources have a direct impact on the quality of life of key populations. However, it can also have a negative influence on critical aspects of the HIV response, including political will, planning,

resource mobilization and implementation. In addition, it has the ability to undermine the efficacy of the response; for example, if MSM are unwilling or unable to access HIV-related services because if the intense stigma and discrimination, it makes it vastly more difficult to prevent new cases and identify existing ones.

The surveys of beneficiaries, frontline workers and CSOs conducted by the TRA reinforced the perspectives about stigma and discrimination shared by various key informants.

In response to a question in the beneficiary survey about challenges faced when seeking HIV-related services, 65% of respondents (33 of 51) indicated that "facing stigma and discrimination" was a challenge. The beneficiary survey also included questions about stigma and discrimination from health care workers, family members and peers; see Table 3.6. Nearly two-thirds of respondents (62%) reported facing some level of stigma and discrimination from health care workers and more than half (57%) reported the same from family members.

Table 3-4: Stigma and discrimination (Beneficiary survey)

Survey Question	Yes	Some-times	No
Do you face any stigma and discrimination from health care workers at the clinic when you meet or talk with them?	20 (40%)	11 (22%)	19 (38%)
Do you face any stigma and discrimination from your family when you meet or talk with them?	12 (24%)	16 (33%)	21 (43%)
Do you face any stigma and discrimination from your peers if you use different HIV services?	10 (20%)	9 (18%)	31 (62%)

The survey of frontline workers asked four questions about stigma and discrimination; see Table 3.7. 43% of respondents felt that KPs faced high levels of stigma and discrimination in the general community and 37% felt they faced high levels in the healthcare setting. Even higher percentages of respondents reported moderate levels of stigma and discrimination in the general community and the healthcare setting with very small percentages reporting low levels.

60% of frontline workers felt they — as frontline workers — faced stigma or discrimination because of their work in HIV; 60% also felt they faced stigma or discrimination because of their work with key populations.

Table 3-7: Stigma and discrimination (Frontline worker survey)

Survey Question	High levels	Mod-erate levels	Low levels
How would you assess the levels of stigma and discrimination faced by KPs in the general community?	15 (43%)	19 (54%)	1 (3%)
How would you assess the levels of stigma and discrimination faced by KPs in the healthcare setting?	13 (37%)	16 (46%)	6 (17%)
	Yes	**No**	
Do you face any stigma or discrimination because of your work in HIV?	21 (60%)	14 (40%)	
Do you face any stigma or discrimination because of your work with KPs?	21 (60%)	14 (40%)	

The five questions in the survey of civil society organizations provided a slightly different perspective on HIV-related and KP-related stigma and discrimination. 30% of CSO respondents reported high levels of stigma and discrimination in the general population; 70% reported moderate levels with 0% citing low levels. The exact same percentages were reported for stigma and discrimination in healthcare settings. However, percentages shifted around HIV-

related stigma and discrimination faced by KPs among their peers with only 15% reporting high levels, 45% reporting moderate levels and 40% reporting low levels.

30% of respondents reported high levels of KP-related stigma and discrimination in health care settings compared to 75% reporting high levels in the general population. The pervasiveness of KP-related stigma and discrimination is supported by the fact that 0% of respondents reported low levels in healthcare settings or in the general population.

Table 3-8: Stigma and discrimination (CSO survey)

Survey Question	High levels	Mod-erate levels	Low levels
How would you assess the levels of HIV-related stigma and discrimination in the general population?	6 (30%)	14 (70%)	0
How would you assess the levels of HIV-related stigma and discrimination in healthcare settings?	6 (30%)	14 (70%)	0
How would you assess the levels of HIV-related stigma and discrimination faced by KPs among their peers?	3 (15%)	9 (45%)	8 (40%)
How would you assess the levels of KP-related stigma and discrimination in healthcare settings?	6 (30%)	14 (70%)	0
How would you assess the levels of KP-related stigma and discrimination in the general population?	15 (75%)	5 (25%)	0

Because many members of key populations are hidden, marginalized and stigmatized, their ability to speak out individually and collectively in appropriate fora needs to be encouraged, supported and protected across sectors. However, ensuring this support is provided can be challenging when levels of stigma and discrimination remain high.

3.4 Governance and coordination of the HIV response

Ministry of Health: The Ministry of Health (MOH) is responsible for providing health services to the citizens of Sri-Lanka. Its mission is 'A healthier nation that contributes to its economic, social, mental and spiritual development'[27]. One noteworthy detail in the strategic objectives is the clear intent to coordinate with health-related government and non-governmental organisations to promote the health of the citizenry. The principle of close cooperation between government and civil society to deliver services is established.

The National STD/AIDS Control Programme: The NSACP, located within the MOH, is responsible for coordinating the national HIV response and managing sexually transmitted infections in Sri Lanka[28]. The NSACP was established as a special programme under the Deputy Director General Public Health Services[29], and is guided in its activities in the first instance by the National AIDS Policy approved by the parliament in 2011, and in the second instance by National Strategic Plans which are updated every five years. The senior management team oversee 15 operational units which includes a Multi-Sectoral unit. The 2019 annual report indicates that this unit plans activities, gives priority to interventions directed towards key populations and vulnerable groups and implements many of these in partnership with other sectors such as prisons, armed forces (tri-forces) and education.

As noted above, the health system is decentralised, and most HIV-related government services are provided or coordinated by STD centres. STD centres fall under and are largely funded by the Provincial and Regional Directors of Health Services. The role of the NSACP is to provide policy and technical guidance to the STD centres and distribute pharmaceuticals

[27] http://www.health.gov.lk/moh_final/english/others.php?spid=26
[28] NSACP Annual report, 2019
[29] External Review Report, National Health Sector Response to HIV & Sexually Transmitted Infections in Sri Lanka, September 2017

and commodities which are centrally procured while general supplies, recurrent and capital expenses are provided through the provinces via the RDHS.

National AIDS Council and AIDS committees: To provide political support and to encourage multi-sectoral engagement and coordination, the National AIDS Council was formed under the chairmanship of His Excellency the President of Sri Lanka. To facilitate the multi-sectoral coordination, a national AIDS committee (NAC) was formed under the leadership of the MOH secretary and nine provincial AIDS Committees were formed at sub-national level. The NAC membership comprises secretaries from other ministries, development partners, and civil society, including CSOs, CBOs, PLHIV and the private sector in addition to the representatives from NSACP. The GF provides support to facilitate the functioning of the NAC and some of its sub-committees.

Technical Working Group on HIV Transition Readiness and Sustainability: To steer the HIV response towards a smooth transition, the NSACP, with support from UNAIDS, established the multi-sectoral Technical Working Group on HIV Transition Readiness and Sustainability Planning (TWG) to guide Sri Lanka's transition to full domestic funding. The working group has recently been established and has only met on once. The focus of discussions at this stage has been the TRA.

Country Coordinating Mechanism: facilitate the implementation of all three components of the GF grant under the leadership of the Secretary of Health. Basic functions of the CCM include the development of the national request for funding, nomination of Principal Recipients, overseeing the implementation of approved grants, approval of reprogramming requests and ensuring linkages and consistency between Global Fund grants and other national health and development programs. Representation by communities at the CCM has been gradually increased to at least three community representatives permanently represented on the CCM. Sub-committees include the Key Population sub-committee and the Oversight sub-committee. It is not clear what will happen to the CCM after the final transition grant ends. Discussion with a representative of the CCM have confirmed that it is highly likely that the CCM will cease to exist after GF funding support stops.

Civil Society: The role and capacity of civil society are explored in more detail in section 6 of this report. Based on the findings, described in that section, it becomes apparent that civil society plays a relatively limited role in the overall governance of the HIV response for key populations. The most prominent governance role is the one played by FPA as a PR for the Global Fund programme. While other civil society organisations have a voice through the CCM, they do not have an active role in governance and the lack of strong network[30] and/or umbrella organisations representing key populations and/or KP-led or KP-focused CSOs limits the participation of KP representatives in governance issues. Civil society arguably has a greater role in *coordination*, mainly because of FPA's role as a PR. The lack of strong network and/or umbrella organisations limits the ability of CSOs and key populations to actively participate in coordination at the macro level.

Concluding comments: The review of literature and key informant interviews has highlighted several issues which impact on the overall governance and leadership of the response:

- The National AIDS Council has not been active for several years and some of the key functions of the council have been neglected in terms of demonstrating political will and support for the response at the highest levels (NSP, External review)

[30] Several organisations refer to themselves as network organisation. Discussions with the management of these organisations has highlighted that even though membership is not restricted, most do not have a national membership and do not necessarily represent the interests of a national constituency.

- In the absence of a functioning National AIDS Council, it is not clear who the NAC is accountable to for successfully implementing the multi-sectoral response
- A clear pathway for establishing a capacitated, national governance and coordination structure for the long-term management of HIV response has not been documented. It may be that the National AIDS Council and the NAC and provincial committees were intended to ultimately fulfill this role but this requires political support, sufficient resources and a clear vision and definition of roles and responsibilities.
- The functioning and effectiveness of the Provincial AIDS councils as platforms for multi-sectoral coordination varies across provinces, with some quite active whilst others are less effective.
- Coordination between the RDHS and STD centre is not satisfactory in some districts (External Review report)
- Civil Society network organizations, which are recognized as formally representing individual civil society organisations for specific KP groups (CSOs and CBOs) have not been established which makes it challenging for other institutions to efficiently engage with civil society.

In light of the above issues and assuming that the CCM will cease to exist after support from the GF ends, it is not clear how the voice of CSOs representing key population groups will be accommodated in governance structures; who will be responsible for driving domestic resource mobilisation efforts; how and where capacity should be established to manage the participation of CSOs in implementation and the nature of the collaborative stakeholder mechanism required to provide strategic direction to and monitor the implementation of an effective HIV response.

3.4.1 Transition risks - Governance and coordination

Description of transition issue	Likely impact
Risk 1. Multi-sectoral governance and accountability mechanism Given that the CCM and it committees will likely cease to exist after the last GF grant, there is a risk that a long-term governance and multi-sectoral coordination mechanism will not have been established and capacitated to oversee the implementation of the multi-sectoral response both at national and sub-national levels. Civil society organizations and members of key populations may lose their ability to participate in oversight and decision-making related to KP programmes. *High priority*	Failure to develop a **common vision and implementation plan** for a multi-sectoral governance and coordination mechanism may lead to confusion about the roles and responsibilities of various institutions and their scope of influence. Reducing the direct engagement of key populations, civil society organizations and other stakeholders in oversight and decision-making processes can undermine the credibility, availability and accessibility of HIV programmes in KP communities. The effectiveness and efficient implementation of the response may be eroded.
High level recommendations: • Initiate and implement a process to develop a common vision for a multi-sectoral governance and coordination mechanism where all parties have a voice, to oversee the implementation of the national HIV response. Existing structures may form part of this mechanism. • The mechanism should be fully operational before the last GF grant ends; it could be run concurrently with the CCM and its committees or it could be a de facto replacement for the CCM in the final year of the last grant.	

3.5 Overview of external funding for the HIV response

3.5.1 Summary of Global Fund financial support

The current grants comprise a total value of $ 6.6 million[31] for the period from 2019 to 2021, a significant reduction of funding when compared to the previous funding cycle. Based on the GF funding landscape tables (see section 5.3 below), it is estimated that the contribution from government over the same period amounts to $20.5 million. The objective of this grant is to support the Governments initiative of ending AIDS by 2025. The strategies are to prevent new infections of HIV/STI among key populations, vulnerable populations and the general population, to provide universal access to HIV/STI diagnosis and treatment, care and support services for those infected and affected by HIV/STI; to strengthen strategic information systems and knowledge management for an evidence-based response; to strengthen health systems at different levels and to ensure an effective multi-sector HIV/AIDS/STI response; to provide a supportive environment for easy access and delivery of HIV prevention, diagnosis, treatment and care services for all.

Over the last 12 years, Sri Lanka received more than $22 million[32] in funding (signed grants) for addressing the HIV/AIDS response in Sri Lanka and approximately $19 million was disbursed and reflects the pace of absorption of funds by the principal recipients.

Table 3-5: Global Fund grants for HIV/AIDS, Sri Lanka – Past and current grants

Round	Principal Recipient	Grant Name/ Number	Phase / Implementation Period (IP)	Start date and End Date	Original Grant Confirmation Amount (USD)
GF Round 6	MOH	SRL-607-G09-H	Phase 1	1 Jan 2008 - Dec 31, 2010	1 009 700
GF Round 6	MOH	SRL-607-G09-H	Phase 11	1 Jan 2010 – Dec 31,2012	1 300 923
GF Round 9	MOH	SRL-S11-G13-H	Phase 1	Jan 1, 2011 - Dec 31, 2012	2 754 587
GF Round 9	Sarvodaya	SRL-911-G14-H	Phase 1	Jan 1, 2011 - Dec 31, 2012	1 254 916
GF Round 9	MOH	SRL-S11-G13-H	Phase 11	Jan 1, 2013 - Dec 31, 2015	4 956 930
GF Round 9	FPA	SRL-913-G16-H	Phase 11	Jan 1, 2013 - Dec 31, 2015	3 370 244
NFM I	MOH	LKA-H-MOH, No: 977	IP 1	Jan 1, 2016 - Dec 31, 2018	5 323 102
NFM I	FPA	LKA-H-FPA No: 976	IP 1	Jan 1, 2016 - Dec 31, 2018	5 442 741
FR 1	MOH	LKA-H-MOH No: 1779	IP 2	Jan 1, 2019 - Dec 31, 2021	3 346 218
FR II	FPA	LKA-H-FPA	IP 2	Jan 1, 2019 - Dec 31, 2021	3 545 720
TOTAL					**32 305 082**

[31] The signed grant value for the FPA grant is $3.3million which is slightly less than the confirmed value in table 3.7

[32] https://data.theglobalfund.org/investments/locations/LKA/HIV; $20 333 605 committed

The GF resources available to the NSACP (PR 1) in 2018 amounted to 33% (LKR 250 million, equivalent to $1.4 million) of the total capital and recurrent expenditure of the NCASP programme (LKR 762 million; $4.25 million) in that year. A detailed breakdown by module and cost category of the grants is provided in Annex 2.

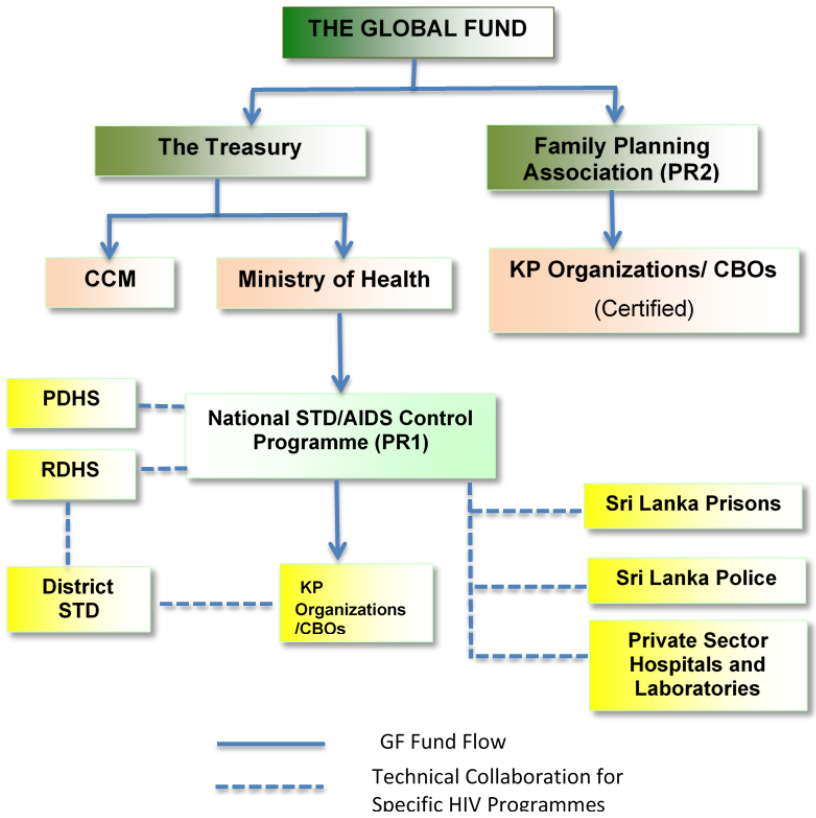
Although the major portion of GF support comprises financial support for direct programme implementation, a valuable contribution is made by providing technical assistance for improved accountability, planning, monitoring and implementation. Examples include project implementation support through regular reviews of the project and expenditure including detailed assessments by the Local Funding Agent (LFA), technical support to review the logistics and supplies arrangements and support to introduce the peer educator and case finding models in Sri Lanka.

3.5.2 GF Disbursement of funds

In Sri Lanka, two principal recipients have been appointed to implement the grant, the MOH representing government and the Family Planning Association (FPA) representing the civil society arm of the dual track funding mechanism (see annex E for details of the grant implementation arrangements). The GF funds to the Family Planning Association, are transferred directly to the FPA outside of the Government Budget and the Ministry of Finance. The Ministry of Finance of the Government of Sri Lanka is responsible for managing the funds allocated to PR 1, the MOH. Within the MOH, NSACP receives GF funds via the Ministry of Health. Based on activities implemented, the MOH releases funds to the NSACP account for managing activities. At the regional level, the 30 STD centres and the 23 branch STD centres are located in 25 districts. STD centres even though physically located in tertiary care hospitals, they are under the management of the provincial authorities except for the 2 STD centres in Galle and Kandy which are managed within the Ministry of Health. The GF funds or the commodities allocated to the STD centres are directly transferred to or purchased and distributed to recipient clinics by the NSACP. The government allocations to the STD centres are managed by the provincial authorities as the STD centres are not spending units.

The FPA utilizes their funds for project activities and manages all payments to the sub recipients (SRs) that are providing services to selected key population groups in 15 selected districts. The Global Fund, fund flow is shown in Figure below.

Figure 3-8: Flow of GF resources to the two PRs for the current grant



RDHS: Regional Director Health Services (District level)
PDHS: Provincial Director of Health Services (Province level)
CCM: Country Coordination Mechanism
KP: Key Populations

3.5.3 Absorption and timeline for Global Fund transition

The current GF grant implementation period covers the period from January 2019 to December 2021. The utilisation rate of available budget by the two PRs indicates that PR1 (NSACP, MOH) was able to utilize LKR 80 million (US$ 445 000) during 2019 which was 31% of the annual budget while PR 2 (FPA) was able to utilize LKR 173.4 million (US$ 963 000) which was 75% of the budget. It is noteworthy that the PR1 (NSACP) utilized 94% of the GOSL budget which amounted to LKR 369 million[33] (USD 2 million) and 100% (LKR 8.9 million, USD 49 000) of United Nations funds. Given that the total Government allocation to the NSACP was LKR 390 million in 2019 (US$ 2.2 million), the government's counterpart-financing obligation has been met. One of the reasons for low utilization of GF funds, which affected both PRs, was the Easter Sunday bombing on April 21, 2019 which prevented the implementation of community programmes in the country for a few months thereafter due to security concerns.

For PR1, the delay in implementing planned activities for the 2019 year is another important reason for low utilization of funds. The reasons for these delays are multiple and relate largely to the transitioning of KP intervention programmes from PR2, but also include delays in initiating detailed planning, getting required approvals from the Ministry and the Global Fund teams. Disagreement on some proposals suggested by the Global Fund also delayed implementation of activities by the NSACP. The large number of vacant posts which needed to be filled (Consultants (7), Medical Officers (6), Management Assistants (6), IT Assistant, Administrative Officer, Chief Clerk and other supportive staff) contributed to slow implementation. The most significant delays relate to the introduction of pre-exposure prophylaxis, introduction of the pilot on self-testing and hiring of international consultants. It

[33] The MOH expenditure comprised almost entirely of salaries and the procurement of ARVs

has also become evident through KII, that inadequate detailed planning and consultations at project design stage, prior to requesting funding from the GF, resulted in implementation challenges.

As noted in the background section above, the allocation for the next funding cycle (2020-2022) reflects an envelope of $6.4 mil for HIV, similar in value to the current two grants. The GF projections of countries that may become ineligible[34] by 2028, suggest that Sri Lanka is likely to become ineligible during this allocation period. This implies a further implementation period from 2022-2024 followed by a three-year transition grant. Sri Lanka is therefore a country that must start preparing for full transition from the GF.

3.5.4 Summary of non-Global Fund partner support

The HIV response is primarily funded by the Government of Sri Lanka with the support of the Global Fund. As noted elsewhere in this report, GF funding is invested mainly in the provision of HIV-related services to KP populations, while the GOSL funds the other components of the HIV response. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Christian Medical Association of India (CMAI) provided technical assistance over a period of 3 years to strengthen the HIV and STD laboratory network. Through CDC, PEPFAR also supported technical assistance to improve strategic information management. Both projects were closed out in 2019. USAID provided funding over a period of two years to support the adoption of several community-led approaches and innovations. The LINKAGES project, implemented by FHI-360, included the Know4sure.lk online outreach intervention and ended in 2019. (The Know4sure.lk online intervention is currently being funded by the GF grant.) The World Health Organisation, and other development partners such as UNAIDS and UNICEF, provide ongoing technical advisory support and fund discrete research, review, consultation and similar activities to support the response.

4 HIV Service delivery and support systems

4.1 Services to key populations

The provision of HIV services to key populations has been a significant component of Global Fund grants to Sri Lanka since 2011. The current grant (2019-2021) prioritizes prevention, testing and linkage-to-care services for these populations, including female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID), tourism service providers (formerly known as beach boys (BB)) and transgender women (TGW). Providing prevention, testing and linkage-to-care services to key populations is a critical component of the overall HIV response in Sri Lanka, given the higher HIV prevalence rates in these populations, their HIV risk profiles and effects of stigma and discrimination on their lives and health-seeking behaviours.

Main Intervention Models

The ways that HIV services have been provided to key populations in Sri Lanka has evolved over time. The rationale for the changes has been to better meet the needs of the different populations and to improve the performance of the service delivery programmes. In recent years, there have been multiple variants developed and implemented by different organizations to provide services to key populations. Currently, there are two basic models being used: 1) the Peer Educator Model (PEM) and 2) the Case Finder Model (CFM). While there are differences between the two models (see below), both have a strong focus on HIV

[34] Projected transitions from Global Fund country allocations by 2028: Projections by component, January 2020 update, The Global Fund

testing with prevention being a secondary concern. Linkage to care is not a significant component of either model because they identify so few HIV cases. Both models rely heavily on the HIV testing services provided by STD centres operated by GOSL and FPA, but neither model — particularly the PEM — is entirely fixed; implementing teams make adjustments to the various activities relevant to the local context and their capacity.

Peer Educator Model (PEM)

The Peer Educator Model is the older of the two service-delivery models, having been launched by NSACP and the Global Fund in 2013. It is often seen as a "traditional" peer educator model that uses trained members of a KP community to provide a range of services to other members of their community. With this model, peer educators (PEs) are supposed to promote a Sexual Health Package (SHP) to their peers; the SHP includes HIV/STI awareness, condom demonstration and provision, distribution of lubricants, distribution of leaflets, promoting voluntary HIV testing, and escorting peers to STD centres or community-led mobile/out-reach clinics for an initial HIV test. In addition to the SHP, the PEM teams are supposed to develop hot spot maps for the key populations they are serving.

The PEM is designed to be implemented at the district level for a specific key population by a local CSO partner organization with knowledge of and/or links to the KP community. The staffing structure for a specific key population (e.g., FSW) being reached in a district by the PEM includes one Management Assistant (MA), one part-time Field Supervisor (FS) and three part-time PEs. If the PEM is being used with multiple key populations in a single district, there would be only one MA, but there would be a FS and three PEs assigned to work with each population. The MA works in the STD centre and, unlike an FS or PE, they do not work in the field. Based on historical staffing structures, which included a larger number of PEs, key informants expressed concerns that three PEs is not sufficient to fully implement the model in many locations.

NSACP and FPA both implement this model in rural or more remote districts. Minor differences exist in how this model is implemented when comparing the NSACP and FPA approaches but essentially, it is the same model. The ratio of PE to supervisors can vary between KP groups and small variations may exist between how the model is implemented in different districts by different implementers. For example, it can require more intensive efforts by an implementer in rural/remote districts to find members of key populations in these areas due to several overlapping factors, including smaller numbers of KPs overall, a lower density of KPs and fewer people willing to identify as a member of a key population because of stigma and discrimination.

One of the fundamental challenges with the PEM is the low yield of HIV testing. *Summary data for all four quarters in 2019 shows no new cases in any key population at seven government STD centres across four districts implementing the model.* Low yield (i.e., the limited ability to find new cases) is generally seen as a serious shortcoming of a testing approach and a sign that a new approach is warranted. In a concentrated, low-prevalence HIV epidemic like the one in Sri Lanka, low yield can be an inevitable consequence of a declining number of undiagnosed cases and the fact that undiagnosed PLHIV are hidden and harder to convince to test. In Sri Lanka's case, the useful life of the PEM may be ending and will need to be replaced by different, more innovative approaches.

It is important to note that peer educators can play an important role in educating KPs about HIV prevention during their field work and to solely measure their contribution based on testing yield does not reflect the work that could be done to avert infections. However, it is essential that the prevention work is effective and not simply a *pro forma* exercise.

A spot-check conducted by the Global Fund in 2019 identified a number of issues with the planning, implementation and M&E processes of the PEM sites operated by NSACP. These issues ranged from insufficient staff to operate mobile/out-reach clinics, non-use of rapid diagnostic tests where mandated, improper communications and lack of coordination. There were also concerns that mapping of hot spots was not being done as frequently or as systematically as needed. It is unclear if these issues have been properly or systematically addressed across the districts implementing the PEM.

Case Finding Model (CFM)

As the name implies, this model prioritizes finding new HIV cases. It is based on a demonstration project conducted in 2018. FPA assessed the demonstration project[35] in early 2020 and concluded: 1) key populations for HIV can lead, manage and deliver effective HIV prevention outreach; 2) full-time field staff and smaller teams allows for better management and coordination; 3) incentives for meeting HIV testing targets focuses field teams on convincing key populations to test for HIV; 4) field coaching provides the technical oversight to ensure compliance with the technical approach and meeting their targets in-real-time; and 5) a focus on HIV case finding allows Sri Lanka to benefit from the opportunity provided by treatment-as-prevention.

CFM is being implemented by FPA for MSM, FSW and TG in high-density districts of Colombo and Gampaha. The model uses a proactive and accelerated approach to enhance HIV prevention outreach, improve HIV case finding and link newly diagnosed PLHIV to care. The model is built around seven elements: 1) a package of HIV prevention community education and access to commodities; 2) getting to *yes to test* for HIV; 3) continuous sourcing of new places and networks; 4) random walking to identify 'outliers' and high-risk characteristic for HIV; 5) new technology for HIV outreach and team work; 6) HIV case management to link to care, ART start and adherence; and 7) rewards and recognition systems to encourage meeting-and-exceeding targets. However, as the name of the model implies, the focus is on case finding with prevention activities playing a secondary/supporting role.

CFM also leverages the growing body of evidence about the effectiveness of treatment-as-prevention in ending HIV. As a result, the model focuses on reducing rates of undiagnosed HIV and linking newly diagnosed people with HIV to treatment and care services.

The model relies on the work of field teams composed of a team leader, HIV educators and HIV case finders. The integrated team, which is affiliated with a local community-based organization, is responsible for the various targets set for it, including education, distribution of commodities (i.e., condoms and lubricant), HIV testing and case finding. The targets are linked to an incentive system that rewards teams that meet them.

The team leader is responsible for ensuring that HIV educators and HIV case finders are achieving their monthly targets. Team leaders also hold team meetings, go into the field with educators and case finders on a daily basis and help deliver the program as a contributing member of the team. Educators manage local networks of key populations and maintain long-term relationships with key population groups in local places. They distribute condoms and lubricants as well as provide condom demonstrations and IE-based education. Case finders accompany key populations to their HIV test and are present after the HIV result is received to support HIV-negative individuals to stay HIV free and HIV-positive individuals to have a confirmatory test and start ART. In many respects, they serve as case managers for their clients. They also conduct real-time mapping to help find key populations who have never tested for HIV.

[35] HIV Case Finding Model: Key Population-led HIV Prevention Outreach (Final Report, March 2020)

There is also a team of coaches who are responsible for providing direct, service-coaching, support and guidance to community-based groups and local clinic services to implement the project. The district coaches are supported by a lead coach, who is responsible for overall technical support, including data analysis, feedback and practice changes that occur in the field work.

The number of field staff per district varies and is dependent upon targets for districts and zones within a district. However, the design of the model calls for more case finders than educators (e.g., in a zone, there could be three educators and seven case finders). The smaller number of educators and a focus on prevention commodities limits the effectiveness of the prevention component of the model. Once a zone has been saturated (i.e., targets are reached, the number of "never-tested" clients declines), the model recommends teams move on to another zone and start the process over again. The purpose of this structure and approach is to encourage team members to work together to provide holistic/integrated services that close gaps across the HIV prevention and testing cascade.

Given the overall prevalence rate in Sri Lanka, HIV testing yield is expected to be generally low, regardless of the approach. However, when compared with PEM, the testing yield for CFM is better. Drawing from the same data set as cited above (insert date), testing yield among TGW in Colombo was 1.02%; among MSM, it was 0.76%; and among FSW, it was 0.17%; during that same period, PEM found zero new cases.

Unit costs within the CFM also vary significantly within Colombo. For example, the cost per MSM reached with prevention services is $123 versus a cost of $59 for FSW. The cost per HIV test varied from $46 for MSM to $83 for TGW. As cited above, these variations are due to a number of factors but are largely a function of the units of output. A focus on testing during the early stages of implementation resulted in a significant number of tests but a relatively low number of people reached with the full package of prevention services. The result is a lower unit cost per test and a higher cost per person reached. It is unclear how the outreach work is structured if a client can be escorted to a test but does not receive the prevention services during that time with the outreach worker.

Prevention, Testing & Treatment

Prevention

The PEM and CFM use traditional prevention activities (e.g., HIV/STI messaging, information leaflets, condom demonstrations and condom and lubricant distribution) to connect peer educators (i.e., outreach workers) with clients/beneficiaries. Prevention services and commodities are available directly from outreach workers, at the drop-in centres for key populations operated by CSOs and at the STD centres operated by the government. However, low coverage of HIV interventions for key populations (see below) means that the majority of KPs who would benefit from prevention activities are not being reached.

In recent years, condom distribution has been a major component of the prevention programme with sizeable increases in the number of condoms distributed to key populations. For example, between 2016 and 2018, NSACP reported a 159% increase in the number distributed, rising from 1.4 million in 2016 to more than 3.6 million in 2018. The largest number/percentage of these condoms — 72% in 2017 and 76% in 2018 — are distributed to the broader FSW community, including venue operators.

The survey of beneficiaries conducted as part of the TRA found "getting condoms and lubricant" was the most useful HIV-related service with 80% of respondents (41 of 51) selecting it.

According to the 2018 IBBS, key populations also report generally good rates of condom use at last sex: 83.6% among FSW, although this was down from the 93% in the 2014/15 IBBS; 82.8% among MSM (last anal sex); 25.5% among PWID; 75.3% among TSP/BB[36] (last sex with a tourist); and 76.3% among TGW (last anal sex).

While the increase in condom distribution and the positive findings on condom use are a positive sign, the 2018 IBBS did highlight a number of serious prevention issues facing the country, including:

- "Health seeking behaviour amongst FSW in general is low, with only 15.9% (Galle), 22.5% (Colombo) and 36.9% (Kandy) of FSW in the year preceding the survey see[k]ing medical care."
- "Sexual violence against FSW is prevalent, with 10.9%, and 15.5% in Colombo and Kandy having been sexually assaults or raped, while this was much lower in Galle at 1.2%."
- "Knowledge about HIV prevention is somewhat low amongst MSM in Sri Lanka, with between one in five and three in five MSM not being able to correctly identify misconceptions (19.5% in Colombo, 49.3% in Galle, 59.7% in Anuradhapura)."
- "The GAM composite indicator on reached by prevention programmes is extremely [low] (given condoms and lubricants and STI test in the last 12 months) with few MSM reached (32.9% in Colombo, 4.7%, in Galle 25.5% in Anuradhapura)."
- "Knowledge about HIV prevention is low among PWID in Colombo, with only one in ten (10.7%) PWID able to correctly identify modes of sexual transmission of HIV and reject major misconceptions about transmission HIV."
- "A third of [TSP] in Galle have never heard of HIV/AIDS (30.5%), most (85.6%) have never discussed HIV/AIDS with any of their partners, and only a third (38.3%) correctly identify modes of sexual transmission of HIV and reject major misconceptions."
- "Knowledge of HIV is mixed, with around one-fifth of TGW in Colombo and Jaffna having never heard of HIV…."

A long-standing challenge with prevention activities for key populations in Sri Lanka is coverage. According to data reported by Sri Lanka to UNAIDS in 2019 (using 2018 IBBS results), coverage was 12.7% for FSW, 27% for MSM, 2.7% for PWID and 38.5% for transgender women. A high percentage of these populations can be found in specific areas in a limited number of provinces, districts and municipalities (e.g., Colombo), which should make them easier to reach, but the overall coverage is still low. For members of key populations living outside these areas, prevention services can be difficult to access because of challenges ranging from distance/proximity to stigma and discrimination. In these same areas, it can be difficult for outreach workers to provide prevention services because the density of KPs is low and individual clients can be hard to find. While it is important to focus on the areas where there are higher numbers of KPs, appropriate HIV services should be readily or reasonably available for members of key populations regardless of where they live.

KP prevention programmes in Sri Lanka have a parallel problem in reaching people who prefer not to identify as a member of a key population, even if their lifestyle, attitudes and/or behaviours align them with one of those populations. According to the 2018 IBBS, estimated percentage of these "hidden" or "unreachable" people in different key populations is high; 65% among FSW, 70% among MSM and 45% of all KP groups; see Table 3-3. While this problem can be more pronounced in areas where KP-related and HIV-related stigma and discrimination is high and access to KP-friendly services is low, it appears to be a significant issue across the country.

[36] The 2010 IBBS refers to *beach boys* (BB) as a key population. Since the report was published, the term used to identify members of the key population is *tourism service provider* (TSP).

The combination of challenges means that overall coverage in Sri Lanka is very low. For example, only 25% of the MSM population are connected with HIV prevention programmes. Prevention work is further complicated by the fact that the effectiveness of standard prevention programmes (e.g., condom and leaflet distribution) can be limited and that not all outreach workers are well suited for the task (e.g., the ability to help clients understand and manage risk behaviours and situations), which means that coverage does not equate to the delivery of a worthwhile service.

In Sri Lanka, traditional prevention activities are slowly being supplemented with new technologies. The ability to do an online risk assessment and book testing appointments on the Know4Sure.lk website is a good example of how technology can help with core HIV prevention. During the last four months of 2019, nearly 40 000 users landed on the Know4Sure website and more than 12 000 of them completed a risk assessment, which can be a very effective prevention tool. Of the 12 000 people who did the risk assessment, 219 booked appointments for testing and 81 kept the appointment and had a test. In general, the anonymity and cost-per-contact of online activities could make these services a compelling addition to the prevention toolkit and it is likely they will grow in importance in coming years. However, for the foreseeable future, the value of in-person, peer outreach for key populations remains high.

As more members of key populations in Sri Lanka start and stay on ART, treatment-as-prevention becomes an increasingly viable and valuable component of the overall prevention strategy. It is one of the reasons why the more coordinated and thoughtful efforts in the case finding model to link newly diagnosed PLHIV to care — and to provide a level of case management — is so important.

Unfortunately, two vital and proven prevention interventions are not available in Sri Lanka at the present time: 1) harm reduction for PWID (e.g., needle exchange and substitution therapy); and 2) pre-exposure prophylaxis (PrEP). Both interventions could play important roles in helping the country end AIDS by 2025. The populations who would benefit from these interventions are relatively small, but they are also hard to reach with other interventions or the available interventions are not practical for them. For example, PrEP could be an invaluable intervention for key populations if it could be made available discretely to those who are not currently engaged with HIV programmes because of concerns about stigma and discrimination.[37, 38]

The larger issue of engaging with HIV programmes is also problematic in Sri Lanka with high percentages of key populations reporting an avoidance of HIV services because of stigma and discrimination. According to the 2018 IBBS, 42.4% of FSW, 31.7% of MSM, 56.4% of PWID and 48.5% of TGW avoid HIV services because of stigma and discrimination.

If the goal is to end AIDS in Sri Lanka by 2025, prevention for key populations should be a significantly higher priority in the HIV response, including strong community-based, peer-driven activities (e.g., outreach work, drop-in centres (DIC)). Prevention should not be treated as a by-product of case-finding, but as a core activity that is essential to the long-term control of HIV in the country.

[37] The effectiveness of the community-based approach to PrEP enrolment and distribution found in the Sustainable East Africa Research in Community Health (SEARCH) study could be a useful blueprint for Sri Lanka. It could be a useful way to leverage the community outreach components of current HIV work with key populations. https://www.medscape.com/viewarticle/933906#vp_1

[38] The success of the trial of the new long-term injectable *cabotegravir* announced at the AIDS 2020 conference could be an unprecedented opportunity for Sri Lanka to introduce a version of PrEP, which could help prevent HIV infections in individuals who are reluctant to access other HIV services because of stigma and discrimination. https://www.aidsmap.com/news/jul-2020/injectable-prep-offers-superior-efficacy-oral-prep-clinical-trial

Testing

Although there are differences between the PEM and CFM models (e.g., management structure, support system, incentive system), the basic approaches used by the models to encourage and support clients to test for HIV are similar. Essentially, outreach workers (i.e., peer educators or case finders) seek out clients who should be tested for HIV and persuade them to have a test. After getting a client to agree to have a test, an outreach worker makes the necessary arrangements and escorts the client to an STD centre, a mobile testing site or a DIC where testing is available. The outreach worker stays with the client while they wait for the test result and discusses it and the next steps with them after it has been shared by the clinical staff.

If the initial test is done at a mobile site or a DIC and is positive for HIV, the outreach worker will talk with the client about the importance of having a confirmatory test done at the STD centre. The outreach worker will again make the necessary arrangements and escort the client to the centre for the test. (Currently, confirmatory tests must be done at the STD centre, not at a mobile testing site.) Since the confirmatory test is not a rapid test, the client must return for the results. The outreach worker will accompany the client when they get the result and will then discuss it and the next steps with them, including the importance of starting ART if the confirmatory test is also positive.

All newly diagnosed HIV patients have CD4 and viral load tests after their initial diagnosis and at six-month intervals thereafter. Newly diagnosed patients are also screened for TB with Mantoux-positive patients further tested for active TB and other mycobacterial infections.

In addition, each new HIV case triggers an effort by a Public Health Inspector (PHI) attached to the STD centre to trace the client's sexual contacts. The work can be challenging because of patient concerns about privacy and confidentiality. Despite these challenges, contact tracing has been an effective way to find additional positive cases.

It is important to note that despite the basic approaches of the two models being similar, the CFM has been somewhat more successful in finding previously undiagnosed cases of HIV since its introduction in 2019, but the real numbers are low.

Despite the focus on testing in the Sri Lanka programme, there are still issues with its implementation. For example, the 2018 IBBS found only a third of FSW have received an HIV test within 12 months before the survey was carried out (17.5% in Colombo, 39.5% in Galle and 17.5% in Kandy). And while knowledge among MSM of where to go for an HIV test is high (73.8% in Colombo, 68.8% in Galle and 66.2% in Anuradhapura), those who have had a test in the last 12 months is low (47.2% in Colombo, 45.6% in Galle, 3.6% in Anuradhapura). There is a similar situation with TGW; the majority know where to go for a test, but relatively few have been tested in the last 12 months (43.1% in Colombo and 11.5% in Jaffna).

The implementation issues with testing raise questions about the reliance on two models (PEM and CFM) with low yield at relatively high cost. While lower yield is expected in an epidemic such as Sri Lanka's, there should be efforts underway to better understand why rates of testing are low among KPs and how they can be improved. For example, key informants report that some KPs are reluctant to test because it essentially requires they disclose their status as a member of a key population (e.g., via the interview about sexual behaviour at the STD centre). It is possible that innovations such as self-testing would increase the number of KPs being tested, but it is also possible that long-standing opportunities such as provider-initiated testing in other contexts (e.g., regular doctor's appointment) could also identify additional cases.

The TRA survey of beneficiaries also identified concerns about their experiences related to service delivery at the STD centres. In response to the question "What challenges do you face

when you want HIV-related services?", the five most-selected responses all related to the centres; see Table 4-1.

Table 4-1: Analysis of challenges faced when accessing HIV-related services

Question: What challenges do you face when you want HIV-related services?
(Total of 51 respondents to the survey of beneficiaries)

Waiting at the STD centre	40 (78%)
Hours of operation of the STD centre	37 (73%)
Repeat visits to the STD centre	36 (71%)
Location of the STD centre	34 (67%)
Getting transport to the STD centre	33 (65%)

It is inevitable that HIV cases will be harder and more expensive to find when there are fewer and fewer of them, particularly in a concentrated, low-prevalence epidemic. However, the high rate of late diagnosis of HIV cases — 32% of diagnoses with an initial CD4 count of <200, according to data reported by Sri Lanka to UNAIDS in 2019 — does indicate that current testing approaches are not reaching people who should be tested. The high rate of late diagnosis also reinforces concerns about stigma and discrimination, hidden populations, low coverage of HIV services and onward transmission of HIV.

Experience in Sri Lanka with peer outreach programmes underscore the lessons from experience in multiple countries around the world: these programmes play an essential role in improving testing among key populations. Because peer outreach workers are themselves members of the key population, they have a higher level of credibility and access to other members of the population group. They also have a better understanding of the various challenges faced by their peers, including KP-related and HIV-related stigma and discrimination, which can have a significant impact on people's willingness to test and to access other HIV-related health services. When given proper training and support, these outreach workers have a distinct advantage in improving attitudes and behaviours about HIV testing among key populations.

The "linking" role of outreach workers is one of their most important functions because of its connection to loss-to-follow-up at two critical points in the overall HIV cascade. First, outreach workers can have a direct effect on reducing the loss-to-follow-up between a positive initial test and a confirmatory test. They have a connection to these people because they were with them through the initial test and it should be a priority for them to ensure that every client who has a positive initial test has a confirmatory test. Second, outreach workers can and should play a central role in linking clients who have a positive confirmatory test to treatment and care programmes. The opportunity to reduce the number of clients who are lost-to-follow-up at both of these points in the cascade is significant and should not be underestimated or missed.

However, despite the programs that are in place, loss-to-follow-up is a serious problem in Sri Lanka. For example, according to 2019 data, 14% of clients who had a positive confirmatory test (60 out of 438) did not return to the centre to get their results. And among those clients who did get their results (378), 28% (106) either did not start ART or dropped out soon after starting.

One of the advantages of the current approach to HIV testing in Sri Lanka is the overlap between HIV testing and services for other STIs, including testing and treatment, at the STD centres. The ability to be tested for multiple diseases can be a useful incentive for key populations, many of whom are at a higher risk for various STIs. However, there are reports

of extended delays at STD centres for non-HIV tests, which reduces the potential advantage of providing integrated testing services.

In addition to the community-based programmes encouraging and supporting HIV testing among key populations, members of these populations also go directly to the hospital or STD centre to get tested. The majority of these "walk-in" tests are done with members of the general population, but, as mentioned above, there are members of key populations who choose not to acknowledge their links to a key population when going for a test.

All initial HIV tests are supposed to be done using a Rapid Diagnostic Test kit (RDT), regardless of where that test is performed. However, there are reports that rapid testing is done primarily at mobile/out-reach clinics. There are also multiple reports of stockouts of the test kits and problems with the distribution system for the kits. When RDTs are not available, ELISA tests are used; because these tests are not rapid, clients are required to make a return visit to the testing site to get their results, which can be a disincentive for some clients. Confirmatory testing is done with western blot tests. (Note: Key informants report laboratory staff are paid incentives and/or overtime to do blood tests, so there is a financial disincentive for them to support expanded use of rapid tests for HIV.)

Another potential gap in the testing cascade used in Sri Lanka is the reliance on trained medical staff to administer HIV tests. In other countries, outreach workers have been trained to do the testing themselves, using rapid tests. This approach can further reduce the barriers to HIV testing among key populations. However, in Sri Lanka, it appears clients generally prefer having someone from a medical cadre do any type of blood draw. So, while outreach workers are prepared to do truly mobile field-based testing, it is unclear if there would be sufficient demand to justify it and there does not appear to be any interest in trying to build a program using outreach workers to do testing, despite the fact that it should result in significant cost savings (e.g., multiple staff members from the STD centre would not be needed to operate the mobile/out-reach clinics); there is an opportunity for NSACP to work with qualified CSO partners to pilot test field-based testing using trained outreach workers.

As is the case with prevention work, HIV testing for key populations should be driven by strong community-based, peer-driven activities (e.g., outreach work, drop-in centres). Government facilities and staff clearly play an important role in testing, but critical issues, including hidden/unreached populations, low testing yield and late diagnosis, require the active and sustained participation of CSOs in the community.

Treatment

Sri Lanka has a policy to *treat all HIV positive persons*. The treatment and care services are provided primarily through the network of STD centres around the country, including the central clinic in Colombo and the clinics at district-level. In 2019, there were, 1,845 PLHIV (of an estimated total of 3 600) receiving HIV care services in government clinics. Tracing of patients who are lost to follow-up is carried out by the clinic and appropriate measures are taken to improve ART retention among the PLHIV population.

In the survey of CSOs conducted by the TRA, 58% of respondents reported 'lack of knowledge, including treatment' was a main reason that clients are lost to follow-up. A slightly higher percentage (52%) reported 'linking PLHIV to care and treatment' could be improved.

95% of the of PLHIV receive first line ART regimens; however, only 73% receive the recommended fixed dose combination drug. Currently, pre-ART drug resistance testing is not in place, but initiatives are underway to introduce this to improve the quality of the care and treatment. All ARV drugs are procured by the MOH, a significant step towards a sustainable response.

Procurement delays for some drugs and cartridges for GeneXpert and CD4 tests occur and pose challenges for the venereologists treating PLHIV. See Section 4.2 for additional information on stock-outs of drugs, reagents and other commodities.

4.1.1 Impact of COVID-19 on Health service delivery

The impacts of COVID-19 on service delivery have been numerous and have been documented in a recently published study conducted in Sri Lanka[39]. Some of the most important impacts result from employing critically important physical distancing and quarantining measures. As a result, the options for outreach to key populations are impacted as gatherings of a certain size is not allowed and patients are reluctant to access services at facilities for fear of contact with infected people.

Community-based/led HIV services largely accessed by key populations are and will continue to be affected, undermining HIV strategies and approaches for reaching key and marginalized communities. In the TRA survey of frontline workers, 100% of the respondents (33 of 33) who responded to a question about COVID-19 affecting their work on the HIV response report it would have a "major impact".

Discussions with FPA highlighted that efforts have been made to provide partial services using social media platforms to stay in contact with KP groups and promote services. These initiatives should be considered as a permanent part of the package of services going forward.

4.2 Analysis of unit costs

The purpose of this section is to examine the cost of delivering KP services including escorting members of KP groups to STD centres for testing and facilitating testing during outreach visits. As a first step, and to facilitate the comparison, the analysis considers the expenditure incurred by both PRs and funded by the GF. Readily available expenditure data on testing and outreach services provided by STD centre staff, is not available from government records. For now, the analysis assumes that the cost of counselling and performing HIV tests and outreach visits for clients from both PRs is the same and therefore does not impact on the relative efficiency between the two modalities. The focus of the comparison is therefore on the cost of providing KP services and facilitating testing by members of KP groups.

This analysis included all the expenditure incurred by both PRs in providing services to KPs together with an allocation of indirect and overhead expenditure for 2019. The costing did not include the cost of any volunteer time or the use of other non-cash resources that may have been included in an economic costing and no expenditure was annualised. The reported values are therefore reflective of cash flow. The source of expenditure data was from the PUDRs and detailed supporting workings. Direct costs were allocated to KP services in districts by the PR accountants as part of routine reporting. Overhead and indirect costs were discussed in detail with each PR, firstly to assess what portion should be allocated to KP services and secondly how these costs should be allocated to different KP services in the four focus districts. In most cases, overhead costs were allocated to each KP service based on the direct costs incurred in the delivery services. For the case finder model the cost of local coaches was included but the cost of the International Coach was *excluded*, based on an assumption that after the first year, local coaches should be able to oversee and support KP services.

[39] COVID-19 Impact on Key Populations, People Living with HIV and Global Fund Sub-Recipient Organisations in Sri Lanka, CARE Consortium, undated.

Unit costs were calculated using the number of KP members reached with a package of services and the number of tests performed including a small number of repeat tests. Given that service packages between KP groups vary, the unit costs are only comparable where the implementer and the KP group are the same. Even in these cases, the geographical context will impact on unit costs and reduce comparability. Calculating a unit costs per case found was not feasible as the reported cases found were not split between districts and by service modality.

Table 4-2: Summary of unit costs (USD) for the peer educator and case finder model

Peer Educator model

District	Colombo District	Kalutara District		Kurunegala District		Matara District	
Principle recipient	FPA	FPA		FPA	NSACP	NSACP	FPA
Key population	PWID	FSW	MSM	FSW	MSM	TSP	FSW
Number of HIV tests	366	83	83	223	266	138	95
Reached (package of services)	183	320	404	421	362	245	174
Unit cost per HIV test ($)	59	114	124	54	107	133	96
Unti cost per person reached ($)	118	29	26	28	79	75	53
Coversion rate (# tested / # reached)	200%	26%	21%	53%	73%	56%	55%

Case Finder model

District	Colombo district		
Principle recipient	FPA	FPA	FPA
Key population	FSW	MSM	TG
Number of HIV tests	1 628	1 929	300
Reached (package of services)	1 291	724	244
Unit cost per HIV test	47	46	83
Unti cost per person reached	59	123	102

Note: Expenditure excludes the cost of testing but includes the cost of overheads, a share of drop-in centre costs and local coaches. The cost of the lead coach, a medium-term international TA has been excluded[40] from the above unit cost. Source: Primary data source GF PUDR

Table 4.1 above highlights a wide variation in the cost per person reached. For example, 2019 data shows the cost per person reached, using the Peer Educator model, varied from $26 (MSM in Kalutara district) to $118 (PWID in Colombo). Similarly, the cost per test across multiple key populations in four districts varied from $54 (FSW in Kurunegala) to $124 (MSM in Kalutara). There also seems to be no consistency within the same KP groups. The variability could results from several factors including the level of expenditure incurred in that district, the productivity of peer educators, the number and density of members of key population groups but most importantly, the total number of persons reached and tested (the denominator). The proportion of people reached that decide to test also varies between the different groups and impacts on unit cost. The highest conversion rate achieved is for MSM in Kurunegala (73%) and the lowest conversion rate is for MSM in Kalutara (21%); there appears to be no consistency across KP groups or within KP groups. The average conversion rate is 46% across all groups excluding PWID. (The PWID ratio is distorted as FPA reported a higher number of tests than people reached with services.)

High variability in unit costs per person reached is also reflected in other countries. In a 2014 cost effectiveness study (Vassall et al)[41] examined the cost effectiveness of a package of services to KP groups including screening and testing. The study data covered a 4-year period and 22 districts in India. The mean cost per person reached was $327[42], but unit costs varied

[40] Including this cost would distort the unit cost and the assumption is made that after the first year, locally based coaches can continue to implement the programme.

[41] Vassall A et al, Cost-effectiveness of HIV prevention for high-risk groups at scale: an economic evaluation of the Avahan programme in south India; Lancet Glob Health. 2014 Sep;2(9):e531-e540

[42] The unit cost includes cost elements which were not included in our costing study and are therefore not comparable

from $26 in one district to $824 in another. As a total programme, the interventions were found to be cost effective although this may not be true of each district.

For the case finder model, the unit cost per person tested is lower, in most cases, than the unit costs per person tested calculated for the peer educator model. This may be due to the more focused attention on testing (i.e., *yes to test*), more concentrated KP populations, higher prevalence in these populations and the intensive coaching and supervision. The number of tests is unlikely to remain at current levels if the CFM were implemented in the same district over a longer period. Any decline in the number of tests would result in an increasing unit cost.

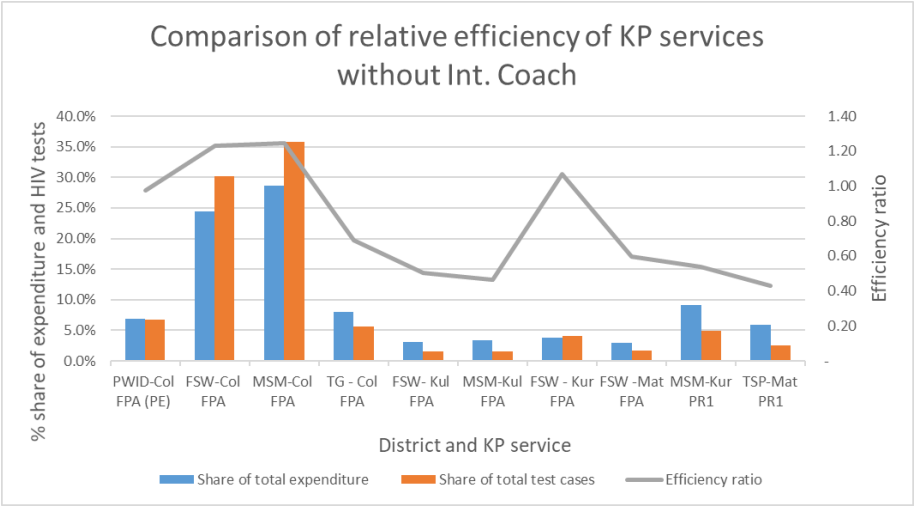
To add to the analysis of unit costs, the TRA calculated a relative efficiency indicator. The indicator is based on the proportion of total KP expenditure allocated to a specific KP service compared to the total number of HIV tests recorded for that KP group in that district. An indicator of 1 (vertical axis on right of graph) indicates that the number of tests recorded as a proportion of total tests is the same as the proportion of expenditure allocated. Values of less than 1 indicate a proportion of tests which is less than the proportion of expenditure (less efficient) and a value of more than 1 indicates a bigger proportion of tests than expenditure (more efficient). Variations can be caused by all the factors referred to above in the discussion of unit costs.

The figure below highlights the relative efficiency of the case finder model when considering testing as a measure, but case finder services also absorb a much bigger share of the total expenditure on KP services. MSM and FSW services in Colombo also reflect an indicator value of more than one because of a bigger share of people tested when compared to share of expenditure. The peer educator model services consume relatively few resources but except for FSW in Kurunegala, generate a share of tests which is lower than the share of expenditure with indicator values of less than one.

Given the many variables that impact on this indicator (and on unit costs) and the fact that many services were not well established, it is not possible to draw clear conclusions from these calculations as values are not comparable across districts and KP groups. The peer educator services which are being implemented by PR1 may mature and start to generate improved number of people reached and tests given the investment made and the case finder model may become less productive as it becomes harder to find new un-serviced KP population groups.

As a best next step, the TRA suggest the inclusion of such an indicator, unit costs and the people reached to testing conversion rate as routine reporting items which should be monitored closely and used to produce a trend over time. This will allow programme management to react more swiftly if the indicator values drop over time, examine and manage those services where indicator values remain low and unit costs high and to develop a better understanding of efficiency in specific contexts.

Figure 4-1: A relative comparison of efficiency between KP services



4.3 Procurement and supply chain management systems

Although procurement systems were initially not a focus area of this TRA, because all ARV's are procured by the GOS[43], the lengthy procurement process and reports of stock outs (see below) required further examination of the systems which support the procurement of ARVs in particular. A capacitated and effective procurement and supply chain management (PSM) system is a critical component of a sustainable response. The procurement of ARVs is the responsibility of a technical subcommittee on care and treatment within the NSACP referred to as the Procurement Review Committee. The sub-committee is supported by the drug estimation and quantification committee. Estimates of procurement needs are submitted early in the year preceding the year for which consumption has been estimated (e.g. early in 2020 for the 2021 year). The estimates are submitted to Medical Supply Division (MSD) which in turn submits the approved procurement quantities to the State Pharmaceutical Corporation (SPC). The SPC is a state entity, which works as the procurement agent of the MOH, but does not fall under the MOH. Buffer stock are usually maintained for 3 months.

Other health products and consumables for the HIV response such as condoms, lubricants and HIV rapid diagnostic are funded mainly through the GF grant ($776 034 for the current grant). The procurement of these commodities (PR1) is coordinated by the GF coordination unit of the NSACP and implemented mainly through Pool Procurement Mechanism. There is no GF budget provision specifically aimed at strengthening the procurement system.

Although this section will focus on the procurement of ARVs, the NSP (2019-2022) reported delays in delivery of kits and reagents for the laboratories; it noted a delay of two years between placing an order and receiving supplies. Several challenges specific to the procurement of ARVs have previously been documented and were confirmed in discussions with stakeholders and include the following:

- The Annual reports for 2018 and 2019 noted the long time it took for the procurement process to unfold. The NSP and the External Review (2017) note the occurrence of stock-outs which may be closely related to the long procurement process (National

[43] A policy decision was made to provide ARV utilizing state funds in 2016 and the country expanded provision of free ART to all PLHIV through the STD centres - A Guide to Antiretroviral Therapy National AIDS/STD Control Programme, Towards Ending AIDS, Sri Lanka, 2016

Medical Regulatory Authority (NMRA)). NSACP indicated that stock-outs were no longer an issue except for paediatric drugs which are procured in small quantities[44].

- Estimating the requirement of ARV drug is a challenge. NSACP indicated that estimating the total number of patients was not difficult but estimating the patient numbers on different regimens was challenging, e.g. due to unpredictable rate of changing to preferred regimens and a lack of drug toxicity data.
- Multiple agencies involved in the procurement process (NSACP, MSD, SPC, NMRA)
- ARVs are supplied and managed by the MSD (via SPC) and private suppliers are not authorized to import ARVs; an international tender is required each time. Although the NMRA can provide waivers, vendors are deterred by the related fee.
- Procurement quantities are small and response rates from international suppliers are poor and impacts on costs.
- There is insufficient laboratory capacity to facilitate routine quality assurance checks (other than fixed combination first line which is carried out by the National AIDS Research Institute, Pune, (NARI) in India) and post distribution sample testing.
- Storage facilities for drugs at the Central NSACP pharmacy stores has been lost due to an expansion of the hospital infrastructure and at many peripheral clinics are inadequate.
- Dispensing of ARV drugs at the STD centres is currently undertaken by Pharmacists and Nursing Officers. Pharmacists are not present at all STD centres which may places an additional burden on nurse time.

In summary, although the risk of stockouts seems to have been addressed and is relatively low, the procurement of ARVs and laboratory supplies remains cumbersome and protracted, and efforts to streamline the process would be beneficial. The procurement processes do not adequately accommodate the need for urgent, emergency procurement of ARVs. Issuing waivers to smaller suppliers at little cost would strengthen the reliability of supplies from in-country vendors and reduce dependency on international suppliers. NSACP is also exploring options of procurement with neighbouring countries. There is currently a high dependence on the GF pooled procurement mechanism for the procurement of other HIV health commodities and this comprises a function which will eventually have to be transitioned to a local procurement agent over the next grant implementation period.

4.4 Human resources for health

The human resource base in the public sector in Sri Lanka is large with approximately 130 000 staff engaged in providing health services at the central level and at provincial, district and divisional levels[45]. Approximately 60% of the total staff fall under the central Ministry of Health while the rest are employed by the provincial government management.

The 34 STD centres, along with 23 branch clinics, are managed and operated by approximately 550 staff. Approximately 25% of the total staff complement is attached to the NSACP while the rest of the staff work within the administration of the 9 provinces in the STD centres.

The staff complement at the STD centres typically includes a Consultant Venereologist, who is the technical expert responsible for the technical functioning of a STD centre. In addition, each centre has a Medical Officer-in-charge who also oversees the administration of the centre and works closely with the Consultant Venereologist. The other centre staff cadres provide clinical services to STD patients, and laboratory, pharmacy and field-based outreach services via the STD clinics. All STD centre staff are paid from the government budget. Management

[44] Discussions with NSACP indicated that some stockouts had occurred due to COVID-19 restrictions but these would not ordinarily have occurred.
[45] Annual Health Bulletin, Ministry of Health, Sri Lanka, 2017

Assistants, located in the centre and in the GF supported districts, are paid from the GF budget through PR1 and are linked to the provision of KP services.

Prior to the implementation of dedicated service-provision models for KP services through the GF grant, field-related tasks were carried out by the Public Health Inspector attached to each of the STD centres. The expansion of KP services, typically provided as outreach services, required personnel with extensive field experience, knowledge of KP groups and with linkages to civil society. The STD centres therefore require the support of personnel identified from the KP population themselves. In response and explained in detail in section 6, CSOs were contracted with GF support to provide the services of Field Supervisors and Peer Educators to expand the interventions for KPs and other high-risk populations.

Outreach services include programmes (mainly lectures) carried out by the Consultant Venereologist targeted at general population groups like school children, youth groups, university students and at high risk (vulnerable groups) like migrant workers, military staff and garment factory workers and at KPs. The KP outreach activities are usually carried out as a once-a-week clinic in collaboration with the CSO/CBO responsible for specific KP groups in 15 selected districts. For each KP programme, the relevant STD centre mobilizes a team that includes the Venereologist or the Medical Officer from the centre, a nursing officer, the PHI, the laboratory technologist, a labourer and a driver. The STD centre team carries out counselling and testing for HIV. The respective CBO participates in the outreach activities and uses the opportunity to deliver a package of KP services using a team of peer educators, out-reach workers, field supervisors and coaches.

With Sri Lanka transitioning from the GF, one of the challenges relates to the recruitment of a cadre of field staff, knowledgeable about and accepted by key populations, to provide services to KP groups if it is decided not to work with CSOs or suitable CSOs are not available in a particular district. The creation of cadres within the government sector for these staff categories will be difficult and may not always be desirable. The anticipated difficulties of hiring suitable field staff to support a robust national KP programme further supports the need to establish mechanisms to partner with CBOs and CSOS either at the national or regional levels to provide effective KP-led interventions.

In a similar vein, it may not be possible to mobilise domestic funding for international consultants for coaching and mentorship services, an important function to build the capacity of local service providers and maintain quality of services. Government does not usually allocate funds for international TA from local resources, especially for long-term mentorship and coaching.

Capacity at NSACP

The NSACP in Colombo manages the National HIV/AIDS response with the support of technical and administrative units like the pharmacy, administrative and finance. The national programme is managed by the Director and the Deputy Director. All Specialists and other identified officers comprise the Senior Management Team that oversees the implementation of the national response. The Consultant Venereologists head up and coordinate technical units. Important technical units include the following:

- Care and Treatment of HIV and STI persons
- Laboratory services
- KP services and epidemiology
- IEC, Condom Promotion, STI care
- Multi sectoral response
- Training - staff
- HIV Testing services

- Advocacy
- Strategic Information Management[46]
- Global Fund Project Implementation Unit.

The newly introduced technical areas supported via the GF do not have focal points and are managed by the GF coordinator. These areas include introduction of pre-exposure prophylaxis, self-testing and interventions for PWIDs.

The largest technical team is dedicated to providing care and treatment (which includes antiretroviral therapy, contact tracing, defaulter tracing, TB screening, psychiatry services and adolescent care) and comprises the majority of the 125 NSACP central clinic staff; no staff are dedicated to providing prevention services. These services are managed under the direct supervision of all the STD centre Venereologists and the Medical Officer in charge. The SIM unit is also a well-defined and established unit and manages all information management related tasks.

The GF Project Implementation Unit (PIU) has relatively few staff and co-ordinates the implementation of the GF HIV grant. The PIU and its support units were not originally established with the intent to manage and coordinate a large number of implementing, sub-recipient CBOs; a function performed by FPA. Although the NSACP is managing a small number of sub-recipients, it does not *currently* have the capacity and operational systems to coordinate and adequately monitor and support the activities of all the SRs involved in providing KP services, should these be transferred from FPA. This, combined with the lack of dedicated focal points and uncertainty about the implementation model going forward, poses a risk to the smooth incorporation and implementation of activities transitioned to the NSACP.

4.5 Health information systems

The health information management system is a critical building block of systems for health and typically includes four key functions: (i) data generation, (ii) compilation, (iii) analysis and synthesis, and (iv) communication and use[47]. The system provides information to decision-makers at all levels of the health system to identify problems, make evidence-based decisions on health policy and allocate scarce resources optimally. A robust strategic information system is critical for strong evidence driven programming, management and accountability.

The importance of information systems are acknowledged in the National HIV/STI Strategic Plan (2018-2022) (NSP); one of five key objectives is "To strengthen strategic information systems (SIM) and knowledge management for an evidence based response". Under the objective, four strategic directions are identified being HIV and STI Surveillance, Programme Monitoring and Routine Reporting, HIV-related research and ongoing knowledge management. Each strategic direction is unpacked and identifies priority interventions which must be implemented to achieve the objective. The NSP points out that the reporting system is '*entirely paper-based which is inefficient and creates delays in the chain of patient processing and impedes effective central'* and notes that the entire HIV case tracking system from screening to viral load suppression needs to be integrated in an electronic data management system. The External Review Report[48] highlights the fact that the case monitoring system is complex and fragmented between different units and sites and is divided between the Epidemiological Unit and SIM unit of NSACP. The report also notes the absence

[46] There is no M&E unit the MOH. This function is managed via health information units and other data management units in the different directorates

[47] Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies; WHO; 2010; accessed on https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

[48] External Review Report, National Health Sector Response to HIV & Sexually Transmitted Infections in Sri Lanka, September 2017

(at the time of writing) of a standard operating procedure and notes the lack of standard formats in certain cases and importantly, the absence of an alert mechanism to immediately raise an alert LFU or linkage loss.

The NSP and recommendations in the External Review Report therefore prioritise, amongst many other actions, the following:

- Fast track the (implementation) of the electronic system for data management through an integrated, web-based data system which also provides for HIV case tracking from screening till viral suppression and proposes a central common database.
- Provide regular feedback from the SIM Unit to ART centres regarding loss to follow-up (LFU) including a strong alert response system to immediately alert the facility staff about occurrence of LFU
- Enhance capacity of NSACP and facility staff to conduct regular analysis of existing data
- Develop robust standard operating procedures and related tools and standard formats outlining clearly roles and responsibilities.

It is clear from the above that the NSACP recognises the importance of strengthening the SIM system for all the reasons mentioned above and transition readiness is largely determined by the extent to which these crucial systems have been put in place and operationalised and recommendations implemented and to what extent the implementation of above is dependent on external funding or TA support.

The NSACP Annual Report (2018)[49] reports that the NSACP initiated development of an Electronic Information Management System (EIMS) during 2017 with the support of the GF through Ministry of Health. The integrated components of the of EIMS, which links central and district levels, include:

(1) STD Clinic Management System
(2) Reporting Module
(3) HIV care, ART management and Monitoring System
(4) Queue Management System
(5) Laboratory Information Management System
(6) Private Sector Module
(7) Pharmacy Management System

The development of the EIMS, an HIV specific system, is still in progress and certain modules are not complete including the reporting module. A unique electronic patient record is created and visible to all STD centres and in the case of members of KP groups, can accommodate a Unique Identifier Code (UIC), the methodology for which was developed by FPA. One staff member at all the clinics has been trained. In most STD centres the other modules of the EIMS are all installed and operational. This paperless system creates a comprehensive patient record for each person. The initial intent was for the reporting module to feed into DHIS2 (general health system) but the general health information system was not considered to be sophisticated enough to accommodate the specificities of the HIV program requirements. There is no automatic sharing of HIV data with the rest of health system due to the need for confidentiality. Data can however be shared in aggregate and specific data requests can be accommodated. Notwithstanding the advantages of using local consultants to develop the system, the NSACP expressed some **concern about the level of support being received** and the rate of implementation. NSACP are the owners and custodians of the EIMS system. NSACP

[49] National STD/AIDS Control Programme Sri Lanka, Annual report, 2018

does not currently have a dedicated M&E team to oversee the implementation of activities by the CSOs and conduct data validation visits and checks.

FPA have developed their own online, web-based project and information management system which can accommodate up to 20 concurrent users for data entry on multiple projects[50]. Project activities, like the GF project, are registered onto the system to support implementation of the project, monitor progress and facilitate reporting. FPA, using local consultants, update the system from time to time and refine it to accommodate new projects. The system differentiates between programmatic reporting and M&E reporting. Reports are available monthly and can be disaggregated down to outreach worker and PE levels; and are used to calculate incentive payments. Patient identification through use of the UIC was introduced in late 2018 but is not being used in all districts; current use is in Colombo, Gampaha and Kandy. FPA indicated that the coding system needs to be further developed and correct implementation validated in the field. Although data errors do occur (e.g. KP group members registered with two different UICs), each implementer is visited twice a year to conduct a review of service delivery and validate output data to ensure accurate reporting. In summary, this is an established HMIS system and maintenance is funded through contributions from multiple projects which supports sustainability. The system has been refined to respond to the specific needs of the project and facilitates the oversight and management of implementing CSOs.

The Global Fund continues to provide significant support for the development of information systems at the NSACP and contributes to the maintenance and refinement of systems at FPA. More specifically, the funding request for the current grant (2019-2021) describes the following supported HIMS activities:

- Strengthening SMI so that EIMS runs smoothly and is expanded to all ART centres in district STD centres.
- Building the capacity of the district STD centres to ensure accurate data entry and improved analysis and understanding of the local HIV/STI situation.
- Supporting operational research and reviews and standardising the M&E systems for the KP program ($213 000 in year one).
- For PR 2, extending intervention mapping and developing geographical density maps to track intervention coverage, distribution of commodities, HTS and PLHIV identified,
- The HIV data currently available in the Monitoring and Evaluation Information Management System of PR2 will be integrated with the GIS system to automate the process.

The table below summarises the total budget for the current implementation period for both PRs to support health information systems including operational research and reviews. The two biggest items comprise the development of a standard M&E system for the KP program in year 1 and the mid-term review in year 2. Excluding these items results in an approximate contribution of $130 000 per annum. Other development partners, mainly UNAIDS and WHO, make valuable contributions by funding TA and research studies on an ad hoc basis such as this TRA study. Other funding challenges not provided for in these budget amounts include the following:

- Although systems maintenance is provided for there is no provision for the **replacement of hardware** which is also not provided for in the MOH budget.
- There is limited funding for the ongoing **EIMS-related training of staff** at the STD centres. This includes both training for new staff but also refresher training for existing

[50] If facilities do not have access to the internet, data is captured on hardcopy first and subsequently captured onto the system.

staff. To address this requirement NSACP has initiated an e-learning platform which provides on-line courses. Although the initial development of this was covered by the WHO, there is a recurrent cost attached to maintaining and updating the platform. Some of these costs were covered by the collaboration with CDC to strengthen strategic information systems, but that three-year project has come to an end.

Table 4-3: Summary of GF budget values for health information systems

Budget element	2019 (USD)	2020 (USD)	2021 (USD)	Total (USD)
PR1: Operational research and mid-term review	12 784	69 476	6 950	89 210
PR1: Routine reporting including EIMS support	321 321	95 035	89 755	506 111
PR2: Routine reporting including maintenance of the technical hub and technical assistance	30 082	32 289	34 683	97 055
Total	**364 187**	**196 800**	**131 388**	**692 376**

Source: Principal recipient budgets 2019-2021

4.6 Laboratory services

The laboratory services for STIs and HIV are provided via the National Reference Laboratory (NRL) situated within the NSACP and the district level laboratories located in 27 of the district STD centres. The district level laboratories are manned by Medical Laboratory Technicians while the laboratory network is managed by a Microbiologist at the NRL. All peripheral laboratories can perform an ELISA test as a HIV screening test while confirmatory HIV tests are carried out only at the NRL in Sri Lanka.

The laboratory capacity for CD4 testing facilities expanded from 3 STD centres (NRL, Galle and Kandy) in 2018 to 10 STD centres in 2019. Viral load testing machines are also available in 3 centres (NRL, Galle and Anuradhapura) and further expansion of these services are currently ongoing.

It is important to review the additional burden on the laboratory sector resulting from the use of ELISA for screening of all antenatal mothers. Based on KII there may be beneficial to review the possibility of replacing the use of ELISA with a pre-verified point of care test

(Rapid Tests) to carry out the antenatal screening of mothers and accelerating the use of rapid tests at STD centres. The NRL should oversee and monitor the procurement and storage of the tests and regularly perform routine lot testing to verify test kit performance.[51]

As the CD4 count machines and viral load testing facilities are now available in selected district level STD centres, efforts should be made to ensure a regular supply of required cartridges to ensure optimum utilization of these tests to further improve the quality of care provided to HIV positive persons.

[51] Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, 2nd edition. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. Downloaded from https://apps.who.int/iris/bitstream/handle/10665/112858/9789241505888_eng.pdf?sequence=1

4.7 Transition risks - Service delivery and HIV support systems

Risk description	Likely impact
2. Stigma and discrimination There is a risk that deep-rooted stigma and discrimination toward members of key populations will continue in Sri Lanka.	There is a wide-ranging negative impact on key populations, including effects on their health-seeking behaviours, risk perceptions and risk behaviours, mental health, family relationships, employment, access to housing and access to legal services. Members of KP groups may remain hidden and/or 'unreachable' and not seek needed services. Systemic stigma and discrimination can influence policy and programme decisions at all levels of the HIV response.
High level recommendations: • Reducing wide-spread and long-standing stigma and discrimination towards members of key populations is a massive task that is beyond the capacity of the HIV response. However, it should be possible to focus on specific actions to reduce the barriers that limit or prevent the use of essential HIV services by key populations. It is particularly important to think about the barriers that limit or prevent use of services by hidden or unreached populations. • There is a parallel opportunity to look at ways to address other aspects of systemic stigma and discrimination (e.g., criminalized behaviors, police harassment, sexual violence) that negatively affect the ability of key populations to have greater control over the HIV risks that they face.	

Risk description	Likely impact
3. Coverage of KP services There is a risk that the coverage of services for key populations will continue to be limited and fail to reach the majority of key population members, many of whom are hidden in the general population.	If interventions fail to reach a large proportion of key populations, many members of the key population groups will not receive essential prevention, testing and treatment related services. This means fewer new infections will be averted and fewer undiagnosed cases will be found at an earlier point of disease progression. This may result in an increase in incidence. Limited access to these services can also contribute to key populations remaining hidden or being classified as "not reachable" because they are not able or prepared to access what services are available.
High level recommendations: • Develop and implement a comprehensive, *national* KP intervention programme to achieve a minimum of 80% coverage by 2025. A full range of HIV-related services should be widely available and readily accessible to key populations at scale, using STD centres and/or community-based programs (e.g., outreach activities and drop-in centres). • Increasing coverage will require rethinking on how to deliver HIV services in geographic areas that cannot support a full KP program due to small numbers of KPs living in the district. Providing essential HIV services to hidden and unreached members of key populations will require a similar rethinking. (See below.)	

Risk description	Likely impact
4. Hidden populations Existing KP programmes are not able to reach "hidden" members of the different key populations. In addition, there has not been sufficient thinking and/or planning about how to connect with these sub-groups.	A continued inability to provide prevention and testing services to hidden and/or unreached members of key populations has the potential to undermine effective work with these populations in other areas, making it more difficult to reach epidemic control in Sri Lanka.
High level recommendations: • Factor hidden and unreached populations into the goals, objectives and targets of KP programmes and approaches to implementation of services.	

Risk description	Likely impact
5. HIV testing yield The yield from the two main HIV testing approaches focusing on key populations is consistently low and the cost per case identified is high.	Given the nature of the epidemic, undiagnosed HIV cases will be increasingly difficult to find and increasingly expensive on a per-case-identified basis. Policy makers and planners may raise questions about the value of the investment in these approaches, which could lead to a reduction in the availability and uptake of HIV prevention and testing services overall.
High level recommendations: • New HIV cases will be harder and more expensive to find as the total number of undiagnosed cases declines. It is important to balance testing yield with the value of the prevention component of outreach programs. However, it is equally important to explore other approaches to testing, both to improve yield and reach people who are not currently being reached, including expanded community testing (i.e., rapid testing done by outreach workers), rapid testing in all settings to reduce lost-to-follow-up, provider-initiated testing and self-testing. • Explore opportunities to improve public perceptions and increase usage of the network of STD centres by repositioning them as positive and supportive providers (e.g., sexual health centres as opposed to STD centres); leverage the link to sexual health to increase HIV testing and strengthen prevention programs.	

Risk description	Likely impact
6. Slow adoption of innovations There is a risk that Sri Lanka continues to resist the adoption of innovative or alternative approaches to activities that could improve the performance and effectiveness of the key-population programs (e.g., PrEP, self-testing, contact tracing app).	The lack of innovation limits the ability of Sri Lanka to develop and implement the adaptable KP programs that it needs for effective and sustained HIV prevention, testing and treatment.
High level recommendation: • Put in place a strategy and plan to develop, test and rollout innovative or alternative approaches to HIV activities to address the multiple challenges in Sri Lanka in a timely manner (e.g., stigma and discrimination, prevention programming for key populations, coverage of HIV testing services, testing yield, hidden populations, loss to follow-up).	

Risk description	Likely impact
7. Protracted procurement systems There is a risk that the protracted and complex procurement processes for ARVs and the procurement of small quantities of ARV's may result in stock-outs of required ARVs at STD centres.	Stock-outs of ARVs impacts directly on the quality of care for PLHIV and increases the possibility of HIV transmission, increased morbidity and mortality.
High level recommendations: • Streamline the procurement process for ARVs and include the participation of all relevant agencies. Research to inform a more accurate estimation and quantification of need should be undertaken. • Develop mechanisms for the urgent procurement of small quantities of ARVs through local suppliers and reduce barriers to participation by local suppliers. • Explore the possibility of partnering with another country for the supply of required drugs or explore the possibility of using a multi-year procurement framework agreement to ensure regular delivery of the required drug combinations. • Explore the benefits that may arise from using a pooled procurement mechanism and innovative procurement tools, to secure a timely supply of ARVs at an acceptable price.	

Risk description	Likely impact
8. Fully implementing EIMS There is a risk that ongoing efforts to **refine and scale up the EIMS** to all districts, (including the use of UICs and a completed reporting module) and the diligent maintenance of the EIMS system are limited as external support reduces over time.	A fully functioning EIMS is not established and maintained and essential and accurate data for planning, managing and monitoring the response is not available which ultimately impacts on the effectiveness and efficiency of HIV-related services.

High level recommendations:

- Use the current grant funding to ensure that the EIMS is fully installed and operationalized in all districts including training of key individuals in the districts. This includes the establishment of electronic data sharing between the EIMS and the FPA grant management system.
- Motivate for the inclusion of adequate funding for ongoing maintenance of the EIMS and training of staff in budget submissions to the MOH and ensure inclusion of the resource need in the business plan submission by MOH to the treasury to secure domestic funding
- Motivate for the inclusion of adequate funding for operational research based on an agreed country HIV research and surveillance agenda.

Risk description	Likely impact
9. Research and evaluation activities Essential, ongoing operational research and program evaluations and reviews are curtailed as external funding declines.	Accurate data about key populations, KP services and progress against outcome and impact indicators is not available which impacts on NSACP's and other stakeholder's ability to plan and manage the response to achieve targets.

High level recommendations:

- Motivate for the inclusion of adequate funding in the MOH budget request to implement an agreed country HIV research, monitoring and surveillance agenda.

Risk description	Likely impact
10. Capacity to manage a complex KP-services program NSACP does not have the capacity to manage, support and monitor the provision of HIV-related services to key populations by multiple CSOs and CBOs. Building this capacity within government may result in an expensive and bureaucratic approach to providing the oversight and support to the CSOs and CBOs implementing a KP-services program.	The lack of capacity within NSACP to provide oversight and support to multiple CSOs/CBOs, particularly smaller, KP-led or KP-focused organizations with their own capacity constraints, could undermine the partnership between government and civil society and reduce the effectiveness of the program. Without a robust and flexible system in place to support partner CSOs/CBOs, the ability of these organizations to provide vital services to key populations could be compromised.

High level recommendation:

- Government and civil society should develop and agree on a practical strategy and fully resourced operating plan for the management and oversight of CSOs and CBOs providing HIV-related services to key populations, which builds on the relative strengths of the involved organizations.

5 Health financing and transition

5.1 Macroeconomic and fiscal environment

As noted above in the context, Sri Lanka was classified as an upper-middle income country (2018) and GDP per capita has increased steadily and was estimated to reach $4 152 per capita in 2020 (see table below). As a result of the impacts of COVID-19, the country was reclassified in 2020 to a lower middle-income country with an estimated per capita income of $4020, somewhat lower than the original estimate. In the post-civil war period, the economy grew at an average of 5.6% in real terms for the period from 2010 to 2019[52]. This period of relatively rapid growth also reflects the policies of a government committed to reconstruction and development. Unfortunately, growth has slowed in the latter portion of abovementioned period and reached a low of ~2.7% in 2019, partly due to the terrorist attack in April of that year. Nevertheless, growth is expected to increase steadily in the medium term to above 4.6% by 2023 (IMF estimate).

Government revenue as a % of GDP is relatively low (11.14% in 2019) and increasing government revenue is a key strategy described in the Fiscal Management Report (2019)[53]. It is the treasury's objective to increase this to 17% by 2022 which would reduce the persistent budget deficit and dependence on regular access to external financing through debt. Public debt levels are relatively high and low fiscal revenues combined with largely inflexible expenditure on human resources, transfers, and interest payments have constrained development spending on health, education and social protection, which is low compared to peer countries (WB country overview).

Table 5-1: Macroeconomic indicators for Sri Lanka (2015-2020)

Indicator	2015	2016	2017	2018	2019*	2020*
GDP (US$ billions)	80.557	82.390	88.013	88.901	86.566	92.111
GDP per capita (US$)	3 842	3 885	4 104	4 099	3 946	4 152
Real GDP growth (percent)	5.008	4.487	3.420	3.209	2.720	3.532
Government revenue (% of GDP)	10.75	11.63	12.07	11.89	11.14	12.88
Government expenditure (% of GDP)	16.40	16.03	16.88	16.57	16.10	17.82

Source: International Monetary Fund 2019, World Economic Outlook database, October 2019 edition.
* - 2019 and 2020 are estimates.

Unfortunately, the COVID-19[54] outbreak is likely to impact on estimated growth rates and exacerbate fiscal pressures. Growth will be negatively affected and a slowdown in economic activity could trigger jobs and earnings losses. A high deficit, increasing debt levels and the need to access financial markets frequently, make Sri Lanka vulnerable to the impacts of uncertain global financial conditions. This challenging environment will make it more difficult to access additional domestic funds for health and other human development initiatives and social protection.

5.1.1 Health system financing overview

In Sri Lanka total current health expenditure (CHE), measured as a percentage of gross domestic product, has changed little between 2013 and 2017: it seems to be rangebound

[52] World Bank Country Overview - https://www.worldbank.org/en/country/srilanka/overview
[53] Fiscal Management Report 2019, Mangala Samaraweera, M.P., Minister of Finance, 05th MARCH 2019
[54] https://www.worldbank.org/en/country/srilanka/overview

between 3.6% (2014) and 3.9% (2016) of GDP[55]. By comparison CHE in Vietnam and Cambodia is approximately 6% of GDP over the same period which seems to point to a relative under-investment in health. However, per capita health expenditure has increased steadily from 2013 ($139) to 2017 ($159) and is higher than per capita expenditure in Vietnam and Cambodia, $130 and $82 respectively for 2017. Steady economic growth and a near-static population has facilitated this growth in per capita expenditure.

Reliance on external sources of funding for health in Sri Lanka is low and Domestic Health Expenditure (DHE) as a percentage CHE is 99% for 2013-2017. Although public health provision in Sri Lanka is free, government health expenditure comprises 43% of domestic expenditure (2017) while the balance is largely funded through out of pocket expenditure (50% in 2017). Other private expenditure and voluntary health insurance (2% in 2017) makes up the balance. These indicators are broadly in line with those in Vietnam but private health expenditure in Cambodia is even higher as a % of DHE (61% in 2017). In total, reliance of the health system on external funding is relatively low at 1% of current health expenditure which provides a robust platform to further transition remaining externally funded elements of public health services.

Table 5-2: Health System Financing Indicators

Financing Indicator	2014	2015	2016	2017
Current Health Expenditure (CHE) per Capita in US$	139	151	153	159
Current Health Expenditure (CHE) per Capita in PPP	409	466	490	504
Current Health Expenditure (CHE) in million constant (2017) USD	1 231	1 371	1 404	1 416
Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	3.6	3.9	3.9	3.8
Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)	99	99	99	99
Domestic General Government Health Expenditure (GGHE-D) as % CHE	45	44	43	43
Domestic Private Health Expenditure (PVT-D) as % CHE	54	55	56	56
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	1	1	1	1
Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE)	9	8	9	8
Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP)	2	2	2	2

Source: WHO – National Health Accounts indicators

5.2 Public financial management

5.2.1 Summary of the budget process

Financing for government from public funds, including the health sector, is determined by several elements of legislation including the constitution and the Fiscal Management (Responsibility) Act No. 3 of 2003. Key participants in this process are the Department of National Planning (Ministry of National Policies and Economic Affairs)[56] which ensures that policies, action plans, programs, and projects formulated and implemented by various government agencies comply with the National Development Policy Framework and the medium-term macroeconomic policy framework. In the Ministry of Finance, the Department of National Budget (DNB) is responsible for preparing the national budget and having it approved by the legislature.

[55] Source for all NHA health expenditure statistics unless otherwise stated: http://apps.who.int/nha/database/ViewData/Indicators/en - National Health Accounts

[56] Public Financial Management Systems—Sri Lanka. Key Elements from a Financial Management Perspective, Asian Development Bank, March 2018

The annual budgeting process unfolds to facilitate the passing of the annual Appropriation Bill by parliament. The *government* contribution to funding the HIV response is estimated and secured through the government budget process and funding is allocated directly to the MOH for HIV response-specific budget lines such as ARV drugs, and through the funding secured via the Finance Commission for the Provinces, which provides for salary and other costs associated with running he STD centres and hospitals where HIV-related services are provided. Resources are not allocated to HIV specific budget line items at that level.

The deployment of human and other resources is determined by the provincial, regional (district) and facility management. An increase in the demand for HIV-related services may not be prioritised at the sub-national level given the demand for other health services (e.g. COVID_19). NSACP has no *direct* control over the allocation of additional staff and resources at the subnational level. Increases in resource needs for the HIV response may therefore require an engagement with budget processes both centrally and at sub-national level depending on the nature of the resource required and the function being expanded.

The ADB PFM systems review (referred to above) identified concerns, one of which was that actual (budget) transfers made to provincial councils by the central government for criteria-based grants and province-specific development grants are less than the amount allocated in the central budget. In a similar vein, consultations have highlighted that within government, the transfer of funds from the treasury may not align with the approved budget allocations in terms of *timing* and that late payment in the first two quarters of the fiscal year are common. It is unlikely that CSOs have the resources to internally fund the implementation activities and late payment may even erode the sustainability of some of the smaller CSOs resulting in a disruption of services and a potential loss of established community-level capacity. Should this occur in a scenario where NSACP or provinces are responsible for paying CSOs for service delivery, significant disruption to service delivery may occur as many CSOs do not have the financial resources to self-fund activities or provide internal bridging finance.

A move to zero-based and performance-based budgeting[57]

To discourage incremental budgeting, the national treasury issued a budget circular in 2016[58], which instructed the spending agencies to use a zero-based budgeting approach to formulate their budget requests to improve efficiency and the distribution of limited resources. The treasury has since issued guidelines and calls for budgets for the fiscal year 2018[59] to be formulated based on the performance-based budgeting approach. In government wide systems such transitions and changes in approach take time and given the high proportion of the budget which comprises fixed payments (referred to above) the scope for significant changes and improvements are limited.

Notwithstanding the above, this approach to **budgeting does create an opportunity for introducing new program activities and budget lines** given strong motivation and the ability to accurately monitor delivery and performance. This echoes the sentiments expressed by the treasury representatives interviewed, who were not concerned about the financial impact of KP services but were adamant about the need for a strong business case and management framework.

[57] Public Financial Management Systems—Sri Lanka. Key Elements from a Financial Management Perspective, Asian Development Bank, March 2018

[58] Budget Circular No. 03/2015 of 29 July 2015

[59] DNB Circular No. 2/2017

5.3 NSP Costing and funding shortfall

The purpose of this section is to examine the estimated total resource need to implement the HIV response and to identify the funding gap when compared to current contributions from domestic sources and the Global Fund. A summary of the NSP costing estimate is presented in the table below. A National Aids Spending Assessment (NASA) has not been completed since 2010 and the allocation of external funding to the HIV Programme in the National Health Accounts (NHA) estimates appears significantly understated. It is therefore not possible to easily corroborate the estimates by comparing these to recent summaries of total HIV expenditure. An examination of the NSP costing workbook reveals use of lump sums without a clear description of the underlying costing assumptions. Nor is it clear what the costing approach was but the workbook seems to suggest a fiscal cost approach, i.e. an approximation of cash flow which excludes any economic opportunity costs.

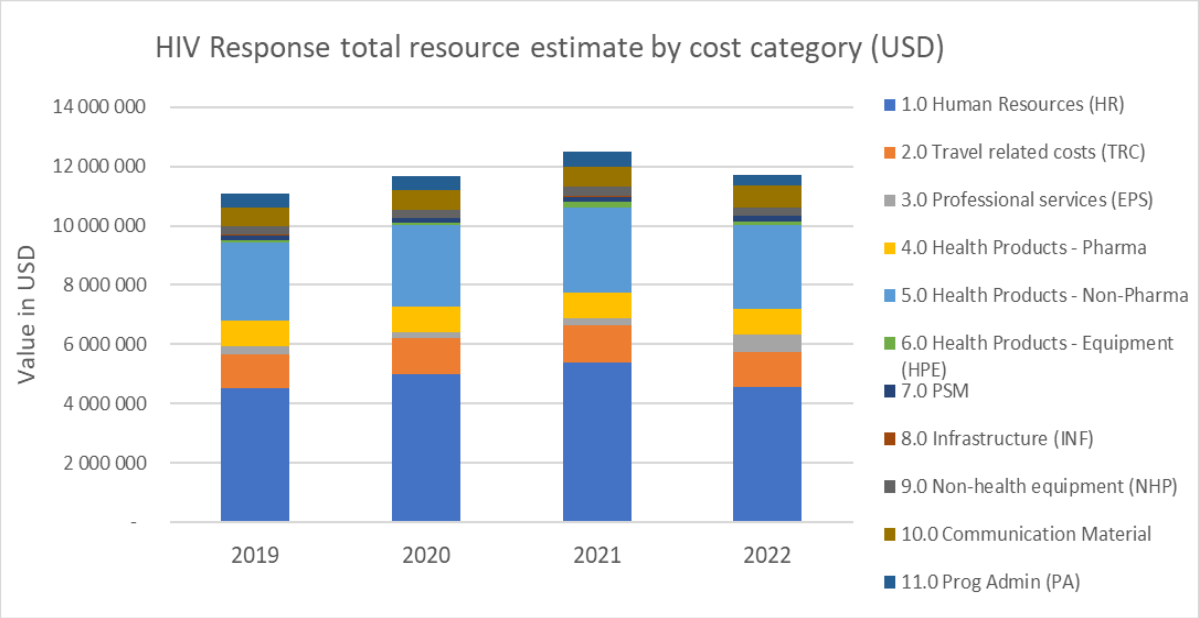
The estimates in the table below indicate a resource need of $59 million over five years and an average of just below $12 million per annum. Health systems strengthening needs comprise 40% of the total while prevention and diagnosis, treatment and care comprise 23% and 29% of the total, respectively.

Table 5-3: Summary of total NSP response resource estimate (USD)

Strategic direction	2018	2019	2020	2021	2022	TOTAL	%
1. Prevention	3 684 093	2 411 656	2 794 757	3 045 267	1 998 187	13 933 959	23%
2. Diagnoisis, Treatment and care	3 785 213	3 406 215	3 467 824	3 689 180	3 304 178	17 652 610	29%
3. Strategic Information	781 068	533 222	455 420	536 917	924 724	3 231 350	5%
4. Health Systems Strenghening	4 466 865	4 491 267	4 746 662	5 010 648	5 293 938	24 009 381	40%
5. Supportive environment	221 370	224 816	225 622	233 539	176 723	1 082 070	2%
Grand Total	**12 938 609**	**11 067 177**	**11 690 285**	**12 515 551**	**11 697 750**	**59 909 371**	100%
Available from domestic resources		6 450 369	6 814 930	7 218 568	7 651 682	28 135 549	
funding from the GF		2 724 952	2 363 371	1 803 617	2 133 333	9 025 273	
Estimated funding shortfall (after GF)		**1 891 856**	**2 511 983**	**3 493 366**	**1 912 735**	**9 809 940**	

The biggest cost category (see Figure 5-1 below) comprises Human Resources (42%) followed by non-pharmaceutical health products (23%). A closer examination of the health systems strengthening value ($24 million) reveals that this comprises largely of human resources for 30 STD centres ($13.2 million) and the NSACP ($6.3 million) and other operating costs. Prevention includes HR ($5.5 million) and procurement of commodities including condoms. Of the prevention HR amount, $4.8 million comprises allowances for over 900 peer educators and 69 Field Coordinators based on a previous version of the PE model. Human resource costs for the 'existing model' reduce to nil in the final year from $1.1 million in year 4 of the projection. A logical reason is not provided and is likely an error. Based on the current PE model, significantly fewer PE are provided for which would imply a reduction in the HR estimate unless the coverage of districts is increased and / or it is decided to increase the number of PE in exiting districts. Of the total for diagnosis, treatment and care ($14.7 million) $7.1 million is for STI drugs and tests while $4.2 million provides for HIV tests, mainly rapid test kits.

Figure 5-1: Analysis of total annual need by cost category

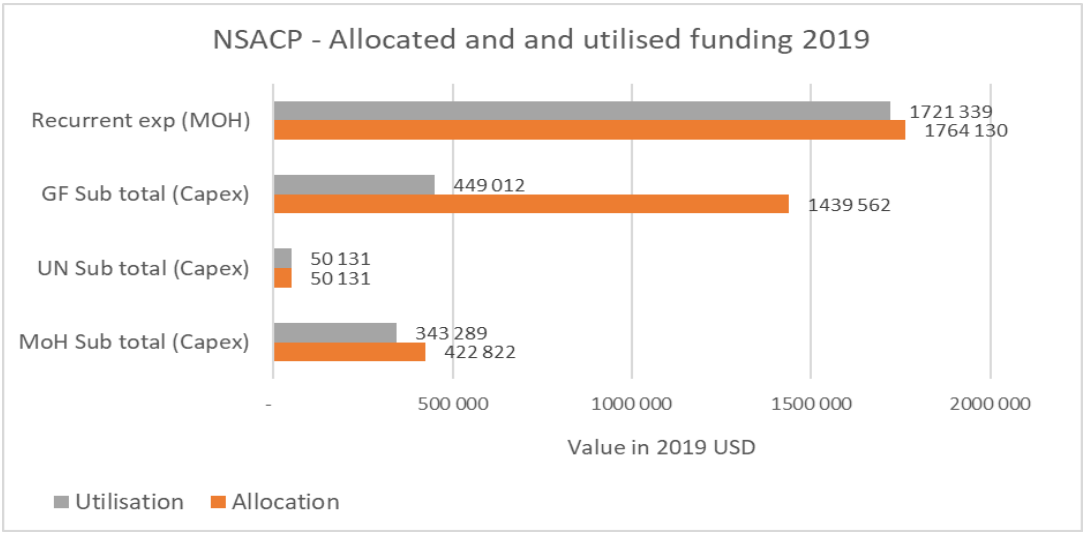


5.3.1 NSACP total allocation

Figure 5-2 below summarises the total NSACP allocation actual expenditure incurred during 2019. The total NSACP allocation is $3.7 million and the amount utilised was $2.6 million[60]. Adding commitments increases the utilised value by $250 000. The MOH allocation comprises 60% of the total NSACP allocation including capital and recurrent expenditure. The GF allocation comprises 39% and the UN Agencies comprise 1% of the total allocation, respectively. The recurrent allocation comprises substantially of human resources ($852 112) and ARVs ($579 701). These allocations were almost fully expended. (Absorption is described in more detail above in section 3.5.3. Adding the FPA allocation for 2019 of $1.3 million would result in a total know allocation to the response of $5 million. The allocation and expenditure of funds at the sub-national level in support of the response is not known but if the outreach activities undertaken by centre staff and other HIV services provided at STD centres is included, the amount is likely to be significant. Even if it is argued that the allocation and utilisation values do not reflect the true need for HIV-related funding, the significant difference between the NSP estimate and the actual allocation is significant; the NSP estimate is more than double the value of the total NSACP allocation. Again, this highlights the need for an accurate assessment of the resources requirement to implement the response over the medium term.

[60] NSACP Annual Report 2019 – Chapter 24

Figure 5-2: Summary of NSACP allocations and utilisation for 2019 (USD)



Source: NSACP Annual Report. A detailed breakdown of the amounts is provided in Annex 5.

5.4 Quantifying the funding shortfall

Based on the GF funding landscape tables (see table 5-3 above), the annual contribution from domestic resources comprises between $6.5 million and $7.7 million in 2022[61]. The GF contribution based on the current GF grant declines from $2.7 in 2019 to $1.8 million in 2021. The GF value for 2022 is an annual average based on the total allocation for the next implementation period. Based on these calculations and a full implementation of the NSP, an annual shortfall remains of approximately $2 million. As the number of patients on ART increases and coverage of services to KPs improves, the total resource need will continue to expand unless interventions are significantly redesigned, or efficiencies are introduced. If the total resource need does *not* increase from current levels for reasons mentioned above, the total annual shortfall without GF funding would approximate $4 million - $5 million per annum in the medium term. As noted earlier in this chapter, total government health expenditure from domestic sources is approximately $1.4 billion per annum and this additional contribution would comprise ~0.35% of this value.

NSACP may need to revise the estimates of resource needs, given multiple factors, including potential changes in KP service-delivery modalities, the need to increase coverage of KP services and improve case detection, a likely shift to dolutegravir-based ART regimens and challenges with the absorption of funds**.** These revisions should be based on a transparent and robust costing of the remaining years of the NSP and be projected to include the next GF implementation period and the transition workplan period based on updated and validated costing assumptions. A logical next step is to describe the funding landscape, including an estimate of available domestic funding for the response, taking into account the impacts of COVID-19 on the fiscus, and the resulting funding gap.

[61] The 2010 NASA estimates domestic expenditure on HIV to be $4.5 million and $4.7 million for 2009 and 2010 respectively

5.4.1 Transition risk – Estimate of resource need and funding gap

Risk description	Likely impact
11. Understanding the funding gap There is a risk that a poor understanding of the total resources required to implement the HIV response makes it difficult to motivate for increased domestic (or external) funding to close the gap between current and expected funding levels and the total resource need.	The absence of an accurate estimate of the total resources required to implement the HIV response, and the associated gap between available funding and the need, undermines advocacy efforts to increased governments investment in the HIV response. This may lead to an underfunded response which has wide ranging implications on the coverage and quality of services and may ultimately impact on the country's ability to sustain gains made and achieve NSP targets.
High level recommendation: • Based on a refined HIV programme which may include innovations, technical efficiencies and revised targets, estimate the total resource need and likely funding gap over the medium term.	

6 Module 6: Civil Society Organizations

6.1. Role and capacity of Sri Lankan civil society

Community involvement has been a vital component of the global response to HIV from the earliest days of the epidemic. The ability of communities to come together to mobilize support and implement activities has been a major factor in the successes of the HIV response in countries around the world. One of the defining characteristics of community engagement with the HIV response has been the diverse ways that communities and community organizations have been defined, structured and operated. For example, communities / community organizations can be structured around a designated location, a particular interest or area of expertise, a shared demographic and/or a shared lifestyle or identity.

Key populations, which are often marginalized due to stigma and discrimination and which typically bear a disproportionate burden of HIV and AIDS, are one of the most important communities in global, national and sub-national responses to the epidemic. As a result, there are thousands of organizations worldwide that exist to serve different key populations. These organizations play a central role in ensuring members of the key population groups are able to access the necessary HIV-related programmes and interventions. In many countries, these organizations are increasingly led by members from the different KP communities and there is a growing recognition that KP-led organizations are well-positioned to understand the needs of their communities and how best to meet them.

In Sri Lanka, the NSP acknowledges the importance of engaging with key populations to eliminate HIV in the country by 2025. There is also a clear recognition by the many stakeholders in the national response, including government, civil society, international donors, development partners, domestic and international experts and the affected communities/populations, that Sri Lankan CSOs must have an essential role to play in the HIV response for members of key populations in the country. Historically, international NGOs made substantial contributions to the HIV response in Sri Lanka, but their involvement is declining.

The value of CSOs in the response is epitomized by the long-standing designation of the Family Planning Association of Sri Lanka (FPA) as a principle recipient (PR) of the GF financial support to the country for HIV programmes for key populations. This designation began with Phase 2 of the Round 9 grant from the Global Fund, which ran from 2011 to 2015; it continued with

the 2016-2018 grant; and they continue to act as a PR in the current grant (2019-2021). In addition to the central role played by FPA as a PR under the current grant, another 21 CSOs operate interventions as sub-recipients (SRs) of FPA. Another five CSOs are SRs of NSACP, the other PR under the current GF grant.

The SRs are actively involved in implementing a wide range of HIV activities supported by the Global Fund. Examples include:

- The HIV prevention and testing programmes for the key populations, including the community outreach activities in the Peer Education Model (PEM) and the Case Finding Model (CFM) described in Section 4
- Support for members of the PLHIV community, including counselling, transportation assistance and ART retention
- Operation of drop-in centres for members of different populations/communities affected by HIV.

The ability of civil society to contribute to the long-term HIV response in Sri Lanka does have challenges. For example, the SRs are highly dependent on the GF grants for their survival. In fact, several were established specifically to implement the GF grants. For most of them, the path to sustainability as an organization is unclear and probably unattainable. The healthier organizations want to focus on their core mission — their raison d'être — but they are often forced to follow the money, reinventing themselves to do different things based on the resources that are available.

Key informants also expressed concerns about the integrity of some CSOs in Sri Lanka. Trust — particularly in the areas of finance and accountability — is essential to a thriving CSO sector and any betrayal of that trust, even by a small number of organizations, can undermine the critical role that CSOs can and should play in the HIV response.

Most of the 26 SRs working with FPA and NSACP are small organizations with limited capacity in different facets of their operations. Although programmes to build their organizational, management and technical capacity exist and are valued by the SRs, they feel this support is inadequate to prepare them for the post-GF future.

The limited capacity of CSOs working on HIV raises questions about the effectiveness of capacity-building programs for these organizations and their leadership/staff. For example, there are complaints that capacity building focuses on trainings, not on longer-term approaches (e.g., mentoring, recurrent TA) that can make a more meaningful and sustainable contribution to CSO capacity across their operations.

The uncertainty about the viability and sustainability of CSOs contributes to a highly fragmented and competitive landscape for these organizations in Sri Lanka. There are capable, well-resourced, health oriented CSOs in the country (e.g., FPA), but they are the exception. As mentioned above, the survival of many of the CSOs working as SRs depends on external funding, which largely comes from the GF at the moment. CSOs recognize this over-dependence on GF support, but they struggle to identify ways they can replace it when it is no longer available. Many of the CSOs are also struggling to define and build their capacity to conduct day-to-day management and operations in a post-GF era. Their dependency on the GF program combined with the institutional burden of participating in this program has left them ill-equipped to think and act more broadly.

In the HIV response, one consequence of the fragmented landscape is the lack of accepted and supported national networks of organizations working with different KP groups in the country. The lack of effective networks limits the ability of key populations to speak with a strong collective voice that would amplify and add imperative to their messages, concerns and

recommendations. The fragmentation also makes it difficult to nurture capable KP-led and KP-focused organizations, which should be the backbone of a national network. As a result, the number, capacity and contributions of KP-led and KP-focused organizations is limited.

6.2 Sustainability of civil society's contributions to the HIV response

The public benefits of CSO contributions in Sri Lanka are well established, including their positive contributions to the HIV response for key populations in Sri Lanka. The value of the CSO contributions in Sri Lanka is also widely supported by evidence from dozens of countries around the world, which clearly demonstrates the importance of civil society's role in the HIV response for key populations. The challenge in Sri Lanka is to ensure that CSOs can continue, improve and potentially expand their vital role in the HIV response as the country simultaneously pushes to end AIDS by 2025 and transitions to a domestic-funded response.

Key informants in government and civil society generally agree on the importance of a sustained role by CSOs in the HIV response, particularly in programmes focused on key populations. There is also a broad acknowledgement that government funding of CSOs would be the best way to ensure these organizations have the financial resources to maintain their role in the response as the availability of support from the GF and other international organizations declines. However, to varying degrees, different stakeholders also recognize there are significant legal, structural, political, technical and resourcing hurdles that must be overcome if government support of CSOs implementing HIV activities with KPs is going to be a viable way forward in Sri Lanka.

Legal

There are a number of legal issues facing CSOs working with key populations in Sri Lanka which could have an effect on their ability to receive GOSL support for their activities. A core issue is the legal and procedural framework for the provision of government funding to CSOs. There are also potential issues related to the overall legal environment for CSOs and the legal and human rights environment for members of key populations.

According to the Ministry of Finance there are no legal impediments to providing government funds to CSOs to deliver HIV services to key populations. However, the necessary policies and procedures to actually allocate and transfer funds to one or more CSOs for this purpose are not well-defined or operational. While it is possible that an existing mechanism could be used, multiple parties within government (e.g., Attorney General, Ministry of Finance, Ministry of Health) will need to agree on the exact policies and procedures required to ensure CSOs are able to receive GOSL funds for the delivery of HIV services (e.g., establish criteria/standards that CSOs would need to meet to be eligible to receive government funds). In addition, the policies and procedures, including any eligibility criteria or standards, must be realistic and feasible, if CSOs — many of which have limited capacity — are going to be able to comply with them.

According to the 2018 CSO Sustainability Index for Asia, which was published in November 2019, the legal environment for civil society in Sri Lanka has deteriorated in recent years with CSOs facing "delays in registration, continued state scrutiny and surveillance, and weak legal and support services." The report also expressed concerns about strict accountability and oversight requirements, which are likely to be difficult or impossible for small and/or nascent CSOs to meet. For example, all CSOs are requested to submit action plans, audited financial reports, annual reports, statements on funding flows, and staff details. The difficult environment facing CSOs in Sri Lanka undermines their ability to promote the public good and provide vital public benefits, including benefits that they are better positioned to provide than government (e.g., peer outreach work with key populations).

A complicating factor for many CSOs is the lack of qualified professional support to build and sustain their operations (e.g., legal, finance/accounting, administrative/managerial); the lack of professional support is particularly problematic in areas outside of urban centres. In addition, there is not a strong culture of *pro bono* assistance in the private sector, so CSOs are likely to have to pay for this support if it is available at all.

According to multiple sources, members of the various key populations in Sri Lanka face persistent legal and human rights challenges, including criminalized behaviours, stigma and discrimination. The level of stigma and discrimination is so high and so ingrained that key populations are often reluctant to seek legal remedies to address the stigma and discrimination, including the use of the services provided by the Legal Aid Commission. In addition, because of their work with these populations, CSOs can face associative stigma and discrimination, which can interfere with their ability to provide needed services and could limit their access to funds from government.

Structural

There are a wide range of structural factors, including the legal issues cited above, which can influence the implementation and sustainability of a funding agreement between CSOs and government that would allow for the long-term involvement of CSOs in the HIV response. These factors include broad national level considerations and more specific issues related to the capacity and operations of government and CSOs.

In the broader context, the findings for Sri Lanka in the 2020 update of the Rule of Law Index[62] produced by the World Justice Project indicates there are a number of challenging structural issues/factors in the country that could influence a funding agreement between CSOs and the government. The Index looks at eight issues/factors: 1) constraints on government powers; 2) absence of corruption; 3) open government; 4) fundamental rights; 5) order and security; 6) regulatory enforcement; 7) civil justice; and 8) criminal justice. In Sri Lanka, one factor (constraints on government powers) exactly matches the global average; the other seven factors are ranked below the average; the overall global ranking is also below the global average. While the rankings in the Index cannot be directly applied to the issue of the funding agreement between government and CSOs, they are highly relevant to the overall environment in which this type of agreement would be forged and maintained.

In the narrower context of capacity and operations, there are a number of diverse structural factors within the involved institutions that are also likely to influence the implementation and sustainability of government funding for CSO activities for key populations, including:

- Government commitment to long-term CSO funding
- Government commitment to funding HIV programmes for key populations
- Management and oversight capacity in government for a CSO funding mechanism
- Qualifying requirements for CSOs to be eligible to receive government funds
- Administrative requirements for CSOs to apply for and receive government funds
- Availability and sufficiency of funds to provide HIV-related services for key populations
- Competition for funds among the CSOs
- Timely disbursement of funds from government to CSOs
- Reporting requirements on how funds were spent and what were the outcomes/results
- Checks and balances to prevent corruption and misuse of funds
- Interoperability between government and CSOs in frontline responsibilities and activities (e.g., STD centre operations and CSO outreach activities)
- High levels of stigma and discrimination against key populations

[62] https://worldjusticeproject.org/rule-of-law-index/country/2020/Sri%20Lanka/

In the absence of clear policies, procedures, structures and mechanisms to provide government funds to CSOs for KP programmes, it is difficult to identify and assess the specific structural factors that will affect the sustainability of CSO involvement in these programmes. However, it is likely that multiple factors in both the broader and narrower contexts will influence sustainability.

There are also a wide range of structural factors facing CSOs themselves, including weaknesses in governance, management and operations. Addressing these weaknesses should be a priority for existing CSOs if they expect to be recipients and effective users of public funds. And where there is a need for new organizations (e.g., more KP-led CSOs/CBOs, national networks for KP groups), it is essential that adequate systems and support are in place to have sound and responsible governance, management and operations.

Although there have been extensive investments in capacity-building activities by multiple projects and organizations in recent years, key informants report the impact of capacity-building activities is limited. While it is clear that capacity-building activities are valued, the concern is that they tend to be driven by one-off/stand-alone trainings, when there is a greater need — and a greater benefit — to having recurring support (e.g., mentors, twinned organizations, networks) to effectively address the structural weaknesses of the CSOs.

To continue their work with key populations in Sri Lanka, CSOs need a straightforward and reliable system to provide various types of support, including managing the flow of funds from government, mutual accountability and reporting systems, M&E/data systems and technical assistance. Government's inclination to build more bureaucratic systems raises questions about their ability to provide the range of support required by CSOs and whether alternative approaches should be explored (e.g., providing a block grant to a CSO to manage the CSO component of the HIV response for key populations).

Political

Despite reports from key informants of a general willingness in government to support the role of CSOs in the HIV response for key populations, multiple sources believe the political will to sustain and expand this role is volatile and could be adversely affected by many different factors, including the general political climate and key personalities in government. Small changes in the political climate or the power structure could limit or eliminate the flow of funds to CSOs because the government and/or vocal constituents do not approve of public funds going to CSOs or, more specifically, to CSOs working with key populations.

As is the case in most countries, there are indications that the political will to involve and fund CSOs in the HIV response is highly dependent on who is in decision-making positions at multiple levels in government, ranging from senior politicians in national government to the managers of individual STD centres. A lack of political will at any level can be disruptive to the operations of a CSO and its ability to provide valuable HIV services to its clients.

The high levels and deep-rooted nature of stigma and discrimination against key populations could easily undermine political support for public funds to be used directly (e.g., through government-implemented programs and activities) or indirectly (e.g., through CSO-implemented programs and activities supported by government resources) for HIV-related activities for these populations.

There is also the broader political issue of protecting the fundamental rights of the members of key populations. For example, there has been a long-running national discussion about repealing Article 365 and 365a of the Sri Lankan Penal Code, which criminalizes same-sex conduct. Although the law is not generally enforced, it is reported to be the basis of ongoing

stigma and discrimination of key populations and it contributes to an environment of harassment and intimidation of members of KP groups. In addition, the fact that the law has not been repealed is an indication of an underlying lack of political will to protect the rights of key populations and reduce stigma and discrimination.

Technical

Any funder has a reasonable expectation that CSOs have the technical capacity to provide the services they are being funded to provide. Consequently, it is essential for CSOs to demonstrate their capability and competence to provide services, deliver results, track their performance and account for their funds if they want to make a case for sustained national funding as part of a transition away from international support. However, in recent history, CSOs in Sri Lanka, which have received support from the Global Fund, have a mixed record of demonstrating their capability and competence.

As mentioned above, there have been extensive investments in capacity-building activities by multiple projects and organizations to strengthen CSOs. But there are serious concerns — including concerns from the recipient organizations — about the value and sustained effectiveness of these activities. Ongoing, recurrent support (e.g., the regular coaching used in the case-finding model) is likely to be needed over an extended period if CSOs working on the frontlines of the HIV response are going to acquire and maintain the required knowledge and skills to meet specific targets and overall objectives.

The capacity gap among CSOs can also be linked to the limited number of KP-led and KP-focused organizations. Effective work with key populations requires a level of knowledge, skill and sensitivity that is not easily acquired by people from outside those populations. The few KP-focused/KP-led organizations that currently exist struggle to survive and increased government oversight is likely to make that struggle even more difficult. Key informants report the repositioning of CSOs with expertise in other areas (e.g., health services generally) to work with key populations has been problematic in Sri Lanka, as it has been in many other countries around the world. While they may understand the work, they do not necessarily understand the target population.

There is a parallel gap in the technical capacity of government to oversee/manage the involvement of CSOs in the HIV response. For example, there are discussions about setting up a dedicated Project Management Unit (PMU) in NSACP, which would directly handle the relationships with all of the individual CSOs receiving public funds for HIV work with key populations. However, the operation of this type of PMU is outside the traditional roles and responsibilities of NSACP. In addition, establishing and operating a PMU — or any similar mechanism for the oversight/management of CSOs — would exceed the current human resource capacity of NSACP. There are also legitimate concerns that operating a PMU will introduce another level of bureaucracy into the equation, which could complicate the relationship between government and civil society and compromise the work with key populations.

The recent shift of some CSOs from PR2 to PR1 in 2020 is an indicator of the preparedness of government to take on a comprehensive role in managing the involvement of CSOs in the HIV response. However, key informants from government and civil society reported the shift was poorly handled with inadequate preparation for the change and insufficient information shared with the involved parties about their roles and responsibilities. The absence of any formal guidance and/or set of standard operating procedures related to the transition from PR2 or the ongoing implementation of CSO activities under PR1 complicated the process and important lessons and opportunities have been lost in the process. The experiences are aligned with the issues raised above about structural factors that could hamper the transition to and the sustainability of civil society's overall contribution to the HIV response.

Government and civil society are not always natural partners, given potentially divergent perspectives and approaches. For example, government typically has a top-down approach to management and implementation, whereas CSOs — particularly those working with key populations — can have a more bottom-up sensibility. There are also differences around how best to ensure accountability with government preferring extensive reporting that CSOs can see as burdensome and detracting from their core activities.

The gap in CSO capacity to work effectively with key populations also exists within government. While there is recognition by government that work with KPs requires some specific knowledge and skills, there is a tendency to downplay its importance. There is also a corresponding tendency to downplay the role of CSOs in working with key populations, based on the assumption that government staff can be as effective as CSO staff, including the CSO peer educators and outreach workers.

Resources

Government has demonstrated a willingness to funding CSOs to play a role in the HIV response. For example, in early 2020, the Minister of Health submitted an official memorandum asking the Cabinet of Ministers to "provide Government of Sri Lanka (GOSL) funds for community based / community led organizations for implementation of peer-led targeted intervention programmes until Ending AIDS targets are achieved by the country." There are reports that the memorandum is being developed into a business plan, which will be submitted for review and consideration by government. In addition, the Ministry of Finance has explored how to design, build and operate a CSO funding mechanism. While there are supporters of CSO funding in government, it is unclear if, how, when, in what amount and for how long these funds will be widely available as the transition from Global Fund to domestic financing moves forward.

In the context of CSOs providing HIV-related services to key populations, one of the most fundamental questions about the provision of public funds for this work is the sustainability of those funds. Because of the start-stop nature of traditional donor funding, CSOs with the expertise to work with KPs, including both KP-led and KP-focused CSOs, have struggled to maintain the staff and infrastructure to provide consistent and effective services. Developing a more sustainable, long-term approach to CSO funding is an important opportunity and outcome of a shift to the use of domestic resources to support these activities.

Concerns about the various challenges and gaps — legal, structural, political and technical — all feed into the broader discussions about the availability, stability and sustainability of resources. At the present time, there are many unanswered questions: Will sufficient funds be made available to support the activities of CSOs providing HIV-related services directly to KPs? Will a responsive and efficient infrastructure be put in place to effectively manage the relationship between government and civil society, including members of the different key populations? Will the needed systems in government and civil society (e.g., IT, M&E, administrative, operations) be in place? Will there be adequate human resources in government and CSOs for management and implementation? These uncertainties all contribute to a lack of transition preparedness and can erode the viability and sustainability of the HIV response.

6.1 Transition risks – Civil society

Risk	Likely impact
12. Funding mechanism for CSOs An efficient financing and procurement mechanism for social contracting of CSOs to deliver HIV prevention services, including the timely transfer of funds, does not exist and may take an extended period of time to develop, approve and implement, assuming it moves forward at all.	When external funding declines, it is possible prevention and treatment support services, which are implemented by CSOs and funded externally, will be scaled down or in a worst case discontinued, resulting in increased infections.
High level recommendations: • When external resources are reduced or are no longer available, the government will need to provide funding to CSOs for them to continue to play an integral role in the HIV response. In order for these funds to flow efficiently to CSOs, there needs to be a practical mechanism in place that meets the needs of both government and the recipient CSOs. • Consider the use of a qualified intermediary CSO as the primary recipient of government funds, which it would then redirect to implementing CSOs. The intermediary CSO would also play a role in monitoring accountability of the use of funds; see Risks 10 and 15. • Establish a small oversight board, including representatives from the Ministry of Finance, the Ministry of Health, NSACP and CSOs to monitor the operation and accountabilities of the funding mechanism.	

Risk	Likely impact
13. Capacity of CSOs CSOs have limited capacity at multiple levels of their operations, including governance, management, technical, implementation, accountability, resource mobilization and M&E.	The limited capacity of these organizations has direct implications on their ability to function effectively, including undermining their ability to provide their clients with HIV services and to be reliable and accountable partners of government. The issue of limited capacity is particularly acute among KP-led organizations.
High level recommendations: • Develop and implement a comprehensive plan to strengthen the capacity of CSOs working with key populations on the HIV response. • CSOs must be mindful of their responsibility to improve and maintain the quality of their performance in all aspects of their operations, including their accountability to both funders and clients.	

Risk	Likely impact
14. Predictable and sustained funding Government may not be able to provide sufficient and sustained funding to civil society organizations for HIV-related work with key populations.	With the decline in external resources allocated for CSOs to do HIV-related work with key populations, a lack of or limits on the availability of government funds for these activities could cripple the response for these populations.
High level recommendations: • There must be a commitment by government to provide predictable and sustained funding to support CSOs working on the HIV response, including for continued HIV case detection and for effective, long-term prevention.	

- Stakeholders in the HIV response for key populations should be strong advocates for long-term government funding for the comprehensive programs serving these populations needed to ensure Sri Lanka meets and maintains its 2025 HIV goal.

Risk	Likely impact
15. Lack of trusted relationships between government and smaller CSOs and CBOs Government wariness about CSOs and CBOs, including their motives and lack of capacity, may adversely affect government's willingness to work with these organizations.	In general, a trusting relationship between government and smaller civil society organizations has not been well established as part of the HIV response. This complicates discussions about the role of CSOs in the response as well as the government's readiness to provide funding for these organizations and its willingness to integrate CSO activities (e.g., peer-based programs) with their programs.
High level recommendations: • The long-term effectiveness of the HIV response for key populations depends on a productive and mutually trusting relationship between government and the CSOs/CBOs implementing HIV activities. Consequently, steps should be taken to identify and address any issues that have the potential to undermine this relationship. • Consider the use of a qualified intermediary CSO to coordinate and manage the different CSOs working on the HIV response with key populations; see Risks 10 and 12.	

Risk	Likely impact
16. Lack of KP-led organizations and networks A shortage of KP-led and/or KP-focused organizations in the country complicates efforts to connect with these populations. For example, the lack of viable national networks and/or umbrella organizations for CSOs working with key populations is problematic as is the absence of KP-led and/or KP-focused CSOs in some parts of the country.	KP-led and KP-focused organizations generally provided key populations with a stronger, more representative voice in broader discussions about priorities and resources in both government and civil society circles. Without these organizations, the engagement of key populations is diminished, which is particularly problematic in a country with pervasive stigma and discrimination towards these populations. The effectiveness of KP programmes will be reduced.
High level recommendations: • Develop and implement a strategy to increase the number of KP-led and KP-focused CSOs with the capacity to play significant roles in the HIV response, including networks for KP organizations. • Identify one or more established and effective CSOs in Sri Lanka with experience working with key populations to lead the initiative to develop and implement the strategy to increase the number of KP-led and KP-focused CSOs; wherever possible, the priority should be to add KP-led organizations.	

7 Conclusion

Sri Lanka has made significant progress in managing the HIV epidemic and aims to achieved ending AIDS by 2025. Significant milestones have been achieved and estimated incidence has declined considerably over the last 10 years. Sri Lanka has a concentrated key population driven epidemic and response efforts have focused on providing a package of services to key populations and identifying people living with HIV to enroll them on ART and provide quality care and treatment services. Sri Lanka is fortunate in that the absolute numbers of new infections is extremely low; estimated to be approximately 100 per annum. It is important to sustain prevention services, best delivered through innovative interventions and partnerships between community organisations and government services to protect gains made and prevent an increase in incidence. The low numbers of new infections may also justify a re-examination of what it means to end AIDS in Sri Lanka. The conventional measure of reducing incidence by 90% from 2010 levels may not be applicable and feasible in this context.

Significant support has been provided by development partners, but the largest ongoing external contribution has been provided by the Global Fund to support the response over many years. In addition to direct support for service delivery, the Global Fund has also focused on the importance of civil society and community involvement in the KP response, including active roles for KP-led organizations and other small CBOs.

Given Sri Lanka's economic growth and it's natural progression into middle income status (temporarily halted as a result of the COVID-19 pandemic), means that support from the Global Fund will be phased out and responsibility for funding the HIV response will transition to the Ministry of Health. The transition readiness assessment examined the HIV response and support systems to identify areas of vulnerability or risk, which if not addressed, will pose obstacles to transitioning and will likely erode gains made.

The transition readiness assessment examined the HIV response and support systems to identify areas of vulnerability or risk, which if not addressed, will pose obstacles to transitioning and will likely erode gains made. The TRA identified 16 important risk areas which need to be addressed to facilitate transitioning over the next 5 years. These risks were categorized into four main groups being governance and leadership, service provision, support systems and participation of civil society organisations. The salient and immediate risks are:

- The **uncertainty about how exactly KP services will be provided** once transitioned to the NSACP and whether an appropriate level of capacity is in place to facilitate the transition. Initial assumptions were made that government would take over districts and KP services (from FPA) by employing the SRs directly. Other options exist for engaging with service providers which need to be explored more extensively
- The fact that **current KP-services are not reaching many hidden or unreachable members** of **the KPs** with the result that service coverage is low. It is unlikely that continuing 'business as usual' will result in the achievement of ending AIDS targets by 2025. The need to develop or refine interventions which are aimed at reaching hidden members of the population and identifying those who are living with HIV is important.
- The uncertainty about the extent and **predictability of sustained funding from domestic sources for CSOs and KP services**) to maintain and scale up services but especially in those districts being transferred to the MOH.

The third and final phase of this assignment comprised the development of a road map of next steps to improve the preparedness of Sri Lanka for transitioning from external funding. These next steps respond directly to the transition risks identified in the TRA and the associated recommendations. Three workshops were held with government and CSO stakeholders to

seek input and feedback on a draft list of next steps. The final list of next steps was consolidated into a roadmap and annexed to the report.

Work on implementing the next steps for all risks and recommendations should commence as soon as possible, given that these need to be investigated and unpacked further, proposed solutions and mechanism need to be developed and tested, an enabling environment established (e.g. regulations and SOPs) and then fully 'bedded down' before the next GF implementation period ends at the end of 2024. Rapid implementation will also improve chances of achieving the end AIDS target by 2025. The National STD/AIDS Control Programme is ideally positioned and is mandated to drive the implementation of the actions in close collaboration with the multi-sectoral sustainability working group and with the support of all stakeholders.

Annex 1 - List of key officials and informants consulted

The table below provides a list of key officials and informants consulted during the implementation of the TRA assignments. Many other stakeholders were consulted as part of group discussions both during the inception visit, during the data collection phase and via the electronic surveys. More details regarding group meetings and the survey can be provided on request.

Key informant	Name of the organisation	Designation
Mrs. B Jayawardena	Ministry of Health	Secretary Health
Dr. L Somatunga	Ministry of Health	Additional Secretary, Public Health Services
Mr. S Manthreenayake	External Resources Department, Ministry of Finance	Additional Director Genera
Ms. A Batagoda	Department of Budget, Ministry of Finance	Planning and Budget Director
Mr. S Bandara	UN Division, External Resources Department, Ministry of Finance	Director
Ms. D Dilani Peiris	National Planning Department, Ministry of Finance.	Deputy Director
Dr. R Siyambalagoda	CCM Sri Lanka Secretariat	Focal Point CCM
Ms. R Bhatia	UNAIDS	Senior Policy Advisor
Dr. R Pendse	WHO	WHO Representative (Sri Lanka)
Ms. R Nacken	UNFPA	Representative, Sri Lanka
Ms. M Dissanayake	UNFPA	Assistant Representative, Sri Lanka
Dr R Hettiarachchi	National STD/AIDS Control Programme, Ministry of Health	Director
Dr. L Rajaakshe	National STD/AIDS Control Programme, Ministry of Health	Deputy Director and Coordinator, HIV care services, EMTCT of HIV and syphilis programme
Dr. K Ariyaratne	National STD/AIDS Control Programme, Ministry of Health	Coordinator, Strategic Information

Key informant	Name of the organisation	Designation
Dr. J Elwitigala	National STD/AIDS Control Programme, Ministry of Health	Consultant Microbiologist, National Reference Laboratory for STI and HIV
Dr. S Benaragama	National STD/AIDS Control Programme, Ministry of Health	Epidemiologist and KP Focal Point
Dr. S Herath	National STD/AIDS Control Programme, Ministry of Health	GF HIV PR1 Project Coordinator
Dr. G Samaraweera	National STD/AIDS Control Programme, Ministry of Health	HIV testing / Prevention and Multisectoral Unit
Dr. C Jayakody	National STD/AIDS Control Programme, Ministry of Health	IEC, Advocacy and Condom promotion
Mr. C Senevithathna	GF NSACP Project Office	GF Project (PR1) Accountant
Dr. G Weerasingha	National STD/AIDS Control Programme, Ministry of Health	Consultant Venereologist (Retired)
Mr. Kahaduwarachchi	National STD/AIDS Control Programme, Ministry of Health	Accountant
Dr. M Rajapaksha	STD Clinic, Kalutara	Consultant Venereologist
Dr. S Somawardena	STD Clinic, Kurunegala	Consultant Venereologist
Dr. N Jayasuriya	STD Clinic, Matara	Consultant Venereologist
Mr. S Berry	International Consultant	Consultant and leads coaching team of Case Finder Model
Ms. N Fernandopulle	Family Planning Association of Sri Lanka (FPA)	Program Manager, HIV, PR2
Ms. T Agus	Family Planning Association of Sri Lanka (FPA)	Executive Director, FPA
Dr. S Samarakoon	Local Funding Agent, Price Waterhouse Coopers, (PwC) Sri Lanka	Public Health Specialist
Mr. N Perera	Diversity and Solidarity Trust (DAST)	Trustee
Ms. B Harendran	National Transgender Network	Executive Director
Mr. M Nissanka	Alcohol and Drug Information Center (ADIC)	Programme Manager

Key informant	Name of the organisation	Designation
Ms. Chamari	Abhimani Women's Network	Executive Director
Mr. R Wickramasignhe	Organisation of Environment and Children Rights Preservation (OECRP)	Executive Director
Mr. N Senadeera	Lanka Plus	Executive Director
Mr. S Nilanka	FPA – Regional grant	Programme Officer
Ms. S Abeykoon	Legal Aid Commission	Senior Legal Officer
Mr. C Piyasekara	Environment and community development information center	Executive Director
Mr. S Wicramasinghe	Mithuru Mithuro Movement	Programme Manager
Mr. Gamini	Samadhi Foundation	Outreach Coordinator
Mr. R de Silva	Enhanced peer outreach project – Global Fund	Team Lead Coach

Annex 2 - Breakdown of the current Global Fund grants

Table 1 below provides a breakdown of the current GF grants to both PR1 and PR2 by module. Across both grants the programme management module absorbs 27.6% of the grant while prevention services for KPs and other vulnerable groups together account for 52.2% of the grant. In this proportion the biggest share is allocated to services for MSM (23.9%) and sex workers and their clients (14.1%).

Table A2-1: Budget by module of Global Fund grant 2019 to 2021 for both PRs

Module	PR 1: MOH; PR 2: FPA	Y1 2019	Y2 2020	Y3 2021	Total and % from respective PR budget	% of total PR1/2 budget
Program Management	PR1	241 954	216 411	206 988	665 353 (19.9%)	27.6%
	PR2	449 977	405 772	377 751	1 233 500 (34.8%)	
RSSH: Procurement and supply chain management systems	PR1	74 548	130 392	82 820	287 760 (8.6%)	4.2%
RSSH: Health management Information Systems M&E	PR1	334 105	164 511	96 705	595 321 (17.8%)	10%
	PR2	30 082	32 289	34 684	97 055 (2.7%)	
Programs to reduce human rights related barriers to HIV services	PR1	9 460	8 310	8 310	26 080 (0.8%)	0.4%
Comprehensive prevention programs for MSM	PR1	394 764	348 650	190 568	93 3982 (27.9%)	23.9%
	PR2	246 118	287 805	178 854	712 777 (20.1%)	
Comprehensive prevention programs for TGs	PR1	44 949	18 228	33 235	96 412 (2.9%)	4%
	PR2	60 127	59 744	59 370	179 241 (5.1%)	
Comprehensive prevention programs for sex workers and their clients	PR1	55 414	44 615	54 518	154 547 (4.6%)	14.1%
	PR2	309 173	305 735	201 660	816 568 (23%)	
Comprehensive prevention programs for people who inject drugs (PWID) and their partners	PR1	40 906	7 749	6 839	55 494 (1.7%)	2.4%
	PR2	36 155	36 691	36 274	109 120 (3.1%)	
Comprehensive prevention programs for people in prisons and other closed settings	PR1	81 657	73 893	66 025	221 575 (6.6%)	3.2%
Prevention programs for other vulnerable populations	PR1	19 236	18 570	10 178	47 984 (1.4%)	4.6%
	PR2	110 007	112 368	43 730	266 105 (7.5%)	
Treatment Care and Support	PR1	142 534	47 853	71 324	261 711 (7.8%)	5.7%
	PR2	43 785	43 785	43 785	131 355 (3.7%)	
TOTAL	**PR1, PR2**	**2 724 951**	**2 363 371**	**1 803 618**	**6 891 940 (100%)**	**100%**
Subtotal (PR1)	PR1	1 439 527	1 079 181	827 510	3 346 218 (100%)	51.4%
Subtotal (PR2)	PR2	1 285 424	1 284 188	976 108	3 545 720 (100%)	48.6%

Table 4.3 below shows the distribution of the current grants by cost category by PR (NSACP and FPA). Across both grants, the largest cost category comprises human resources (HR), 44.5% of the total. However, when looking at the PR grants separately HR comprises 71.8% of the FPA grant and a much lower proportion (15.6%) of the NSACP grant. The largest items on the NSACP grant comprise non-pharmaceutical health products (23.2%), external professional services (14%) and non-health equipment (12.6%). For FPA, other significant items include external services and overhead costs.

Table A2-1: Budget by cost category by Principal Recipient

Cost Category	PR 1: MOH; PR 2: FPA	Y 1: 2019 (US$)	Y2: 2020 (US $)	Y3: 2021 (US $)	Total US$ and % from respective PR budget	% of total PR1/2 budget
Human resources (HR)	PR1	200 493	145 823	177 111	523 428 (15.6%)	44.5%
	PR2	901 921	959 115	684 989	2 546 025 (71.8%)	
Travel related costs (TRC)	PR1	135 826	116 509	102 146	354 481 (10.6%)	7.5%
	PR2	65 850	54 568	43 485	163 903 (4.6%)	
External Professional services (EPS)	PR1	279 355	124 981	64 344	468 679 (14%)	11%
	PR2	109 815	81 157	99 307	290 279 (8.2%)	
Health Products Non-Pharmaceuticals (HPNP)	PR1	144 422	408 705	222 908	776 034 (23.2%)	11.3%
Health Products Equipment (HPE)	PR1	104 072	38 486	40 608	183 166 (5.5%)	2.7%
Procurement and Supply chain management costs (PSM)	PR1	74 548	130 392	104 169	309 109 (9.2%)	4.5%
Infrastructure (INF)	PR1	27 435	11 455	14 331	53 221 (1.6%)	0.8%
Non-Health Equipment (NHE)	PR1	283 500	68 611	70 183	422 293 (12.6%)	6.3%
	PR2	4 474	4 858	5 280	14 612 (0.4%)	
Communication Material Publications (CMP)	PR1	10 627	4 363	3 516	18 505 (0.6%)	0.7%
	PR2	11 897	10 743	9 798	32 438 (0.9%)	
Indirect and Overhead costs	PR1	179 250	29 856	28 195	237 301 (7.1%)	8.8%
	PR2	149 330	131 612	91 112	372 054 (10.5%)	
Living Support to client / Target Populations (LSCTP)	PR2	42 136	42 136	42 136	126 408 (3.6%)	1.8%
TOTAL	**PR1, PR2**	**2 724 951**	**2 363 370**	**1 803 619**	6 891 940 (100%)	100%
Subtotal (PR1)	PR1	1 439 527	1 079 181	827 510	3 346 218 (100%)	48.6%
Subtotal (PR2)	PR2	1 285 424	1 284 188	976 108	3 545 720 (100%)	51.4%

Annex 3 – Transition road map

SRI LANKA HIV TRANSITION READINESS ASSESSMENT

ROADMAP OF HIGH-LEVEL RECOMMENDATIONS AND PROPOSED ACTIONS

This Transition Roadmap constitutes the final product of the transition readiness assessment. It presents high-level recommendations which respond to the transition risks and vulnerabilities described in this report and consolidates the actions proposed to implement the recommendations with the feedback obtained during three virtual workshops.

The purpose of this roadmap is to provide direction and guidance to the NSACP and other stakeholders and provides a framework within which to formulate solutions and more detailed tasks for implementation, assign responsibilities and timelines. The roadmap can also inform the development of the Global Fund funding request for the next implementation period.

The development of a roadmap is not the end of the process nor should it be viewed as a set of actions which are cast in stone. Instead, it is a dynamic document which should be updated from time to time and should guide the development of detailed operational plans that draw from the transition readiness report and that will lead to the implementation of the recommendations and ultimately to a sustainable and effective HIV response in Sri Lanka.

Work on implementing the proposed actions for all risks and recommendations should commence as soon as possible, given that these need to be investigated and unpacked further, proposed solutions and mechanism need to be developed and tested, an enabling environment established (e.g. regulations and SOPs) and then fully 'bedded down' before the next GF implementation period ends at the end of 2024. Rapid implementation will also improve chances of achieving the ending AIDS goal by 2025. The National STD/AIDS Control Programme is ideally positioned and is mandated to drive the implementation of the actions in close collaboration with the multi-sectoral sustainability working group and with the support of all stakeholders.

Risk 1. Multi-sectoral governance and accountability mechanism
High level recommendation: • Initiate and implement a process to develop a common vision for a multi-sectoral governance mechanism where all parties have a voice, to oversee the implementation of the national HIV response. Existing structures may form part of this mechanism. • The mechanism should be fully operational before the last GF grant ends; it could be run concurrently with the CCM and its committees or it could be a de facto replacement for the CCM in the final year of the last grant.
Proposed actions to address the recommendations: • Conduct a comprehensive mid-term review of the HIV programme including its governance and coordination mechanisms and related systems. • Establish a committee, in which all stakeholders have a voice, to develop and confirm the vision and mission of a sustainable HIV programme including its multi-sectoral governance and coordination mechanisms, that need to be in place following Global Fund financing for HIV in Sri Lanka. Governance and coordination mechanisms must provide for representation from CSOs. • To inform the committee's activities, conduct a review of available AIDS governance and coordination structures including understanding TOR of all the AIDS councils, committees, multisectoral committee, CCM and sub-committees at central and regional levels to assess their capacity and 'fit for purpose' as mechanisms for efficient coordination of the response. • Develop and document a strategy to capacitate and operationalization the coordinating mechanism and secure resources to fund the mechanism.

Risk 2. Stigma and discrimination
High level recommendations: • Reducing wide-spread and long-standing stigma and discrimination towards members of key populations is a massive task that is beyond the capacity of the HIV response. However, it should be possible to focus on specific actions to reduce the barriers that limit or prevent the use of essential HIV services by key populations. It is particularly important to think about the barriers that limit or prevent use of services by hidden or unreached populations. • There is a parallel opportunity to look at ways to address other aspects of systemic stigma and discrimination (e.g., criminalized behaviors, police harassment, sexual violence) that negatively affect the ability of key populations to have greater control over the HIV risks that they face.
Proposed actions to address the recommendations: • Work closely with members of different key populations at national and sub-national levels to better understand where and how stigma and discrimination has the most serious effects on their HIV risk and their access to and use of HIV-related services. • Work with the various stakeholders in the HIV response to identify and understand the multi-level nature of stigma and discrimination (e.g., intrapersonal, interpersonal, community, organizational/institutional and government/structural[63]) that effects KPs in Sri Lanka. • Assess if any activities in Sri Lanka to reduce HIV and/or KP-related stigma and discrimination have been effective in the past. If there have been effective activities, explore how to expand and/or improve on them. For example, many stigma-reduction programs are not sustained over time, which limits their reach and their effectiveness. Also look at effective stigma-reduction programs in other countries for activities and lessons applicable in Sri Lanka. • Implement new and proven approaches to address HIV- and KP-related stigma and discrimination that limits access and use of HIV-related services by key populations, including regular training and mentoring on stigma and discrimination for health care workers. Work closely with key populations when pilot testing activities to get their input on the approach and its effectiveness. • Develop formal mechanisms to ensure quick and strong actions on complaints related to stigma and discrimination in the health sector.

Risk 3. Coverage of KP services
High level recommendation: • Develop and implement a comprehensive, *national* KP intervention programme to achieve a minimum of 80% coverage by 2025. A full range of HIV-related services should be widely available and readily accessible to key populations at scale, using STD centres and/or community-based programs (e.g., outreach activities and drop-in centres). • Increasing coverage will require rethinking on how to deliver HIV services in geographic areas that cannot support a full KP program due to small numbers of KPs living in the district. Providing essential HIV services to hidden and unreached members of key populations will require a similar rethinking. (See below.)
Proposed actions to address the recommendations: Due to the links between Risks 3, 4 and 5 a set of integrated and related actions have been proposed under Risk 5.

[63] Heijnders M, Van Der Meij S. The fight against stigma: an overview of stigma-reduction strategies and interventions. Psychol Health Med. 2006;11: 353–63.

Risk 4. Hidden populations not receiving services
High level recommendation: • Factor hidden and unreached populations into the goals, objectives and targets of KP programmes and approaches to implementation of services. • Put in place a strategy to develop, test and rollout innovative or alternative approaches to HIV activities to address the multiple challenges in Sri Lanka (including the hidden populations of Sri Lanka) (e.g., persistent stigma and discrimination, limited prevention programming for most at risk populations, limited coverage of HIV testing services, linking PLHIV to treatment, adherence low testing yield and the existence of hidden or not reachable segments of key populations) and ensure key populations not only have access to vital HIV services, but also use those services.
Proposed actions to address the recommendations: Due to the links between Risks 3, 4 and 5 a set of integrated and related actions have been proposed under Risk 5.

Risk 5. HIV testing yield
High level recommendations: • New HIV cases will be harder and more expensive to find as the total number of undiagnosed cases declines. It is important to balance testing yield with the value of the prevention component of outreach programs. However, it is equally important to explore other approaches to testing, both to improve yield and reach people who are not currently being reached, including expanded community testing (i.e., rapid testing done by outreach workers), rapid testing in all settings to reduce lost-to-follow-up, provider-initiated testing and self-testing. • Explore opportunities to improve public perceptions and increase usage of the network of STD centres by repositioning them as positive and supportive providers (e.g., sexual health centres as opposed to STD centres); leverage the link to sexual health to increase HIV testing and strengthen prevention programs.
Proposed actions to address the recommendations: (The links between Risks 3, 4 and 5 create an opportunity to address them through a set of integrated and/or related actions.) • Establish a representative working group with a small oversight/steering committee to develop a comprehensive national KP intervention program that will guide the strengthening and scaling-up of KP services in the country, including a strategy to engage with hidden and unreached members of key populations; the working group should include qualified representatives from government, civil society and the KP community and it should be supported by local and international experts as needed. • Increase opportunities and locations to have an HIV test (e.g., expanded community testing, private clinics, provider-initiated testing, self-testing). • Expand the availability/reach of HIV testing to other populations with higher risk behaviours (e.g., remand prisoners, returning migrant workers). • Consider ways to reposition and rebrand the STD centres to reduce the negative perceptions (e.g., Room 33) and make them more appealing to clients, including key populations. • Provide space for CSOs in STD centres for their activities as a way to contribute to their sustainability and to better connect their outreach work with the services delivered at the facility.

Risk 6. Slow adoption of innovations
High level recommendation: • Put in place a strategy and plan to develop, test and rollout innovative or alternative approaches to HIV activities to address the multiple challenges in Sri Lanka in a timely manner (e.g., stigma and discrimination, prevention programming for key populations, coverage of HIV testing services, testing yield, hidden populations, loss to follow-up).
Proposed actions to address the recommendation: • Set up a cross-cutting working group to consult with stakeholders and develop the strategy and corresponding protocols and/or standard operating procedures for the testing, approval, introduction and scaling up of innovations. • Establish a small *ad hoc* advisory group of qualified representatives from government, civil society and KP communities as well as local/international experts to provide support as needed to NSACP about relevant innovations**.** • Support a dialogue among key stakeholders to identify innovations that could be piloted and potentially implemented in Sri Lanka.

Risk 7. Procurement processes
High level recommendation: • Streamline the procurement process for ARVs and other health commodities and develop mechanisms for the urgent procurement of small quantities of ARVs through local suppliers and reduce barriers to participation.
Proposed actions to address the recommendation: • Evaluate and revise existing procurement processes to streamline procurement, reduce lead times and provide for input from all relevant stakeholders where appropriate. This may include the use of multi-year procurement framework agreements to ensure regular delivery of the required drug combinations. • Explore the possibility of partnering with another country for the supply of required drugs and other important health commodities. • Explore the benefits that may arise from using a pooled procurement mechanism and innovative procurement tools, to secure a timely supply of ARVs at an acceptable price. • Conduct research to inform a more accurate estimation and quantification of need and develop a comprehensive multi-year procurement plan.

Risk 8. Health Information Management Systems
High level recommendation: • Use the current grant funding to ensure that the EIMS and prevention information management system are fully installed and operationalized in all districts including training of key individuals in the districts. This includes the establishment of electronic data sharing between the EIMS and the FPA grant management system. • Motivate for the inclusion of adequate funding for ongoing maintenance of HIMS and training of staff in budget submissions to the MOH and ensure inclusion of the resource need in the business plan submission by MOH to the treasury to secure domestic funding.
Proposed actions to address the recommendation: • Develop a plan to accelerate the implementation of the outstanding components of the EIMS, the implementation of the prevention information management system and establishing inter-operability between these systems and the national health information systems. This may include the possible recruitment of TA to support the current service provider.

- Develop a detailed, medium term business case for the ongoing maintenance and replacement of HIMS hardware, maintenance of systems software and training schedule to support the motivation for domestic funding (referred to above).
- Develop a strategy to gradually expend the capacity of suitably qualified HIMS systems support staff and service providers to reduce the dependency on externally funded service providers.

Risk 9. Research and evaluation activities

High level recommendation:

- Motivate for the inclusion of adequate funding in the MOH budget request, to implement an agreed country HIV research, monitoring and surveillance agenda.

Proposed actions to address the recommendation:

- In consultation with all stakeholders, establish a comprehensive, multi-year research agenda listing required research, surveys and reviews to support monitoring, evaluation and planning for the HIV response.
- Include an adequate provision for funding the research agenda in the MOH budget request and related business planning.
- Develop strategies to build local capacity for research and evaluation activities.

Risk 10. Capacity to manage a complex KP-services program

High level recommendation:

- Government and civil society should develop and agree on a practical strategy and fully resourced operating plan for the management and oversight of CSOs and CBOs providing HIV-related services to key populations, which builds on the relative strengths of the involved organizations.

Proposed actions to address the recommendation:

- Use a qualified intermediary CSO to coordinate and manage the different CSOs and CBOs working on the HIV response with key populations (see Risks 12 and 15).
- Build the capacity of NSACP to handle direct oversight of an intermediary CSO and broad oversight over the full KP-services program, including key activities during the transition from GF funding to domestic funding and ongoing monitoring and evaluation activities (e.g., via a dedicated M&E team).
- Establish links between government and civil society partners to improve the understanding of respective roles and responsibilities and build a system of mutual accountability.
- Develop a strategy and operating plan, which roles and responsibilities of government and civil society partners, including the role/responsibilities of the intermediary CSO. The plan should include ongoing activities for capacity-building and accountability.

Risk 11. Understanding of the funding gap

High level recommendation:

- Based on a refined HIV programme, which may include innovations, technical efficiencies and revised targets, estimate the total resource need and likely funding gap over the medium term.

Proposed actions to address the recommendation:

- Conduct a comprehensive costing of the HIV response based on a refined HIV programme.
- Using the comprehensive costing, project future resource needs, available funding and estimate the total, annual funding gap over the medium term.
- Motivate for increased domestic funding to cover the funding gap to secure stable and predictable funding for the HIV programme.

Risk 12. Funding mechanism for CSOs
High level recommendations: • When external resources are reduced or are no longer available, the government will need to provide funding to CSOs for them to continue to play an integral role in the HIV response. In order for these funds to flow efficiently to CSOs, there needs to be a practical mechanism in place that meets the needs of both government and the recipient CSOs. • Consider the use of a qualified intermediary CSO as the primary recipient of government funds, which it would then redirect to implementing CSOs. The intermediary CSO would also play a role in monitoring accountability of the use of funds; see Risks 10 and 15. • Establish a small oversight board, including representatives from the Ministry of Finance, the Ministry of Health, NSACP and CSOs to monitor the operation and accountabilities of the funding mechanism
Proposed actions to address the recommendations: • Explore different mechanisms that can be put in place to ensure the efficient and sustained flow of government funds to CSOs implementing HIV-related activities with key populations, including the use of an intermediary CSO; the mechanism should include reasonable accountability policies and procedures. • Consider developing criteria (e.g., minimum standards) that CSOs would need to meet to join the pool of organizations eligible to receive government funds; these criteria/standards must make reasonable allowances for small and/or nascent CSOs (e.g., KP-led organizations), which typically have lower capacity, to ensure they are not excluded from the pool. • Ensure government and civil society discuss the strengths and weaknesses of a proposed mechanism to make sure it is workable and sustainable.

Risk 13. Capacity of CSOs
High level recommendations: • Develop and implement a comprehensive plan to strengthen the capacity of CSOs working with key populations on the HIV response. • CSOs must be mindful of their responsibility to improve and maintain the quality of their performance in all aspects of their operations, including their accountability to both funders and clients.
Proposed actions to address the recommendations: • Conduct a comprehensive capacity and capacity building needs assessment for qualifying CSOs. • Launch a collaborative initiative involving government, civil society, external funders and members of key populations to define and develop an effective and responsive capacity-building programs for CSOs working with key populations on the HIV response. • Review, redesign and implement tailored capacity-building activities to meet the needs of CSOs, including their ability to provide services and support to key populations. Capacity-building activities should focus on longitudinal support, not one-off activities; they should also consider the longer-term viability and sustainability of the participating CSOs. • Use robust self-assessment tools to monitor CSO performance, demonstrate their commitment and ability to strengthen their capacity and prove their accountability.

Risk 14. Predictable and sustained funding
High level recommendations: • There must be a commitment by government to provide predictable and sustained funding to support CSOs working on the HIV response, including for continued HIV case detection and for effective, long-term prevention. • Stakeholders in the HIV response for key populations should be strong advocates for long-term government funding for the comprehensive programs serving these populations needed to ensure Sri Lanka meets and maintains its 2025 HIV goal.
Proposed actions to address the recommendations: • Identify and act on opportunities to advocate for sustained funding for CSOs implementing KP programs; where and when possible, these opportunities should be done as formal or informal collaboration between stakeholders. • Include specific lines for CSOs implementation of KP activities, including prevention, in annual budgets and the next NSP response resource estimate.

Risk 15. Relationships between government and smaller CSOs and CBOs
High level recommendations: • The long-term effectiveness of the HIV response for key populations depends on a productive and mutually trusting relationship between government and the CSOs/CBOs implementing HIV activities. Consequently, steps should be taken to identify and address any issues that have the potential to undermine this relationship. • Consider the use of a qualified intermediary CSO to coordinate and manage the different CSOs working on the HIV response with key populations; see Risks 10 and 12.
Proposed actions to address the recommendations: • Develop a practical framework for building and maintaining a productive partnership between government and civil society that will ensure the delivery of relevant, high-quality HIV-related services to key populations; the framework, which should be developed jointly by government and civil society, should also be the basis for the necessary policies, procedures, systems and structures to manage and implement the partnership. • Establish links between government and civil society partners to improve the understanding of respective roles and responsibilities and build a system of mutual accountability; this same action is proposed under Risk 10.

Risk 16. KP-led organisations and networks
High level recommendation: • Develop and implement a strategy to increase the number and capacity of KP-led and KP-focused CSOs with the capacity to meet the criteria to receive government funds and to play significant roles in the HIV response, including networks for KP organizations. • Identify one or more established and effective CSOs in Sri Lanka with experience working with key populations to lead the initiative to develop and implement the strategy to increase the number of KP-led and KP-focused CSOs; wherever possible, the priority should be to add KP-led organizations.
Proposed actions to address the recommendations: • Assess the scale and scope of the need for KP-led and KP-focused organizations to determine the priorities for addressing the shortage (e.g., by type (organization, network), by population, by location, by demand for services/support); this assessment should directly involve members of key populations to understand their needs and perspectives.

- Conduct an independent assessment of the performance (i.e., strengths and weaknesses) of existing KP-led and KP-focused organizations to learn from their experience.
- Work with credible and accountable members of key populations to build support within the population to help catalyse and nurture the development of new organizations and networks.
- Develop and implement the strategy to increase the number of KP-led and KP-focused CSOs; wherever possible, the priority should be to add KP-led organizations. This process should be a joint effort between government and civil society, including representatives from the different key populations.
- Establish a set of criteria to ensure that qualifying KP-focused organizations have the requisite attitude, knowledge and skills to provide appropriate services and support to key populations; their ability to connect with a key population in open, non-stigmatizing ways is essential.

Annex 4 – Allocation and utilisation of funds NSACP – 2019

Source: NSACP Annual Report – 2019; Chapter 24

Summary financial details during 2019

Financial source	Description	Fund allocation (1000 LKR)	Fund utilisation (1000 LKR)	% utilisation
1. Capital expenditure				
MoH	Building constructions	38,402	33,519	87%
	Training	36	36	100%
	Training and Research	387	387	100%
	DDG (PH)1	25,000	16,637	67%
	Service agreements	2,827	2,563	91%
	Repairing of vehicles	1,896	1,789	94%
	Furniture/office equipment	7,023	6,425	91%
	MoH Sub total	75,571	61,356	81%
UNFPA	Workshops, programmes and printing	1,012	1,012	100%
WHO	Consultations, reviews, training	3,377	3,377	100%
UNICEF	PMTCT	4,571	4,571	100%
	UN Sub total	8,960	8,960	100%
GFATM	Human Resource (HR)	35,835	23,046	64%
	Travel related costs (TRC)	24,277	13,307	55%
	External professional services (EPS)	49,930	11,457	23%
	Health products (HPNP)	25,813	1,826	7%
	Health products- equipment (HPE)	18,601	18,261	98%
	Procurement related (PSM)	13,324	3,349	25%
	Infrastructure (INF)	4,904	159	3%
	Non-health equipment (NHE)	50,671	4,189	8%
	Publications (CMP)	1,899	678	36%
	Indirect and overhead costs	32,038	3,980	12%
	GF Sub total	257,293	80,252	31%
Total capital expenditure		**341,823**	**150,568**	**44%**
2. Recurrent expenditure				
MoH	Personal emoluments (salaries etc.)	152,298	147,997	97%
	Travelling, stationary etc	550	545	99%
	Fuel & supplies	7,765	6,908	89%
	Maintenance expenditure	2,950	2,862	97%
	Electricity and water	7,500	7,069	94%
	Security, cleaning service and other	7,275	6,841	94%
	Loan interest/transfers	660	645	98%
	Antiretroviral drugs	103,610	103,610	100%
	Other drugs	12,307	12,307	100%
	Medical/ Surgical Items	20,388	18,872	93%
	Recurrent Sub total	**315,303**	**307,655**	**98%**
Total capital and recurrent		**657,126**	**458,222**	**70%**