National HIV/STI Strategic Plan Sri Lanka, 2023-2027

MINISTRY OF HEALTH
SRI LANKA

NATIONAL
STD/AIDS
CONTROL
PROGRAMME

Message from the Director General of Health Services

Sri Lanka has made much progress in the national response to prevention and control of STI/ HIV/AIDS in the country. A concerted effort led by the National STD/AIDS Control Programme over the last four decades in partnership with several stakeholders have helped Sri Lanka to maintain a low-level HIV epidemic since 1987 when the first HIV infection was detected in the country.

Sri Lanka has committed to "end the AIDS epidemic as a public health threat by 2030" to harmonize with the 2030 agenda for achieving United Nations Sustainable Development Goals. This can be met only if the fast-track targets set by United Nations Joint Programme for HIV/AIDS are achieved: 95% of people living with HIV knowing their HIV status; 95% of people who know their status on treatment; and 95% of people on treatment with suppressed viral load thereby reducing the likelihood of spreading the infection is greatly reduced. Fast-Track also includes ambitious targets of reducing new infections, zero AIDS related deaths and zero discrimination.

The challenge is to create a country where HIV is no more a public health threat. The NSP includes a wide range of prevention interventions to reduce the annual number of new HIV infections, particularly among the key populations most affected, strengthening treatment and care to achieve zero AIDS related deaths and achieving zero discrimination by the elimination of discriminatory laws and practices in health care settings and addresses social and legal barriers and advancing human rights and gender equality.

The Ministry of Health is committed to invest in the national response to prevention and control of STI/HIV although domestic funding will remain crucial at present due to the economic crisis country is experiencing but with the expectation of heavy reliance on external funding.

I congratulate the Director and the team of the National STD/AIDS Control Programme and all stakeholders including the key populations and development partners involved in developing the National Strategic Plan 2023-2027 which will be the guiding document to show the pathway to accelerate the delivery of a set of evidence-based high –impact HIV prevention and treatment interventions to achieve the goal of ending AIDS by 2030.

Dr. Asela Gunawardena

Director General of Health Services

Ministry of Health

Message from Deputy Director General-Public Health Services 1

The National STD/AIDS Control Programme (NSACP) of the Ministry of Health is the main government organization which coordinates the national response to prevention and control of sexually transmitted infections including HIV/AIDS in Sri Lanka in collaboration with many national and international stakeholders.

The steering committee appointed by the Ministry of Health together with all stakeholders have articulated the National STI/HIV Strategic Plan (NSP) to strengthen the health system and community support to end AIDS as a public health threat in Sri Lanka by 2030 in line with the Sustainable Development Goals. The NSP has given high priority to optimize equitable access to prevention programme resources, testing opportunities in a variety of settings, introducing new diagnostics and provision of comprehensive treatment for STI/HIV/AIDS, continuing to work towards addressing legal regulatory barriers and implementing a range of initiatives to address HIV related stigma and discrimination which affect key population groups and influence their health-seeking behaviours and strengthening generating strategic information for policy development and programme management.

I would like to thank everyone involved for the hard work and dedication shown in developing the plan. I request all stake holders to collaborate with NSACP and use the NSP as the guiding document to implement the identified interventions to achieve country targets on HIV/ STI including creating a conducive environment for people living with HIV, their affected families and key population groups.

Dr. S. M. Arnold
MBBS, MSc, MD (Community Medicine)
Deputy Director General - Public Health Services (1)
Ministry of Health

Message from the Director NSACP

The National Strategic Plan for Prevention and Control of STI/HIV/AIDS 2023-2027 was prepared through a wide range of consultations, including government, non-government organizations, civil society organizations, key populations, people living with HIV and development partners. The recommendations of NSP 2017-2022 review, programme reviews conducted by experts throughout the five-year period, strategic information generated by national level STI/HIV surveillance, STI/HIV/AIDS care reporting and research data, global strategies and best practices were also taken into consideration.

The NSP will optimize the implementation of HIV prevention interventions which are tailored with the objective to reach the key populations at higher risk (including gay men and other men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners) and also the general population including youth and women to end the AIDS epidemic by 2030 as a public health threat in Sri Lanka. The NSP is addressing the need to strengthen the health system and social contracting of communities, increasing capacities for task sharing, engagement of multiple stakeholders from non- health sectors and non- government organizations, providing treatment services to all who know their HIV status and achieving viral load suppression to reduce onward transmission and improve survival and quality of life. It will also strengthen strategic information management systems to generate data for policy and programme planning, use of a robust monitoring and evaluation system, and address underlying social and legal barriers to create a supportive environment for prevention and control of STI/HIV/AIDS and access services. The NSP ensures all programmes are implemented based on equality and non-discrimination respecting human rights, and includes accountability mechanisms.

The NSP was developed on the understanding that HIV/AIDS is a national issue and the response should be a multi-sectoral approach with involvement of “whole of society”. Implementing the NSP will require forward-thinking partnerships at all levels of policy, programme planning and implementation, monitoring and evaluation and financing.

I thank the consultants, medical officers and staff of NSACP and all stakeholders in participating in the development of the NSP and my grateful thanks to Dr Janaka Weragoda –Consultant Community Physician in completing this enormous task with much patience and commitment. I also thank the country team of GFATM and Regional Grant of GFATM, Local Funding Agency-GFATM, WHO, UNAIDS for their support throughout this endeavour.

Dr. Janaki Vidanapathirana

MBBS, MSc, MD (Community Medicine)

Director - National STD/AIDS Control Programme

Forward

The national response to prevention and control of sexually transmitted infections and HIV/AIDS commenced with the entry of the virus to the country in 1987. Since then a series of short and medium term plans containing evidence based strategies and interventions were developed and implemented by the National STD/AIDS Control Programme of the Ministry of Health. High level political commitment, international donor support, involvement of multi-sectoral stakeholders including civil society and communities helped the country to maintain a low level HIV epidemic. As of end 2022, the adult HIV prevalence rate is <1%.

The NSP draws on the evolved consensus of stakeholders from the health sector across state, private sector, non-health sectors, NGOs, CSO and communities including key populations and people living with HIV and other partners at central, provincial and district levels. The National Strategic Plan 2023-2027 is developed to advocate for continued commitment by all stakeholders to achieve the country pledge to reach the 2030 target of ending AIDS as a public health threat as defined in the Agenda on Sustainable Development Goals. The challenge for Sri Lanka is to reduce the number of new HIV infection by 90% from the baseline value of 2010. The current NSP is elaborating on the new set of ambitious targets set by UNAIDS: 95% of all people living with HIV to know their HIV status, 95% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have viral suppression by 2025. Sri Lanka has made much progress and by end 2022, has reached 82% of the first target and 86% and 85% of the second and third targets respectively.

The NSP outlines a set of national priorities giving special attention to prevention of new HIV infections especially among key populations taking note of the changing HIV epidemiological landscape in the country with the main mode of transmission gradually shifting towards same sex relationships surpassing the traditional method of heterosexual .transmission which dominated for decades. Identified key interventions include scaling up coverage and quality of sexual health package, HIV testing services, prevention technologies such as pre-exposure prophylaxis, STI/HIV/AIDS treatment and care, generation of strategic information for action, supportive environment which protects and promotes human rights and gender equality and strengthening health and community systems to promote a long- term, sustainable HIV response. The NSP is addressing the need on collaboration with all stakeholders, optimizing the on-going and introduction of innovative activities targeting key populations, vulnerable populations, general population and youth through a multi-sectoral involvement and investing on high impact but low cost interventions.

Table of Contents

List of Figures

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYFHS	Adolescent and Youth friendly Health Services
BB	Beach Boys
BCC	Behavior Change Communication
CBO	Community Based Organization
CLM	Community Led Monitoring
CCP	Consultant Community Physician
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DBS	Dried Blood Spots
DIC	Drop-in Centre
EID	Early Infant Diagnosis
EIMS	Electronic Information Management system
ELISA	Enzyme Linked Immunosorbent Assay
EMTCT	Elimination of Mother to Child Transmission
EQAS	External Quality Assurance Scheme
FGD	Focus Group Discussion
FHB	Family Health Bureau
FPA	Family Planning Association
FSW	Female Sex Worker
GAM	Global AIDS Monitoring

GAMCA	
GFATM	Global Fund to Fight AIDS, TB and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioral Surveillance Survey
IDH	Infectious Disease Hospital
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
ITA	International Technical Assistance
KAP	Knowledge, Attitude and Practices
KP	Key Population
LFU	Loss to Follow Up
LIMS	Laboratory Information Management System
LGBT	Lesbian Gay Bisexual Transgender
M&E	Monitoring and Evaluation
MLT	Medical Laboratory Technologist
MO/Epidemiology	Medical Officer - Epidemiology
MoH	Ministry of Health
MoF	Ministry of Finance
MO NCD	Medical Officer Non Communicable Diseases
MO MH	Medical Officer Mental Health
MO/MCH	Medical Officer Maternal and Child Health

MO	Medical Officer
MSM	Men who have sex with males
NAC	National AIDS Committee
NBTS	The National Blood Transfusion Service
NGO	Non-Government Organization
NRL	National Reference Laboratory
NSACP	National STD/AIDS Control Programmed
NSP	National Strategic Plan
OI	Opportunistic Infection
OST	Oral Substitution Treatment
PAC	Provincial AIDS Committee
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PEPSE	Post Exposure Prophylaxis after Sexual Exposure
PHLT	Public Health Laboratory Technician
PIMS	Prevention Information Management System
PLHA	People Living with HIV and AIDS
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWN	Positive Women's Network
PWUD	People Who Use Drugs
RDHS	Regional Director of Health Services
RE	Regional Epidemiologist

RSA	Rapid Situation Assessment
SD	Strategic Direction
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SIM	Strategic Information Management
SLBFE	Sri Lanka Bureau of Foreign Employment
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TG	Transgender
ToT	Training of Trainers
UNFPA	United Nations Population Fund
VDRL	Venereal Disease Research Laboratory test
VL	Viral Load
WHO	World Health Organization

Executive summary

The National STI/HIV Strategic Plan was developed to express the country trajectory to steer the Fast-Track approach of the Joint United Nations Programme on HIV/AIDS (UNAIDS) to achieve the ambitious 95-95-95 coverage targets articulated to end the AIDS epidemic by 2030 as a commitment to the agenda 2030 of -Sustainable Development Goals.

The current NSP was built on the achievements of the previous strategic plans, and the challenges identified by programme reviews, strategic information generated by prevention interventions and treatment and care and guided by the overarching National Health Policy and the National AIDS Policy. The development process consisted of a desk review, key informant interviews, consultative meetings conducted by sub committees and oversight of the National AIDS Committee. The country process was led by the Deputy Director General Public Health and the Director NSACP with full participation of a wide range of stakeholders including key populations. Technical advice was provided by an international and a national consultant.

The NSP has taken note that, over the years, the national response to STI/HIV has shown considerable positive results by using a strategic mix of evidence based interventions targeting the key populations whilst also reaching vulnerable sub groups and general population including youth and women together with political commitment, leadership, multi-sectoral and community involvement.

The NSP has identified 5 strategic areas for action: prevention, diagnosis-treatment-care and support, strategic information management, health systems strengthening, and creating a supporting environment.

Strategic objectives were identified for the five strategies with their respective strategic directions. For each strategic direction a set of evidence based interventions were identified and the costed National Activity Plan supplemented it. A results based framework was developed with key indicators which will be expanded to a comprehensive National M&E

Plan. The majority of interventions will be implemented by the district STD Clinics with support from the civil society, community based organizations and communities adhering to government policy of a decentralized rights-based HIV programme with multi-sectoral involvement and community participation. At the central level the NSACP will be coordinating the implementation process, providing technical guidance and monitoring and evaluation of the progress.

The NSP has given priority to intensifying combination prevention of differentiated key population interventions. The coverage and quality of the physical out-reach through the peer led model to deliver the sexual health package will be strengthened through capacity building and monitoring and evaluation. The intensified case finder model will be amplified and performance based assessments will be introduced. Provision of pre-exposure prophylaxis will be streamlined. The virtual out-reach model which was developed to augment the physical out-reach will be used as an additional approach to deliver HIV awareness, risk assessment and testing to those who may not otherwise access a clinic for testing. HIV self- testing oral fluid test will be promoted to encourage more KPs to "know their HIV status" thereby reaching the first 95 target. The NSP has identified the necessity to use a variety of channels of communication such as face-book, mobile apps to reach out especially to youth to provide knowledge on safer sexual practices, availability of testing services and anti-retroviral therapy, pre exposure prophylaxis and post exposure prophylaxis as data generated by the NSACP has shown that in year 2022, around 12% of the diagnoses were in the 15-24-year age group. The HIV prevalence among 15-24-year age group is a proxy measure of newly acquired HIV infections which indicated the spread of the infection in the society. The NSP is cognizant of the efforts of the Family Health Bureau to integrate age appropriate comprehensive sexuality education (CSE) into the school curriculum.

Provision of comprehensive treatment and care has been a priority area for Sri Lanka. The HIV treatment cascade had a few hiccups due to the Covid-19 pandemic, hence the NSP is proposing a multitude of interventions as a part of differentiated HIV testing services to improve the treatment cascade. NSP has taken note of bridging the observed gap between

diagnosis and linking to treatment by intensifying community awareness, pre and post- test counselling, strengthening the three-test diagnostic algorithm. Anti-retroviral therapy will be provided as per the WHO recommended guidelines with the first-line drug regimen to be tenofovir-emtricitabine/lamivudine and dolutugravir. Laboratory facilities for screening for HIV and STIs will be continued across all STD clinic laboratories with strengthening ~~inclusion~~ of quality assurance strategies. With the establishment of HIV drug resistance (HIV-DR) testing facility, the NSP recognizes the need to put in place guidelines and standard operating procedures to sustain quality services and moving towards laboratory accreditation. Several strategies have been identified to strengthen collaboration between the National Prevention of Tuberculosis and Chronic Chest Diseases NPTCCD) control programme. The NSP has also addressed the issue of improving management of co-morbidities and opportunistic infections in the background of nearly 24% of the diagnoses in 2021 had been in advanced HIV disease stage.

The NSP is cognizant of the developments achieved in strategic information management and is calling for amalgamation of electronic patient based information system and prevention information management system. NSP is encouraging interoperability of systems with district clinics and other health platforms such as the maternal and child health which collects data on antenatal screening for HIV and syphilis as an intervention to maintain the “elimination of mother-to-child transmission of HIV and congenital syphilis in Sri Lanka” as declared by WHO, National Blood Transfusion Service which provides a safe blood supply to the nation adhering to a strict set of guidelines.

Creating a supportive environment for prevention and control of HIV/STI is a vital component in the NSP. It will address gender equity and respectful care for every citizen including gender diverse groups without any discrimination as enshrined in the Constitution of the Democratic Republic of Sri Lanka. The NSP is drawing attention on the need to repeal the laws and regulations which have a direct power on same sex relationships, gender diverse groups, commercial sex workers, key populations and people living with HIV.

The NSP has addressed the need to strengthen procurement supply management chain to provide an undisrupted supply of medicines, diagnostics, commodities such as condoms and lubricants as a lesson learned during the covid-19 pandemic.

The health system is being strengthened with social contracting of community organizations to accelerate the on- going physical and virtual outreach through peer educators and case finders and the NSP is addressing this issue by identifying the need to develop a "road map" to solicit the support of policy makers to formalize the social contracting system for community engagement for a sustained national response after donor funding declines.

The NSP is also addressing the need to develop infrastructure facilities as floor space in almost all district clinics and laboratories, central clinic and the National Reference Laboratory is near exhaustion due to the increased client load, expansion of the spectrum of tests, increased counselling sessions, and preventive activities. The NSACP is mindful of developing technical capacity of service providers by national and international training, safety of care providers and deployment of staff based on a Human Resource Plan.

The NSP is promoting integration of HIV/STI prevention to other health and non-health programmes, in the spirit of "whole-of-society" to reach out to a large proportion of citizens in the country as HIV/AIDS is not only a health issue but a national development issue.

The NSP has been developed to achieve the programme objectives by implementing the identified interventions within the given time framework monitored by the respective indicators to the benefit of all stakeholders "leaving no one behind" to contribute to realization of SDGs by achieving key global and national HIV goals.

1. National HIV/STI Strategic Plan (2023-2027)

1.1 Introduction

1.1.1 Country context

Sri Lanka is an island situated immediately below the southern part of India. It has a rich cultural heritage which dates back to almost 2500 years. Sri Lanka gained independence in 1948 from the British Colonial rule. In 2020, the estimated total population was 21.9 million and the annual population growth rate was 0.53 per cent during the year 2020, which added around 116,000 persons during 2020 to the total population, due to natural increase[1].

It is an ethnically, linguistically and religiously diverse nation and adopts a democratic political system. The President of Sri Lanka is the head of state, the commander in chief of the armed forces, and is elected by the people. The President, under the constitution and laws, appoints and heads a cabinet of ministers responsible to Parliament. A separate cabinet minister is appointed for health services. For administrative purposes, Sri Lanka is divided into 9 provinces and 25 districts. The Provincial Council system was introduced in 1987 by the 13th Amendment to the Constitution of the Democratic Socialist Republic, hence, each province is administered by a Provincial Council which is composed by representatives directly elected by people of the respective province and is headed by a Governor who is nominated by the central Government[2].

Sri Lanka has achieved high levels in social and health development are a result of the several evidence-based policies and strategies adopted by successive governments of Sri Lanka. Sri Lanka graduated to Lower Middle-Income Country (LMIC) status in 2010 following the end of nearly three decades of civil war.

---

[1] *Ministry of Health. Annual Health Bulletin: 2020*

[2] *The Parliament. The Constitution Government of Democratic Republic of Sri Lanka.1978.*

The country Human Development Index (HDI) reflected high human development with a value of 0.782, in 2021, positioning Sri Lanka at 73 out of 188 countries[3] with a life expectancy at birth of 78.6 years for females and 72 years for males and a literacy rate of over 95.7%[4]. It is a success story to celebrate for a developing country. Further, by 2020, the maternal mortality rate was lowered to 30.4 per 100,000 live births and infant mortality to 7.5 per 1000 live births. Complementing these achievements is Sri Lanka being able to maintain a low-level HIV epidemic since the entry of HIV to the country in 1987[5]. Gender equality is a fundamental right as enshrined in the Constitution of the Democratic Socialist Republic of Sri Lanka and girls and women have equal access to the benefits of state education as reflected in achieving primary school education gender parity and access to, social and health services[6]. These achievements provided the distinction for Sri Lanka to be placed among the top five Asian countries in human development. Sri Lanka was certified by WHO as a country which has eliminated mother to child transmission of HIV and congenital syphilis, malaria, lymphatic filariasis. Sri Lanka is a signatory to several international conventions and treaties related to gender equality and non-discrimination. In 2015, Sri Lanka committed to the 2030 agenda of sustainable development to achieve the 17 United Nations Sustainable Development Goals (SDGs). With respect to HIV/AIDS, Sri Lanka is moving this agenda using evidence-based strategies and interventions focusing on low cost but high impact interventions to end AIDS by 2030.

1. 2 Development process of the National Strategy and Action Plan

The process of developing the NSP for HIV/STI 2023-2027 was led by the NSACP with financial support from the Global Fund. An international consultant and one local consultant for programs matter and a local consultant for costing were engaged by NSACP for this purpose. The global fund assigned an international consultant for providing guidance for the NSP on transition and sustainability after GFATM ends.

[3] Human Development Report 2015 United Nations Development Programme https://www.undp.org › files › files › migration
[4] *Department of Census & Statistics. Census of Population and Housing 2011*
[5] National STD/AIDS Control Programme. Ministry of Health. Annual Report 2021.
[6] The Parliament. The Constitution Government of Democratic Republic of Sri Lanka.1978

Technical guidance was provided by a National Steering Committee (Annex 1) formed by NSACP. Seven Technical Working Groups (TWG) were formed with the mandate to: (1) Assess the progress of the current NSP (2018-2022) according to targets and goals defined, (2) Identify the main areas to be improved in the programme to achieve set targets, and (3) Identify new activities at national and district level to strengthen to achieve the Goal of ending AIDS in Sri Lanka by 2030. The methodological approach was a desk review, key informant interviews, participatory consultations with relevant staff of NSACP and from district STD clinics, other government and non–health sector representatives, non-government organizations (NGOs), community-based organizations (CBOs), academia, CCM members, and key Populations (KPs), vulnerable populations, youth and general public. The recommendations of the Working Groups and from other consultations were presented, discussed, and synthesized at a NSP Development Workshop held in September 2022. The draft NSP was subsequently circulated to Global fund, WHO, UNAIDS and all stakeholders including NGO/CBO. The current NSP was formulated into final form by a group of local experts after reviewing comments/ suggestions from all stake holders. Furthermore, current NSP considered the health technology assessment for cost effective, quality health outcomes. The costed work plan was developed for a period of three years 2023-2025 for activities identified under each strategic direction.

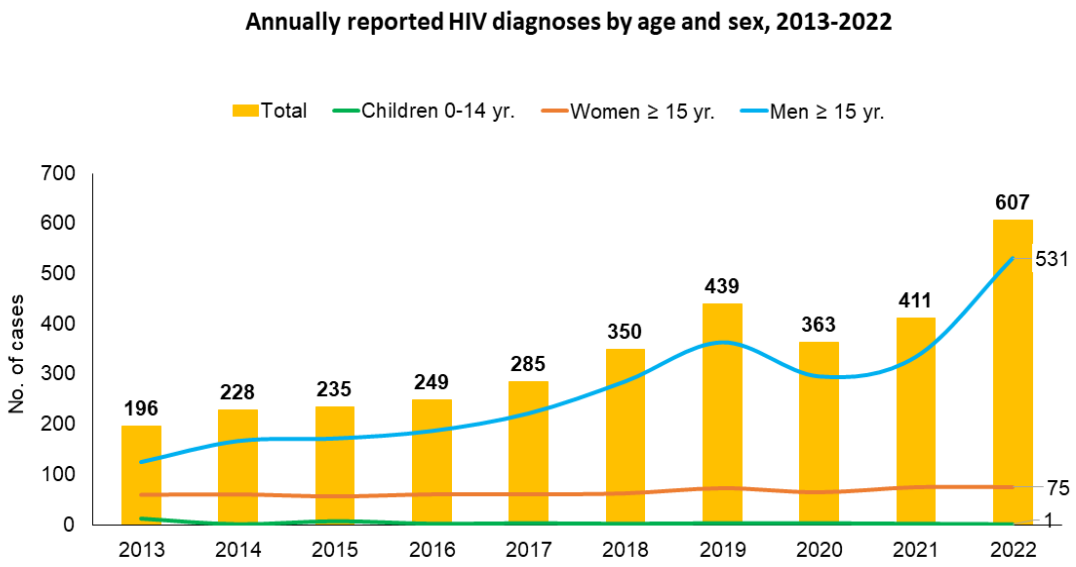
2. National STD/AIDS Control Programme

2.1 Epidemiology of HIV, national response and challenges

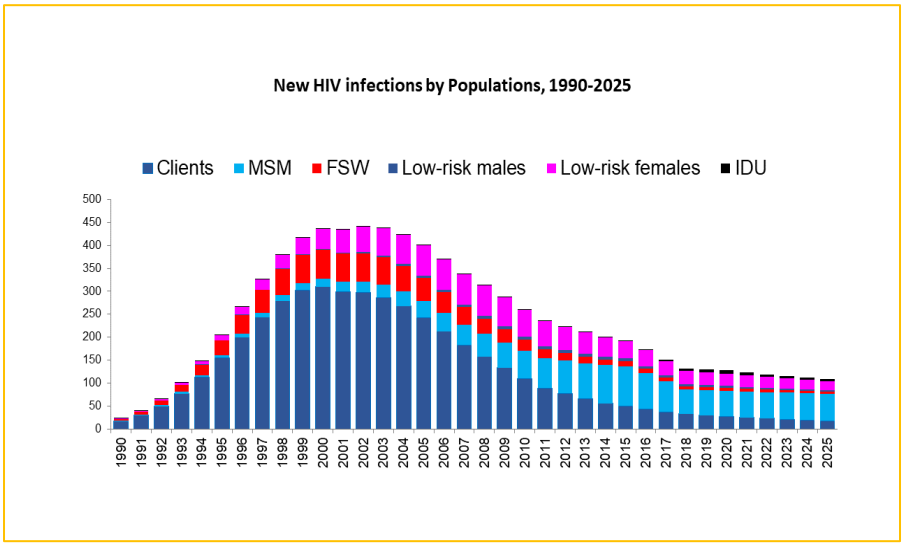
Since the beginning of the HIV/AIDS epidemic, Sri Lanka continues to maintain a low-level epidemic. The AIDS Epidemic Model estimates that 4100 people are living with HIV by end 2022[7]. The estimated adult HIV prevalence is <0.1%. Almost three decades since the detection of the first HIV infection in Sri Lanka, as of December 2022, a cumulative total of 5011 HIV infections have been reported to the National STD/AIDS Control Programme. Of them 1050 have been reported as AIDS and 693 have succumbed to the illness. Reported data shows that there is a steady upward trend of HIV positives. A noteworthy observation is the widening ratio between males and females. The numbers detected over the period of 2011 to 2022 shows a 242% increase. This could be due to an actual increase in new cases, to increased testing facilities, improved surveillance and better data management. Availability of ART provided free of charge in all STD clinics has encouraged more people to come forward for HIV testing. During the year 2021, a total of 411 cases and in 2022, a total of 607 newly diagnosed cases were reported to the NSACP.

HIV sentinel surveillance is a routine intervention of the NSACP but the planned survey for 2021 was disrupted due the Covid-19 pandemic. The survey done in 2019, revealed that the highest prevalence was found among the men who have sex with men (1.5%), followed by transgender women (1.4%). Prevalence was low among female sex workers (0.1%), clients of sex workers (0.1%) and people who inject drugs (0%). These rates are higher than the reported data of previous years.

[7] SIM Unit Data, NSACP



The AIDS Epidemic Model predicted an emerging HIV epidemic among men who have sex with men is seen to becoming a reality today.

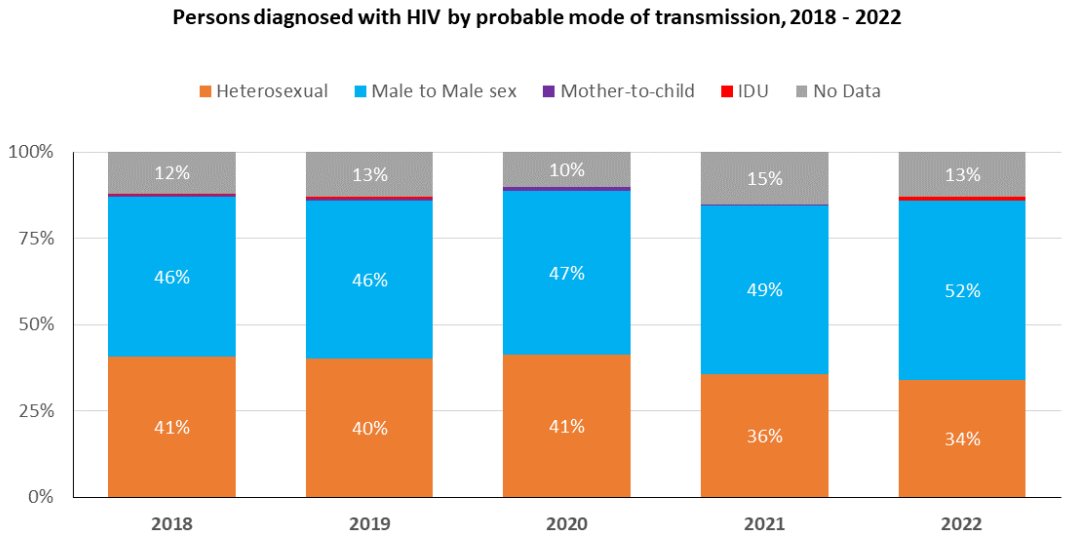


Source- National STD/AIDS Control Programme. Annual Report 2021

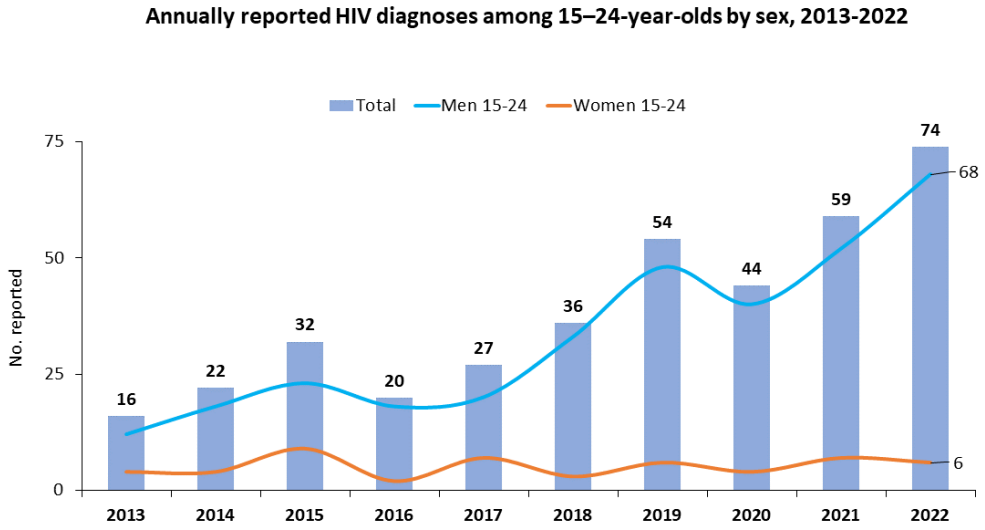
The prediction values are upheld in the analysis of actual data from 2017-2021. As shown in the above graph, the changing trend of probable mode of transmission is more towards

men who have sex with men. During 2017-2020, heterosexual transmission was the main mode of transmission and in 2021, transmission among men who have sex with men has surpassed other populations and has accounted for almost 49% as opposed to 36% due to unprotected sex between men and women[8]. During 2021, no cases of mother to child transmission of HIV and transmission through injecting drug use were reported. During the year 2021, a total of 411 cases were newly diagnosed which was a 13% increase from the previous year.[9] Data have not been available for 15% of the newly diagnosed cases reflecting gaps in data collection or disclosure.

[8] NSACP Annual Report 2021
[9] ibid



Since incidence testing is not available in Sri Lanka, HIV infection among young people is used as a proxy measure for new infections and a steady upward increase in the trend of infections among 15-24-year age group is observed.



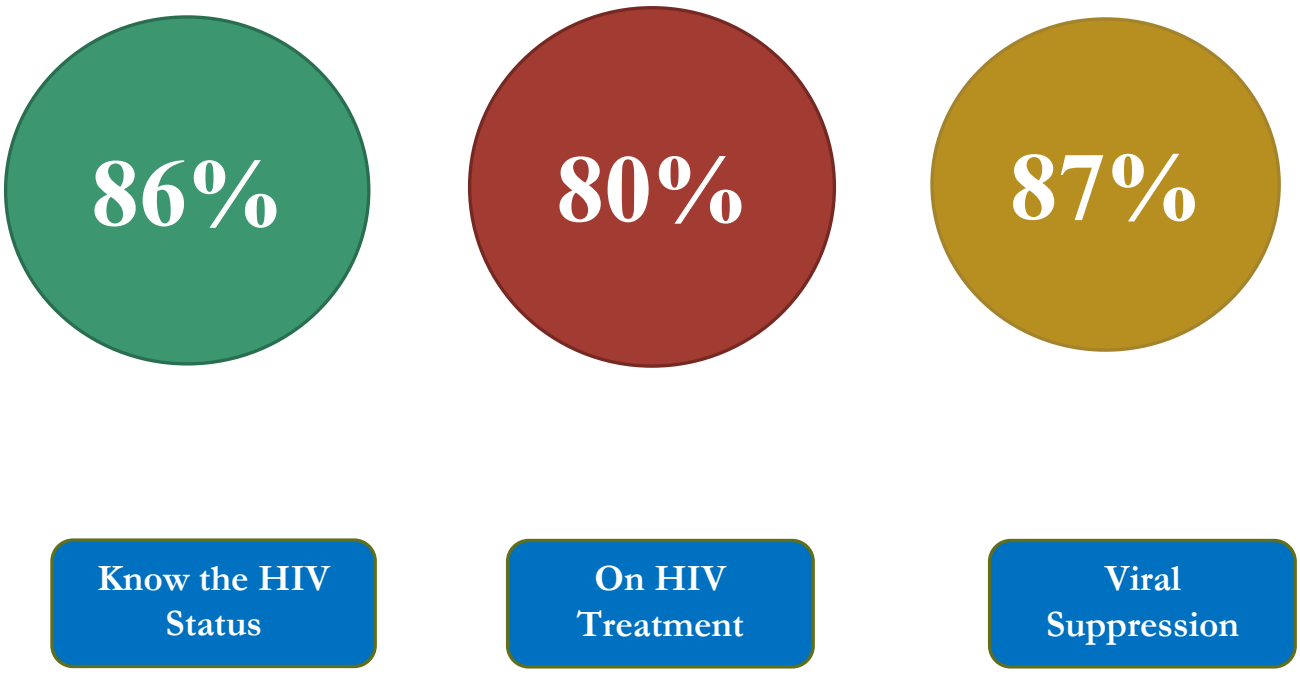
Out of the 607 total cases reported in 2022, 12% (n=74) were in the 15–24-year age group. Of this, 92% (n=68) were young men and nearly 80% of these young men reported male-to-male sexual encounters.

District level disaggregation of 2022 data shows that Colombo, Gampaha and Kalutara districts of the Western Province and Kurunegala in Northwestern province and Galle in the Southern Province have reported higher HIV prevalence.

Late-stage diagnosis has fluctuated between 25% in 2015 to 27% in 2021. Low CD4 count levels is taken as a proxy measure to diagnosis late-stage diagnosis.

IBBS (2018) data reveals condom less sex in last sexual act was among MSM (18%), FSW (17%), TG (24%) BB (25%) and PWID (75%).

Figure: Status against UNAIDS 95-95-95 targets as of 2022



The achievements for testing and treatment cascade in 2022 were 86%, 80% and 87% respectively. This NSP identifies strategies to reach the first target (the gap of 9%), linking to care (gap of 15%) and the results of the last pillar can be updated only when the total number of PLHIVs complete the viral load clearance after six months of commencement of ART. In addition, there were some PLHIVs who did not have the viral load test due to a disruption of the supply chain of test. The above results call to intensify coverage of services to KP groups by both physical and virtual out-reach and making people aware of the availability of such services including rapid diagnostic tests and oral fluid self- testing to achieve the first 95%.

2.2 National Response

The NSACP spearheads the national response for prevention and control of STI/HIV/AIDS with several stakeholders. The National Health Policy, National HIV/AIDS Policy, National HIV/AIDS Policy in the World of Work guides the national response. The National Maternal and Child Health Policy and the National Reproductive Health Policy has anchored prevention and control of HIV in their strategies. Since the detection of the first Sri Lankan with HIV infection, the government of Sri Lanka, anticipating an impending HIV/AIDS epidemic made plans to mitigate such a threat. Several short, medium and long-term plans were implemented with support from international agencies. The result is that the country as of today is maintaining a low-level HIV epidemic.

In order to track the trends of the epidemic sentinel surveillance surveys were conducted from 1993 and the last survey was done in 2018. Integrated Biological Behavioural Surveys and Population Size Estimations are carried out periodically to track the risky behaviours and practices which promote the spread of the virus and the sero-prevalence rates among different KP groups. The data is also used in the AIDS Epidemic Model (AEM) to make epidemiological projections and various outcome scenarios. Results of all these sources are used for policy planning, programme planning and monitoring and evaluation.

The Government of Sri Lanka took note of the global recommendations that low HIV prevalence countries should focus in implementing evidence based targeted interventions to key populations who are at a higher risk of HIV infection. Based on occupation, sexual behaviours and sexual practices, population groups such as female sex workers, men who have sex with men, intra-venous drug users, beach boys, prisoners have been identified as the most at risk populations for transmission of HIV infection in the country. Although the country is categorized as a low prevalence country, there are biological, behavioural and structural, factors which may fuel a future epidemic. Condom free anal and vaginal sex, frequent change of sexual partners, buying and selling sex, flourishing sex industry, expanding MSM networks, internal and external travel, influence of a multitude of communication channels, engaging in harmful use of alcohol and hard drugs in the context of sexual behaviours, sharing contaminated needles and syringes when injecting narcotic drugs, presence of sexually transmitted infections, poor access to health services, stigma and discrimination, poverty, low education level are considered as risk factors.

Targeted interventions for KP groups have been tailor made to address these risk factors and a sexual health package (SHP) was developed and implemented with the support of several stakeholders including KP communities and community-based organizations. A peer educator model (PEM) was introduced as the vehicle to deliver the SHP which promotes behaviour change by educating on HIV/STI and associated risky behaviours, promotion of safer sexual practices, provision of condoms and lubricants, promoting HIV testing and STI screening and linking to services for treatment and care which would eventually reduce HIV transmission. To increase the coverage, the PEM was complemented by the introduction of a case finder model (CFM) in Colombo and Gampaha which are two districts reporting higher prevalence levels of HIV than the other districts. Then it was graduated to a hybrid intensified case finder model which address both prevention and testing for case finding and is operational to reach key populations with technical and financial support of the GFATM. The current NSP considers KP led organizations delivering services to their own communities is a relevant and effective strategy.

The NSACP is being supported by NGO/CBO in reaching out to KPs across the country and penetrating into networks and accessing those considered as “hidden” or “difficult to reach populations” to provide the sexual health package. The Family Planning Association (FPA), one of the leading NGOs in the country, which is working for maternal health, family planning, HIV/AIDS was recruited as the principal recipient-No 2 of the Global Fund to support NSACP which is the principal recipient No-1. The FPA was able to recruit several NGO/CBO to deliver the standard SHP to key populations. The capacity of these organizations was developed in the context of confidentiality issues, methods of communication, data collection, data transmission. The FPA played an enormous role in monitoring and evaluating these activities based on the monitoring and evaluation plan of the NSACP and linking data to the NSACP. Commencing in 2018, the FPA was transitioning the interventions to the government STD clinics as the GFATM has entered the transition mode.

NSACP developed different strategies for HIV testing services. It is the 4th generation ELISA test which is commonly used in clinic settings and testing facilities were expanded by introducing rapid diagnostic finger prick HIV test to be instituted at the community and also for KP testing at the STD clinics. In 2019, with GFATM support, the NSACP was able to introduce HIV self-testing (HIV- ST) oral fluid test which is also referred to as the saliva test. The procurement process for Rapid Diagnostic Tests (RDTs) was being transitioned from the GFATM to GoSL. However, the current economic crisis in the country became a huge challenge for this transition.

Pre exposure prophylaxis (PrEP) was introduced in 2019, following a demonstration project and has been scaled up to cover all the districts as of end 2022. Demand generation programs are being conducted with the support of NGO/CBO/CSO, community networks and STD clinics. National guidelines and protocols are available for PrEP as the clients requesting for PrEP implies likelihood of the potential to be infected. Drugs are being procured with GFATM support.

Post exposure prophylaxis (PEP) for occupational injuries in health settings which was

commenced in 2008 is being continued and post exposure prophylaxis after sexual exposure (PEPSE) is now introduced. National guidelines and protocols are available to assist in delivering quality care. In 2021 a total of 2615 people were assessed following occupational injuries in healthcare settings and 123 for PEPSE. After the follow up period none were found to have acquired the virus.

The virtual outreach intervention was introduced by the NSACP targeting KPs at risk of HIV is to enlist more clients for HIV testing to "know their HIV status" thereby contributing to achieve the first 95 of the UNAIDS. The first 95 target is linked to prevention, treatment and care services and is expected to contribute to a reduction of new infections. The web-based programme named Know4Sure.lk was initiated with the support of PEPFAR and is currently supported by the GFATM. It was tailor made by the NSACP and KP groups to encourage KPs to assess their HIV related risk, request for HIV testing, condoms and lubricants and accessing clinics for screening for STIs. A guideline "Virtual Combination HIV services in Sri Lanka" is available to increase the quality of the service. It was more popular with MSM and transgender groups but during the Covid-19 pandemic, female sex workers were using on-line platforms such as face book, dating apps to solicit clients. The **on-line apps**, social media platforms became the only source of information for clients who needed support for HIV related risk assessments and testing.

In addition to the KPs, the national programme has identified several vulnerable groups such (1) migrant workers, (2) armed forces and (3) tourist industry workers for interventions. The migrant workers programme was internalized to the Sri Lanka Bureau of Foreign Employment (SLBFE) but there were disruptions during the Covid 19 outbreak, but it will be put on track again. The tri-forces programme is institutionalized to the three-armed forces and NSACP is collaborating for capacity building training programmes. The general public including women and youth have also been addressed through awareness programmes, workplace programmes and integrating into Family Health Bureau women's health programmes and youth programmes and the youth programmes of the Ministry of Youth and Sports. These activities have helped to reach to a wider population for behaviour change and access HIV services keeping in mind that clients of sex workers are not a

segregated group and is the most difficult to reach key population. The AIDS Epidemic model estimates that there are around 261, 000 clients of sex workers in the country. (261,000 -AEM 2019 data).

These collaborative efforts are expected to accelerate the trajectory towards the UNAIDS 95-95-95 target. Promoting and providing HIV testing services is expected to achieve the first pillar of 95% of estimated people living with HIV know their HIV status and the second pillar of enlisting for anti-retroviral treatment and care and the third pillar of viral suppression.

Comprehensive management of STI has been a strong component of the national programme. There are 41 STD clinics across the country managed by trained staff for HIV/STI screening, treatment and care. National Guidelines, protocols, standard operating procedures (SOPs) are available for standardized STD management to improve the quality of management and data of individual case reports are tracked using standard formats by the Strategic Information and Management (SIM) unit. The NSACP is adopting the policy of provider-initiated testing and counselling (PITC) at STD clinic facilities in addition to catering to volunteer testing. Screening for cervical cancer is a routine procedure in STD management and will help Sri Lanka to achieve the goals of cervical cancer elimination programme. HPV-DNA testing of HIV positive women will be introduced with the support of the Family Health Bureau (FHB) and if necessary, the management protocol will be modified.

The Epidemiology unit of the Ministry of Health is the unit responsible for surveillance of hepatitis infection. The HPV vaccination was introduced to the national immunization schedule in 2017. Two doses of recombinant quadrivalent vaccine are now given, 6 months apart, to all girls on completion of 10 years of age (grade 6). In the year 2021 coverage of completion of the 2nd dose was 69%[10].

[10] Ministry of Health. The family Health Bureau, Annual Report 2019

The infrastructure and workforce of the National Reference Laboratory (NRL) was powered to provide necessary diagnostic tests and support district STD clinic laboratories. Tests such as haematological, bio-chemical tests, CD4 count, HIV-RNA- PCR viral load testing, HIV-DNA – PCR for the diagnosis of neonatal infection were introduced. HIV drug resistance testing is being established with the support of the GFATM to support the clinicians to switch to a suitable ART regimen based on the gene sequencing profile in the event a clinical or biological failure is observed and for surveillance purposes. A pre-treatment surveillance study was completed to determine the prevalence of HIV DR. The NRL is geared to use the VDRL as a screening test, TPPA as a confirmatory test for syphilis and the three RDT tests are used to confirm a screening positive HIV sample to reduce the turnaround time. Tests for gonorrhoea, chlamydia are available and molecular tests - nucleic acid amplification tests (NAAT) are being considered. Antibiotic surveillance for *Neisseria gonorrhoeae* is carried out regularly.

Screening antenatal mothers for syphilis was established in the early fifties when STD services were formalized and structured based on the British Model. This intervention was conducted under the leadership of the FHB across all government antenatal clinics and the coverage had reached to around 90% by year 2000. In 2002, the prevention of mother to child transmission programme was launched on this foundation which aimed at universal screening of antenatal mothers for HIV and it synergized the antenatal screening for syphilis testing. New-borns are diagnosed with HIV DNA PCR testing according to a WHO protocol. The two interventions went hand in hand, and in 2019, Sri Lanka was certified by the WHO to have eliminated mother to child transmission of HIV and congenital syphilis. Sri Lanka is striving to sustain the zero transmission of HIV and syphilis from mother to child against the economic burden of treatment and care of maternal HIV infection, neonatal HIV infection and congenital syphilis.

National Blood Safety Policy laid the foundation for Sri Lanka to provide a HIV free blood service to the country and over two decades there have not been transfusion transmitted HIV infections. Pre donation information on HIV and counselling of donors to eliminate donations at higher risk of HIV infection, voluntary and non-remuneration donations,

confidential risk assessment and screening donated blood for HIV, hepatitis B&C, syphilis and malaria using highly sensitive laboratory tests by trained staff to identify and discard infected blood units are the interventions adopted to provide a safe blood supply to the nation. The above policy statements of the NBTS in relation to prevention of HIV infection through blood and blood products is endorsed in the National HIV/AIDS Policy. Both the National Blood Transfusion Service (NBTS) and the NSACP were the key actors in this success story. The challenge is to maintain these hard warned gains in a background of the current economic crisis in the country.

The government made a policy decision in 2004 to provide anti-retroviral therapy through the government STD clinics for those diagnosed with HIV infection. World Bank funded this intervention up until GFATM took over in 2011 and transitioned to domestic funding in 2016. As of end 2022, a total of 2947 people living with HIV were on anti-retroviral therapy, The NSACP adopts the policy of "test and treat all" irrespective of the CD4 count and "treatment as prevention" to cut off the transmission of the virus once viral load suppression status is achieved. People living with HIV can access any STD service of their choice and HIV care including ART is provided free of charge. Initial bio-chemical, immunological, virologic and clinical assessment is done by trained medical officers and linked to ART which is provided according to national guidelines adapted from WHO guidelines. CD4 and viral load testing is available at the NRL and selected STD clinics and a mechanism is adopted to transport samples in a timely manner from other centres. Viral load testing is carried out at baseline, six months and annually thereafter to track viral suppression. Counselling is carried out before commencement of ART especially in relation to adverse effects, retention, adherence, safer sexual practices and follow up. These interventions are expected to achieve the second 95 and the third 95of the UNAIDS targets. The ART estimates are done by a committee of experts and unfortunately there was a disruption of the supply due to gaps in the procurement supply and management chain. The current NSP is addressing this issue under strategy 4. One of the fundamentals of STI control is contact tracing of the index case which the NSACP has been adopting since its inception and for HIV contact tracing also patient initiated and provider-initiated approaches are being practiced with the consent of the index case and maintaining

confidentiality. The current NSP is drawing attention to also include community involvement as the community membership have more liaisons with one another. A guideline will be developed for Index Patient Contact Tracing.

Opportunistic infections are diagnosed and treated according to the national guidelines. TB-HIV co-infection is treated jointly by the chest physicians and ART specialists and HIV-hepatitis B/C infections are jointly managed by hepatologists and ART specialists.
The NSACP is continuing to work together with several stakeholders to create a supportive legal milieu by removing age old punitive laws and legislations which promote stigma and discrimination and enforce laws derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.

The SIM unit was established in 2006 and as of today it has established an EIMS to collect HIV/STI case reported data and PMIS for data management of all prevention interventions undertaken by STD clinics and communities. Data generated by various data bases are used to inform policy, plan programmatic interventions and most importantly monitoring and evaluation.

In this backdrop, the current NSP is prepared to accelerate the interventions already taking place and introduce innovative methods to increase the coverage and quality of services to prevent new HIV infections, treat all and improve the well- being of those infected at an individual level and reduce the number of new HIV infection as a public health gain for the country. A continuing feature of this strategic plan is health promotion and primary prevention coupled with secondary prevention by increasing HIV testing services to know the HIV status and stigma reduction and provision of ART as “treatment as prevention”. The NSP will also be focusing on strengthening partnerships with all stakeholders and coordination of interventions across government health sector, non –health sector stakeholders, NGO, CBO and communities.

2.3 Challenges

The External Review of the National STI/HIV Strategy was undertaken in 2021 in consultation with national stakeholders. It has highlighted a series of challenges that need to be addressed in the NSP 2023-2027 if Sri Lanka is to continue making progress toward ending AIDS by 2030 as a public health threat.

Concern has been voiced that existing NGO peer-led approaches are not reaching many persons engaging in high-risk behaviours. KPs in Sri Lanka are still to some extent marginalized and stigmatized by legal and sociocultural environments that tend to drive KPs underground and make them difficult to reach. New approaches that reach deeply into KP networks and provide them with services to meet their needs and preferences are needed (i.e.,"differentiated" services). Concern has been voiced as to the capacity and sustainability of NGOs/CBOs for implementing effective combination prevention services for KPs. Capacity building in new and recently introduced intervention models and approaches is needed. Capacity and long-term sustainability of NGOs/CBOs to provide high-quality services has been hindered by their reliance on short-term "project" funding provided via external sources.*[11] Long-term mentorship of the NGOs/CBOs, particularly those providing services for KPs, is required to ensure and improve the quality of the services those organizations provide. The review highlights that planning to finance these organizations and their activities domestically is needed to ensure their sustainability when external financing ends. It draws attention to introduce possible self-sustaining pathways for those organizations by diversifying their functions. The current NSP has identified different strategies towards this end taking into consideration the need of capacity building in programmatic themes and financial and programmatic sustainability to be self-contained once external funds cease to operate (SD 4).

Although the focus of prevention efforts in national AIDS programs is usually on key populations (KPs) and other vulnerable population sub-groups, a consensus has emerged that prevention efforts must also be extended to reach the general population, which

*Concern has been voiced that the "performance-based disbursement" approach under which NGOs work has caused them to focus exclusively on reaching (but not necessarily exceeding) targets and "padding" accomplishments to reach targets.

includes persons who may be KPs but are not willing to identify as KPs and accept services from NGOs/CBOs providing services to KPs along with youth. Prevention efforts among KPs in Sri Lanka have been relatively effective as evidenced by the high use of condoms among KPs in some cities as per availability of data, but use of other proven prevention interventions such as pre-exposure prophylaxis (PrEP) introduced recently has been limited. This NSP has taken into account the need to scale up this activity (SD 1.1) Prevention efforts among other vulnerable population sub-groups and the general population have to date received less attention and have achieved mixed results. The country dialogue has identified migrant workers, tri-forces and tourist industry workers as sub groups vulnerable to HIV and the current NSP has considered them in the current NSP (SD 1.2).

The review recommends expanding programmes to reach to KPs and vulnerable population sub-groups with combination prevention services. The current NSP, taking into account the recommendations of the external review will be calling to strengthen interventions to reach the general population including women and girls, men and boys in collaboration with other health ministry service platforms and non-health ministries such as youth and sports and voluntary organizations. The current NSP fully supports the Family Health Bureau in its efforts with the support of the UNFPA to introduce comprehensive sexuality education (CSE) in a spiral manner from Grade 7 onwards by integrating into the school curriculum which will benefit to improve sexual health of adolescents.

The external review highlights the need to intensify the HIV treatment cascade to provide continuum of care and reduce lost to follow up cases and improve the standard of care for STIs.

In order to enable HIV and STI prevention initiatives to be successful (and indeed some to even be implemented), a more supportive or “enabling” environment is needed. The NSP 2018-2022 acknowledged the existence of legal barriers/criminalizing laws, stigma and discrimination toward PLHIV, KPs and use of condoms, unfriendly health facility environments, and limited awareness of HIV and AIDS in the general population, government and community leaders, and the media. The highest priority recommendations

of the Program Review focused on addressing stigma and discrimination and adverse legal barriers. While some progress has been made, more needs to be done. This NSP will be supporting the creation of an enabling environment for KPs to access services without being stigmatized or discriminated as enshrined in the Constitution of the Democratic Socialist Republic of Sri Lanka that no citizens shall be discriminated against on the rounds of race, religion, language, caste, sex, political opinion, place of birth or anyone of such ground[12].

Although substantial progress has been made in achieving the UNAIDS 95-95-95 targets, challenges remain. Regarding the "first 95", that is the proportion of PLHIV that know their HIV status, the challenge is to find the remaining PLHIV that have not been detection. The latest population-based data on HIV testing coverage among KPs from the 2018 Integrated Biological Surveillance (IBBS) Survey [8] suggests that KPs may constitute a significant share of PLHIV that do not yet know their HIV status. The IBBS data indicated that the proportion of female sex workers (FSW) that had never been tested for HIV ranged between 29% and 34% in the cities sampled, men who have sex with men (MSM) between 12% and 83%, and beach boys (BB) between 46% and 79%. Finding "the last 10%" is always more challenging than making 10% gains at lower levels of coverage. HIV testing must become accessible in order to reach such persons. Lab infrastructure, HIV test kit and reagent availability, and staffing issues must be addressed. The current NSP is recognizing the need to increase coverage and quality of HIV testing by using different testing approaches as given in SD 2.2

Strengthening the linkage between HIV testing and initiating treatment, the "second 95", is also needed. At present, nearly one in five persons (18%) are lost between diagnosis and initiation of treatment who will thus be non-suppressed virally and remain a source of transmission[13]. "Treat all" irrespective of CD4 count has been adopted as a policy in 2016 and this NSP is including strategies to strengthen the application of this policy. Improvements in the reliability of supply of ART drugs and in the use of the Electronic Information Management System (EIMS) defaulter tracing mechanism for online tracking

[12] The parliament. The Constitution of Democratic Socialist Republic of Sri Lanka.
[13] NSACP Annual Report 2020

of all patients from diagnosis throughout the treatment cascade are among the priorities going forward.

Regarding the “third 95” concerning viral load suppression, the baseline viral load is followed by the first assessment at 6 months and thereafter at 12 months and repeated annually on reaching undetectable status. Viral load testing for all PLHIV has been adopted as a policy, but implementation has been less than optimal due to the crisis situation. Several issues need to be addressed, including unreliable availability of reagents for viral load tests and the need for further decentralization of lab support for viral load testing to reduce the time taken to obtain a report from the central lab, including increased point-of-care testing. This NSP, is taking note of these gaps and calls for mapping viral load diagnostics and human resource availability across the country S.D. 2.2.

In the area of strategic information management, establishing strong electronic information systems and databases will empower the NSACP to triangulate data from many diverse sources and enable it to understand gaps and to use the data to act on those gaps. It is essential to have a real time monitoring and alert response system that includes KP intervention programmes. New information system elements were introduced during the 2018-2022 period, most notably the

Prevention Information Management System (PIMS) and the Electronic Information Management System (EIMS). Only some of the clinics are connected to the central data base and others use paper based or google forms to send their data to the centre that hampers real time monitoring across the country. Better use needs to be made of the data produced by these systems, especially at the local level of the health system. Further refinements in surveillance and development of an “M&E culture” are needed to support ambitious program aspirations.

Many of the challenges noted in the Program Review and in consultations with national stakeholders are health systems issues not specific to HIV and STIs. These include overall health infrastructure, health facility and staff capacity, logistics systems, and laboratory capacity. Addressing these issues must be undertaken collaboratively with other units

within the MoH, but if successful will enhance performance across a wide range of health programs and services over and above HIV and STIs.

For Sri Lanka to achieve the goal of Ending AIDS by 2030, it is important to mobilise all relevant high-level committees, including the National AIDS Committee and obtain support from His Excellency the President. Advocacy efforts with media and policy makers need to be enhanced as along with efforts at engaging high level officials to operationalize tools to further reduce stigma and discrimination. It needs to be understood that it is the responsibility of all people from all sectors – government, NGOs, CBOs, KPs, PLHIV – to work together in a coordinated way to ensure an effective response to HIV/AIDS/STI.

Finally, for the NSP 2023-2027 special consideration must be placed on the changes that have occurred in the country in the last two or more years in behavioural, health systems and economy at macro- and micro- levels due to the COVID-19 pandemic and the ongoing economic crisis. An effort was made to capture those changes in the NSP in the key populations, healthcare service delivery, responsiveness, stakeholder collaboration, behavioural changes owing to economic issues, and changes in expectations to propose low-cost strategies that are both practical and sustainable.

3. National Strategic Plan 2023 -2027

3.1 Guiding principles

1. Strategies based on evidence;
2. Human rights and reduction of stigma and discrimination;
3. Gender based approach;
4. Meaningful involvement of people living with HIV;
5. Community participation and engagement;
6. Coordinated approach;
7. Multi-sectoral partnerships;
8. Transition and building national ownership and capacity for sustainability;
9. Quality improvement and quality assurance;
10. Leadership, political commitment and good governance

3.2 Vision, Mission and Goal

Vision

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

Mission

Promote sexual health, prevent new HIV/STI infections and provide accessible and equitable comprehensive STI/ HIV care services to improve health outcomes of people living with HIV (PLHIV)

Goal

Ending the AIDS epidemic in Sri Lanka by 2030 as a public health burden.

3.3 Priority areas

1. Combination prevention of STI/HIV/AIDS targeted interventions for KPs and vulnerable groups for maximum impact.
2. Scaling up HIV testing approaches with universal access to treatment, care and support.
3. Enhanced STI/HIV surveillance.
4. Improved integration of HIV into other health service and non-health service delivery packages to reach out to the general population and youth.
5. Generating strategic information and operational research for policy and programme planning and monitoring and evaluation
6. Public-private partnership for improved prevention, treatment and care for people living with HIV.
7. Creating an enabling environment by addressing human rights and gender equity.
8. A sustainable national response through a strengthened health system and a social contracted community system.

3.3.1 Targets

1. 95% of people living with HIV know their HIV status by 2025
2. 95% of those diagnosed with HIV are on antiretroviral therapy by 2025
3. 95% of PLHIV on anti-retroviral therapy have achieved viral suppression by 2025
4. Sustain elimination of mother to child transmission of HIV and congenital syphilis
5. Less than 10% of people living with HIV report internalized stigma by 2025
6. Reduce new HIV infections by 90% from the baseline value of 2010 by 2030.
7. Reduce AIDS related deaths by 90% from the baseline value of 2010 by 2030

3.3.2 Strategies

1. Prevention
2. Diagnosis, treatment and care
3. Strategic information management
4. Health systems strengthening
5. Supportive environment

3.3.3 Strategic objectives

1. Prevention of new HIV infections among key populations, vulnerable populations, general population including youth and antenatal mothers.
2. Provide universal access to HIV/STI diagnosis, treatment, care and support services for those infected and affected by HIV/STI.
3. Strengthen strategic information systems and knowledge management for an evidence-based response.
4. Strengthen health systems at different levels and ensure an effective multi-sector HIV/AIDS/STI response.
5. Provide a supportive environment for easy access and delivery of HIV prevention, diagnosis, treatment and care services for all.

Each SD is described below:

3.4 Strategy 01: Prevention

Strategic Objective: Prevention of new HIV, hepatitis and STIs among key populations, vulnerable populations, general population including youth and antenatal mothers.

The strategic objective 01 - designates under five strategic directions.

SD1.1. Prevention of transmission of HIV, hepatitis, syphilis and other STIs among Key Population (KP) groups. The KP groups includes; FSW, MSM, TG, BBs, PWUD/PWID and prison inmates
SD 1.2. Prevention of transmission of HIV/STI among vulnerable groups. The vulnerable groups include; (a) external migrants, internal migrants and their families (b) armed forces (c) tourist industry workers
SD 1.3. Prevention of transmission of HIV/STI among general population including young people of age 15-24 years
SD 1.4. Prevention of transmission of HIV, syphilis, hepatitis B & C through infected blood, blood products and organs or tissue transplantation
SD 1.5. Prevention of mother to child transmission of HIV, syphilis and hepatitis

3.4.1 Strategic direction 1.1- Prevention of transmission of HIV, hepatitis, syphilis and other STIs among KPs (MSM, TG, FSW, BBs, PWUD / PWID and prison inmates).

Rationale

This NSP will be continuing to give the highest priority for prevention of HIV transmission by implementing targeted interventions to key populations at high risk of transmitting the virus as it is the most efficient method to reduce the spread of HIV. The greatest challenge of this NSP is the changing demographic profile with same sex relations among men

becoming the main mode of spread, sexual behaviours mediated by recreational drugs and alcohol, condom-less sex, and the impact of the internet on the lives of young men who have sex with men in recruiting casual sex partners from chat groups and poor access to health services. In this background, this NSP is optimizing the combination of differential services of behavioural, biomedical and structural interventions which are on –going to reduce the number of new HIV infections in the country.

Community involvement and community participation is at the core of this NSP and is recognizing the need to continue the peer educator model (PEM) to deliver the sexual health package (SHP) to men who have sex with men, sex workers, people who inject drugs and beach boys which was developed by the NSACP with the objective of behaviour change for safer sexual practices, providing condoms and lubricants, promoting HIV testing, and linking to treatment and care services. The NSP is cognizant of full transition of the PEM approach to NSACP using domestic funding for social contracting community based organizations to deliver KP related services while acknowledging the need to continue the intensified hybrid case finder model in Colombo and Gampaha with GFATM support till the economic crisis in the country improves. The NSP will also support continuation of Drop-In-Centres (DIC) to assist KPs to get tested to know the HIV status and the tailor made web based Know4Sure.lk, and introduce placing strategic messages on virtual platforms where MSM, TG, sex workers chat on line and seek partners as they are becoming a popular method of communication as well as reaching groups which operates in a discrete manner and are reluctant to reach services.

The NSP calls to continue the KP clinics conducted by the NSACP after the usual clinic hours and on Sundays to provide services for people who are reluctant to access the routine clinics. The NSACP supports the TG clinics conducted by the Family Planning Association (former Principle Recipient -2 of the global fund), sensitization programmes, capacity building of transgender youth to address issues of stigma and discrimination and empowering them to use social media platforms more effectively to share their stories and address myths and incorrect information on transgender issues and concerns and seek healthcare services.

Closed settings such as prisons are globally identified as high risks settings of HIV. HIV prevention and control in prisons was initiated by the NSACP in 2005 and the interventions have been institutionalized. The challenges faced during the COVID-19 pandemic has been addressed and authorities have revived the programme and is on-going. There are 30 prisons functioning all over the country and on average around 25,000 prison inmates are found at a given time with around 10,000 to 125,000 admission annually. The prevalence of HIV among people in custodial settings is low. The current NSP is supporting the continuation of the institutionalized peer led intervention model which reach around 15,000 to 20,000 annually through trained prison officers and peer prisoners.

This NSP, will also support the continuation of PrEP services which are made available to MSM, TG and FSW across the country as per the national guidelines to deliver daily or event driven schedule according to individual needs and capacity building of staff of STD clinics and the community in the context of demand generation to recruit more clients. Occupational post exposure prophylaxis (PEP) and post exposure prophylaxis for sexual intercourse (PEPSE) will be continued with close monitoring, continuous capacity building and undisrupted supply of health products and commodities. The NSP recognizes the need to update the current guidelines and protocols regularly for all these interventions.

This NSP is promoting the new approaches introduced by the NSACP to expand the scope of HIV testing for KPs by introducing rapid diagnostic tests (RDTs) using the finger prick method and HIV self- testing (HIV-ST) using oral fluid samples.
The procurement supply management chain will be strengthened for availability of undisrupted health product such HIV tests, condoms and lubricants and ART (addressed in SD 4) which are essential components of the sexual health package.

The current NSP will be giving priority to strengthen the social contracting system for community based organizations in prevention and control of STI/HIV in the background of transitioning from GFATM funds despite the economic challenges faced by the country. The NSP is proposing to develop a “Road Map” to formalize the process for a sustainable

social contracting system and prepare the required legal and policy framework for same. This will be addressed in SD 4.

This NSP has given consideration to cost effectiveness of interventions, availability of human resource, financial capacity and implementation capacity and most importantly to the public health gains for the individual and the country.

Major priority actions that need to be expanded include:

Strategic Direction 1.1	**Prevention of transmission of HIV, hepatitis, syphilis and other STIs among Key Population (KP) groups (FSW, MSM, TG, BBs, PWUD/PWID and prison inmates)**
Major Activities	
1.1.1	Accelerating coverage and quality of on-going delivery of Sexual health Package (SHP) for KPs through physical and virtual out reach
1.1.2	Increase the coverage and quality of community based programme for people who inject drugs (PWID).
1.1.3	Strengthen HIV/STI prevention services in prisons.
1.1.4	Scale up coverage and quality of PrEP, PEP and PEPSE services to reach different KP groups.
1.1.5	Develop a “Road Map” to formalize the social contracting system

3.4.2 Strategic direction 1.2 - Prevention of transmission of HIV/STI among vulnerable groups (migrant workers, armed forces, and tourist industry workers)

Rationale

The community dialogue process has identified three vulnerable groups to be addressed in the current NSP and they are (a) migrant workers including external migrants, internal migrants, returnee migrants and families left behind of migrants, (b) Armed forces (c) Tourist Industry workers.

Internal migrants

External M**igrant Workers**.

The National Labour Policy, National AIDS Policy, National Labour Migration Policy and the National Policy for Health of Migrant Workers are policies which gives guidance for providing healthy migration and healthy living for migrants. The policies emphasize HIV vulnerability faced by migrants as an important issue even though Sri Lanka is listed among the countries with low HIV prevalence.

Sri Lanka Bureau of Foreign Employment (SLBFE), reports reveal that during the past few years the annual turnover for foreign employment is around 210,000 -250,000. At a given time around two million Sri Lankans are working overseas. The majority of them are in the Persian Gulf state and other Middle Eastern countries. Almost all of these migrant workers are in the sexually active age group. While migration is not a direct risk factor for HIV infection, there are economic, socio-cultural, and political factors in the migration process make migrant workers particularly vulnerable to STI/HIV infection. Long periods of absence from home, isolated living in a foreign country, limited access to information and services, and limited rights at the host country are some factors associated with vulnerability.

The HIV prevention and control programme for external migrants was initiated by the NSACP in 2007 and was fully integrated to the pre-departure training conducted by the SLBFE in collaboration with NSACP. Since this activity has been internalized it should be

a routine function of the SLBFE of national interest as the migrant workers are the highest foreign exchange providers to the country. The training programme was disrupted during the Covid-19 pandemic. The training curriculum has not been evaluated since revision in 2016.

Migrants seeking employment in Gulf Cooperation Council (GCC) nations require a mandatory HIV testing as a requirement for medical clearance for visa purposes before departure. The HIV testing has to be done by the centres approved by the Gulf Accredited Medical Centre Association (GAMCA). The testing services are not subjected to quality control by the NSACP and GAMCA centres do not share data with the NSACP and results are not communicated to the potential migrant through a counselling process. In some countries migrants are deported to the country of origin if the HIV test is positive. Sometimes the reason for deportation is not explained to them and on return because of the unknown HIV status could infect their partners. This NSP calls to re-orientate the external migration programme which was once operating successfully.

Armed Forces

Worldwide Uniformed services, are frequently ranked among the population groups most affected by HIV and STIs. Military personnel are two -to-five times more likely to contract STIs than the civilian population and, during conflict, this factor can increase significantly (UNAIDS 1998). However, the situation is different in Sri Lanka. The HIV prevalence among the armed forces have remained <0.1% for almost three decades. The HIV Prevention and Control Programme for the armed forces which was initiated in 2005 is now institutionalized. Capacity building on HIV/AIDS prevention and control is conducted with the support from the NSACP and HIV testing is undertaken at the time of recruitment and at regular milestones. Condoms are provided by the NSACP and condom wending machines have been installed in some camps, and HIV testing for returning officers of UN peacekeeping forces is mandated to be undertaken on the first day of returning and again after 3 months.

Tourist industry workers,

Tourist industry workers such as hotel workers and tour guides are identified as a vulnerable group due to their close contact with tourists and the increased probability of having sex with casual partners, which increase their risk of contracting sexually transmitted infections including HIV/AIDS. Country being marketed as a spot for sex tourism also has been identified as a risk factor which could potentially increase the rate of HIV transmission within the country (Review of the National RESPONSE to HIV/STI Epidemic in Sri Lanka. 2021. External Review Report).

This NSP is aiming to accelerate access to a combination prevention with behavioural, bio-medical, and structural components tailored to meet the needs of key and vulnerable populations.

Priority actions that need to be undertaken include:

Strategic Direction 1.2	**Prevention of transmission of HIV/STI among vulnerable groups. The vulnerable groups include; external migrants, internal migrants and their families, armed forces and tourist industry workers**
Major Activities	
1.2.1	Strengthen HIV prevention programme to cover the migrant's complete journey (pre-departure, settling in the host country, departure from host country, integration to mother country, society and family) through strong collaboration with Sri Lanka Bureau of Foreign Employment (SLBFE).
1.2.2.	Develop new information sharing methods through social media / virtual platforms / Mobile Apps on HIV/STI prevention as a method of enhancing knowledge during the stay in the host country

1.2.3.	Establish a structured service system in which returning migrant workers are offered HIV/STI counselling and testing facilities integrated into existing health service packages
1.2.4.	Reach out to men and women and adolescent girls and boys left behind by migrants.
1.2.5.	Establish a functioning system to receive HIV testing data related to out-bound migrants from private laboratories to NSACP
1.2.6	Develop a STI/HIV prevention package for internal migrants. with community participation and involvement of property developers, contractors of super highways, Municipal Council and Pradeshiya Saba officials and identify implementation mechanisms.
1.2.7	Support to continue internalize HIV prevention programmes in tri-forces
1.2.8	Develop an evidence based programme to prevent transmission of HIV among tourist industry workers.
1.2.9	Conduct epidemiological surveys to identify other vulnerable populations

Strategic direction 1.3- prevention of transmission of HIV/STI among general population including young people (15-24 years)

Rationale

The general population on HIV issues are felt as needed due to (1) Low level of knowledge on HIV - The Demographic and Health Survey 2016, observed that only 24% of married women in the 15-24-year age group had comprehensive knowledge on HIV (2) stigma and discrimination surrounding HIV and AIDS and (2) the continuing presence of sizeable numbers of persons engaging in high-risk behaviors that are not being reached by programs directed to KPs.

Adolescents and youth:

NSACP statistics show that in the year 2021, out of total reported cases 14% (59 persons) were in the 15–24-year age group. Out of them almost 80 % were young men who were engaging in same sex relationships[14]. It can be reasonably argued that the current 15-24-year age group may be still schooling or few years ago were in school and they have probably had no knowledge on STI/HIV including accessibility and availability of sexual health services including HIV or skills in reducing high risk sexual and drug use behaviors.

The current NSP recognizes the need to support the FHB in introducing the already developed scientifically accurate comprehensive sexuality education (CSE) curriculum with age appropriate facts which are also relevant to cultural context, into the government school system.

HIV/STI prevention and control is anchored into the Family Health Bureau, Yowun Piyasa (Adolescent and Youth Friendly Health Services centre) centres which are dedicated for youth and Mithuru Piyasa: (Women Friendly Health Services centre) which supports girls and women subjected to gender based violence. This NSP address the need to support the Family Health Bureau (FHB) by providing the necessary IEC messages, training of healthcare providers and collecting strategic information as a measure to monitor the programme and understand the needs of people accessing these facilities and addressing them. In order to reach the out of school youth population, the current NSP seeks the support of youth clubs and organizations to include the subject of HIV/AIDS in their health campaigns.

The current NSP identifies some additional service points of the FHB for integrating HIV/STI services, such as the Well Woman Programme which can provide an opportunity for women above 35 years to be educated on HIV and link to services. The FHB has initiated an intervention for public health midwife (PHM) to register adolescents during her home visits and identify adolescents who are at risk of violence, abuse etc. The current NSP identifies the need to collaborate with FHB to develop a suitable programme for such

[14]Ministry of Health. National STD/AIDS Control Programme. Annual Report 2021.

identified adolescents to face challenges which makes them vulnerable to HIV/STI. The current NSP, is also recognizing the need to collaborate with the NCD Directorate to integrate HIV/AIDS knowledge into workplace programmes and is also seeking the support of non-health ministries to include HIV/AIDS awareness into their programmes to enable a cross section of the general population including men to understand the basic facts, methods of prevention and services available for STI/HIV/AIDS.

Priority actions that need to be undertaken include:

Strategic Direction 1.3	**Prevention of transmission of HIV/STI among general population including young people of age 15-24 years**
Major Activities	
1.3.1	Strengthen the collaboration between the existing public health system (PDHS/RDHS, FHB, directorate of NCD, Mental Health etc) and integrate HIV/STI prevention activities at district and provincial level to reach men and women, adolescent girls and boys.
1.3.2	Support FHB to integrate age appropriate comprehensive sexuality education (CSE) into the public school curriculum
1.3.3	Support FHB in addressing HIV/STI in Yowun Piyasa (Adolescent and Youth friendly Health Services center-AYFHS) for adolescents and Mithuru Piyasa for survivors of gender based violence
1.3.4	~~Capacity building of youth educators/tutors of Ministry of Youth in communicating HIV/STI knowledge~~
1.3.5	Strengthen multi-sectoral approach with relevant stake holders to address SRH issues scientifically (education, youth affairs, sports, Media and work places)

1.3.6	Integrate HIV/STI Prevention into University system with the support of University Grants Commission.
1.3.7	Integrate STI/HIV Prevention into medical school curriculum and to intern medical officers.
1.3.8	Strengthen the collaboration with the National Child Protection Authority to educate the officers to have accurate knowledge on HIV/STI including risks and vulnerabilities and policies and laws
1.3.9	Establish a helpline/hotline to provide SRH counselling for general population including women and youth
1.3.10	Increase the use of virtual platforms and social media for sexual and reproductive health education for young people

Strategic Direction 1.4 - Prevention of transmission of HIV/syphilis/ hepatitis B & C through infected blood and blood products

Rationale

The National Blood Transfusion Service (NBTS) is the sole supplier of blood and blood products to all state hospitals and some private hospitals registered with them to provide a safe supply of blood and blood products. Implementing the policies of the National Blood Policy of Sri Lanka has helped Sri Lanka to report no transfusion related HIV infections since year 2000. National guidelines and protocols are followed to manage HIV positive blood units. Infected donors are informed in a confidential manner to refrain from further blood donations and counselled for linking with treatment, care and support services. The NBTS and NSACP work in collaboration in implementing these activities. These policy implementations have resulted in a safe blood supply for transfusion and is one of the safest in the South Asia region.

Since the year 2000, transfusion associated HIV infections have not been reported in the country. Yet, the NBTS reports that blood samples collected for transfusion have tested positive for HIV infection and the rate is increasing. In the wake of the situation where

HIV prevalence among young people 15-24 years is increasing, the current NSP recognizes the need to amplify awareness on basic facts of HIV including responsible blood donation and encourage self- deferral for those whose sexual and or drug injecting behaviours puts them at an increased risk of HIV infection and ensure strict voluntary and non-remuneration blood donations. The NSP also recognizes the need to register all private blood banks with the NBTS and the directorate of Private health sector development to adopt a system of continuous monitoring of private blood banks.

The NBTS has developed guidelines for clinical use of blood and adopts a protocol developed in consultation with the NSACP to manage a blood unit which test positive for HIV. This NSP recognizes the importance of interoperability of data bases of the two institutions to generate accurate and timely data for action. NBTS conducts an External Quality Assurance System (EQAS).

The current NSP recognizes the need to sustain the best practices adopted by the NBTS in maintaining a safe blood supply to the nation and the current economic crisis should not dissuade any of the strategies that are being practiced.

Priority actions that need to be undertaken include:

Strategic Direction 1.4	**Prevention of transmission of HIV/syphilis/ hepatitis B & C through infected blood, blood products and organs or tissue transplantation**
Major Activities	
1.4.1.	Strengthen collaboration between NBTS and NSACP.
1.4.2	Awareness programmes to focus on sustaining non-remuneration donations and HIV risk free donations to sustain a safe blood supply to the country.
1.4.3	Ensure the NBTS data base on HIV testing is shared with the NSACP and NSACP uses such data to manage the index case for continuum of HIV care and treatment of syphilis.

Strategic Direction 1.5 - Prevention of mother to child transmission of HIV and congenital syphilis

Rationale

In 2019 Sri Lanka became the third country in the SEARO region declared by the Global Validation Committee (GVAC) of the WHO to have eliminated mother-to-child transmission (EMTCT) of HIV and congenital syphilis.

Universal screening of antenatal mothers for syphilis and HIV is a public health strategy adopted by the NSACP in partnership with the Family Health Bureau. The FHB is the nodal agency responsible for maternal and child health services in the country. The Family Health flagship programme of the FHB reaches almost all families in the country through various service packages delivered throughout the life cycle. In 2002, through a joint effort of the FHB and NSACP integrated prevention of mother to child transmission of HIV and syphilis into the pre- conception, antenatal and intra partum service packages. The objective was to promote voluntary HIV testing among antenatal mothers by promoting sexual health decision making with male participation to know the HIV status to initiate anti-retroviral therapy to prevent mother to child transmission of HIV. Male participation was aimed at reducing sexual and gender based violence as it is the woman who will be the first to know the HIV positive status.

Mothers tested positive are provided anti-retroviral therapy and managed according to National Guideline for Management of HIV infection in Pregnancy. Children born to HIV positive mothers are treated according to a national protocol and HIV-PCR-DNA testing is available at the National Reference Laboratory of the NSACP. Sri Lanka has reached universal antenatal screening for HIV and syphilis and the WHO in 2018 certified Sri Lanka to have eliminated mother to child transmission of HIV and syphilis. The current NSP is cognizant of continuing these hard earned successes through the adoption of WHO

recommended four-pronged approach amidst the challenge of the current economic situation of the country.

The triple elimination process of MTCT of HIV, syphilis and viral hepatitis is considered in the current NSP in a background of a very low prevalence of hepatitis B and C infection among STD clinic attendees. Data on the prevalence of hepatitis B& C among the general population is lacking. The prevalence of the hepatitis B surface antigen among children < 5 years was zero in a recently completed survey. All neonates are vaccinated for hepatitis B which is a component of the penta-vaccine given at 2, 4, 6 months of age.

Priority actions that need to be undertaken include:

Strategic Direction 1.5	**Prevention of mother to child transmission of HIV, syphilis and hepatitis**
major activity	
1.5.1	Support FHB sustain universal screening of antenatal mothers for HIV and syphilis
1.5.2	Develop capacity of STD clinic staff to identify and reduce the unmet family planning needs of KP and the HIV infected cohort.
1.5.3	Ensure all HIV infected pregnant mothers are initiated on ART according to national guidelines and their new-borns managed according to guidelines
1.5.4	Provide nutrition and social support for HIV infected mothers and families
1.5.5	Introduce screening for hep B &C for high risk antenatal mothers and develop a screening tool
1.5.6	Strengthen the PMTCT data sharing with FHB and generate data to improve coverage and case management.

3.5 Strategy 02: Diagnosis Treatment and Care Services

Strategic Objective: Provide universal access to HIV/STI diagnosis, and treatment, care and support services for those infected and affected by HIV/STI

The strategic objective 02 - designates under five strategic directions.

SD 2.1	Provide quality HIV diagnostic services
SD 2.2	Provide quality STI diagnostic services
SD 2.3	Sustained and equitable access to quality, person centered treatment and care facilities to improve the well-being of all people living with HIV
SD 2.4	Increase coverage and quality of sexual health and STI treatment and care
SD 2.5	Scale up HIV and Tuberculosis (TB) service collaboration

SD 2.1 Provide quality HIV diagnostic services.

Rationale

The National Reference Laboratory of the NSACP is the nodal centre in charge of HIV laboratory diagnostic services. HIV testing facilities were made available in the country from 1988 just one year after the detection of the first HIV case in Sri Lanka. One important strategy to end AIDS is to accelerate HIV testing services. HIV testing is traditionally being done at STD clinics and at all 41 functioning STD clinics across the island and in the recent past it has been extended for testing key populations in community settings with the involvement of trained lay providers. HIV testing services from any of these facilities are accessible to any person who need the service including KPs who are at a higher risk of infection. As per the National HIV/AIDS Policy mandatory HIV testing is not recommended.

The objective is to identify people living with HIV through differentiated HIV testing services and effectively link to them to HIV treatment, care and support as well as HIV prevention services based on their status. . At present routine ELISA based blood test, rapid

finger prick blood test and HIV oral fluid self-test (saliva test) are available in Sri Lanka as screening tests and is provided free of charge in government health settings. The provider initiated testing and counselling (PITC) is offered in STD clinic settings and was expanded in hospital clinical settings on suspicion of HIV infection based on signs and symptoms. The guiding principle is application of the test regardless of the approach to the benefit of both the individual tested and to improve health outcomes at population level.

Rapid diagnostic tests are provided by the NSACP to hospitals across the country from Base Hospitals upwards. Paid tests are available in private sector hospitals and in GAMCA testing centres for outbound migrants.

The current NSP promotes, Sri Lanka to maintain the high level of testing for HIV due largely to adhering to the WHO recommended 5 C's principle: consent, confidentiality, counselling, correct test result and connection (linkages to prevention, treatment, care and support). The current NSP is cognizant of the last principle where people who have had a positive screening test do not attend STD clinics for treatment and care. The current NSP highlights the importance of researching into these cases to explore the reasons for default and take remedial measures to address the barriers that hinder or delay linkages to treatment and care. There is a need to strengthen links with the private hospitals and private laboratories to refer newly diagnosed HIV cases to the NSACP without any delay. However, mitigating defaulting is a challenge in the absence of a policy direction for such referrals from the private sector. The NSP also notes the need to increase the healthcare provider workforce and build their capacity to provide the 5C's for HTS.

The triple test algorithm is used to confirm HIV diagnosis to increase the turnaround time. Testing is done at the highest possible standard by trained medical laboratory technicians (MLT) under the guidance of a consultant microbiologist.

Although the standing on the "first 95" is strong, the current NSP has taken into account the 2018 IBBS data regarding testing coverage of KPs which suggest that the HIV testing challenges faced by Sri Lanka may be larger than is suggested by the 83% figure. The IBBS data indicated that the proportion of female sex workers (FSW) that had <u>never</u> been tested

for HIV ranged between 29% and 34% in the cities sampled, men who have sex with men (MSM) between 12% and 83%, and beach boys (BB) between 46% and 79%. This NSP is focusing on increasing mobilization for HIV testing which is addressed in SD 1.

Although HIV testing is conducted in prisons the numbers of HIV test performed is inadequate. The current NSP calls to increase the coverage of HIV testing in prisons by internalizing HIV services and ensuring a continuous supply of HIV test kits, and access to all preventive measures that are available for the general population.

Diagnostics such as CD4 cell count, viral load testing, PCR-RNA testing are also available in the country. The current NSP proposes a needs assessment to scale up diagnostic services such as CD4 cell count testing and viral load testing given the resource constraints in the districts. A major step forward has been establishing HIV DR testing at the NRL as a support to select the most efficient ART regimens based on the gene sequencing profiles and for pre-treatment surveillance purposes (see SD 2.3). HIV-DNA testing for diagnosing paediatric infections will be continued.

The current NSP is also focusing on strengthening quality assurance of laboratory testing and obtaining laboratory accreditation. The NSP, address the need of an expert committee to make projections and estimates for diagnostic test kits, reagents and establish a procurement supply management chain (PSM) to ensure a continuous supply with no stock-out situations (refer SD4). The Laboratory Information Management System (LIMS) has to be strengthened to gather strategic information on HTS across the continuum of care and prevention. Addressing the critical enablers to provide a supportive environment is addressed in SD5.

Priority actions that need to be undertaken include:

Strategic Direction 2.1	Provide quality HIV diagnostic services
Major activities	
2.1.1	Strengthen differentiated HIV testing services/approaches
	Increase PITC in STI clinics, TB clinics and hospital settings
2.1.2	HIV confirmation by using the national three tests algorithm to reduce turnaround time
2.1.3	Optimize use of CD4 and Viral Load testing as point of care tests after a needs assessment
2.1.4	Ensure availability of diagnostic tests for management of opportunistic infections
2.1.5	Strengthen quality assurance of HIV testing through national reference laboratory.
2.1.6	Ensure drug resistance surveillance for HIV
2.1.7	Ensure availability of hematological, biochemical tests for the management of PLHIV
2.1.8	Ensure sustainability of HIV DNA PCR testing for early infant diagnosis (EID)
2.1.9	Develop and update HIV testing guidelines and SOPs accordingly
2.1.10	Accreditation of NRL and other testing sites
2.1.11	Adequate training of staff and supportive supervision

Strategic direction 2.2: Provide quality STI diagnostic services

The 2021 Program Review observed that the quality of existing clinic STI clinical and laboratory services in Sri Lanka is already among the best in the region but strengthening them further is key to reaching elimination targets for STI, HIV and viral hepatitis. Doing

so would also align with regional recommendations to integrate strategic plans across these three overlapping disease areas.

Throughout history, Sri Lanka has been planning and implementing prevention and management of STIs based on global strategies by offering a comprehensive STI management package. A critical component of the STI continuum of treatment and care is the availability of diagnostic facilities for all STIs and of high quality. The NRL together with a network of district STD laboratories are responsible in providing STI diagnostic services. The NSP recognize the need to optimize laboratory services since the majority of district STD clinic laboratories are unable to conduct basic STI tests such as syphilis tests for serology, gonococcal culture tests due to lack of human resources.

The current NSP identifies the major gaps in infrastructure of NRL and district STD clinics (addressed in SD4) and diagnostic facilities at all levels and the need to improve and accelerate diagnosis by introducing molecular testing facilities, establishment of automated diagnostic systems to 1) further reduce the incidence of T. pallidum, N. gonorrhea, and congenital syphilis to align with the targets set by the global STI strategy 2) identify asymptomatic STIs especially among women which if undiagnosed and left untreated would led to pelvic inflammatory disease and its consequences and sequelae such as ectopic pregnancy and infertility 3) diagnosis of human papilloma virus which cause cervical cancer. The NSP identifies the need to sustain the gonococcal antibiotic surveillance system which has a history spanning over four decades.

The NSP identifies the need to introduce a structured training programme for new recruits to the NRL and district labs and regular re-fresher training for other staff. Cadres for human resources for laboratory services and deployment based on availability of laboratory facilities and disease burden are to be included in the Human Resource development plan and is addressed in SD4. The NSP identifies the need to develop a public-private partnership to outsource tests in crisis situations. The NSP has taken note of continuing the quality assurance system adopted by the laboratory system and the need towards laboratory accreditation for STI services.

The strategy is to accurately estimate based on evidence of all diagnostic test kits, reagents, laboratory consumables and include in the Procurement and Supply Management plan to ensure an uninterrupted supply chain (SD4).

The LIMS has to be streamlined to capture STI related laboratory data to the EIMS to enhance case management and reduce delays in treatment. The information system should also be strengthened to signal stock out situations of laboratory diagnostic tests and reagents.

Priority actions that need to be undertaken include:

Strategic Direction 2.2.	**Provide quality STI diagnostic services**
Major activities	
2.2.1	Ensure STI tests (smear tests, Culture) are available in each STD clinic
2.2.2	Upgrade all STD laboratories to the required standard for accreditation and offering quality services
2.1.3	Introduce HPV DNA testing at NRL and other STD clinics in phase manner

Strategic direction 2.3 - Ensure sustained and equitable access to quality, person centered treatment and care facilities to improve the well-being for all people living with HIV

Rationale

The ART programme in Sri Lanka was initiated in 2004 and is fully integrated with STI services. Presently, ART services are provided at 30 health centres. The WHO "Treat all" strategy has been adopted island wide since 2016. As of end 2022, there were 2947 patients on ART. With respect to UNAIDS 95-95-95 target, among the 86% who know their HIV status 80% were commenced on ART and 87% have achieved viral suppression.

Sri Lanka provides a core package of evidence based essential HIV interventions including ART to people living with HIV free of charge through the government run STD clinics.

The package of services includes baseline clinical, immunological, hematological, bio-chemical and virological assessment, provision of patient-centred treatment, adherence counselling, STI screening and treatment, follow up, social support, promotion of safer sexual practices, provision of condoms, monitoring the service cascade and index partner contact notification. The preferred first line ART was the WHO recommended combination of tenofovir-emtricitabine- efavirenz but it is now being changed to include dolutegravir with tenofovir with emtricitabine/lamivudine as per the new WHO recommendations. National ART and care guidelines will be regularly updated adapting WHO recommendations. Data shows that around 80 % of PLHIV who know their HIV status have been commenced on ART and 87 % have achieved undetectable viral loads which prevent onward sexual transmission. During the period of the current NSP, provision of treatment and care package will be optimized across the full continuum of HIV services to achieve a coverage of 95% to be on ART and 95% to achieve viral suppression. Procurement supply and management chain will be strengthened to avoid stock outs and achieve positive treatment outcomes (refer SD4).

Since around 23-27% of new diagnoses have reached the advanced AIDS status, the current NSP is taking steps to strengthen advanced disease management (ADM) in order to reduce morbidity and mortality.

Data generated by the Electronic Information Management System (EIMS) will be used to address gaps between HIV testing and treatment initiation, loss to follow up after commencing ART, response to therapy (clinical, immunological and virological). To close the gap between drop outs from the time of diagnosis and initiation of ART, the NSP proposes to strengthen counselling by providing training to healthcare providers, community peer educators and out- reach workers.

Priority actions that need to be undertaken include:

Strategic Direction 2.3	**Sustained and equitable access to quality, person centered treatment and care facilities to improve the well-being for all people living with HIV**
Major activities	
2.3.1	Ensure provision of comprehensive package of interventions including ART on the basis of "treat all" policy
2.3.2	Generate strategic information on treatment and care to ensure all diagnosed cases are linked to treatment, retained in care and have achieved sustained viral suppression.

Strategic Direction 2.4 - Increase coverage and quality of sexual health and STI treatment and care

Rationale

The 2021 Program Review observed that the quality of existing clinic STI services in Sri Lanka is already among the best in the region but that strengthening them further is key to reaching elimination targets for STI, HIV and viral hepatitis. Doing so would also align with regional recommendations to integrate strategic plans across these three overlapping disease areas.

The Program Review observed that strengthening STD clinic services requires closing a critical gap – the low reach and uptake among key populations. This aligns with the priority assigned in the NSP 2023-2027 to increasing the coverage and effectiveness to reach KPs with information and services (see SD 1.1). Prioritizing STI diagnosis and treatment can be viewed as a "gateway" for improved HIV and STI prevention.

Beyond increasing KP reach and service utilization, the NSP 2023-2027 observed a number of other needs and challenges to increase the coverage and quality of STI services. This

concern; ensuring supply of routine tests at all STD clinics and essential tests at the provincial and NRL levels, upgrading laboratory testing capacity at STD clinics and strengthening STD surveillance.

Routine diagnostic investigations for common STIs such as syphilis, gonorrhoea, trichomoniasis is available in almost all STD clinics. Some clinics lacks the ability to perform gonococcal culture test. Nucleic acid tests for gonorrhoea and chlamydia is not available at present in the NRL. This NSP calls to strengthen STI diagnostics, treatment and care as the presence of STIs have consequences on women such as pelvic inflammatory disease which may lead to ectopic gestation and infertility and is a risk factor for transmission of STIs.

Priority actions that need to be undertaken include:

Strategic Direction 2.4	**Increase coverage and quality of sexual health and STI treatment and care**
Major activities	
2.4.1	Develop a comprehensive STI prevention and treatment package
2.4.2.	Create a conducive clinic environment for accessibility and acceptability of STD clinic services for all clients, including KP and youth population
2.4.3.	Increase demand generation for STI services
2.4.4	Ensure periodical drug resistance surveillance for selected STIs
2.4.5	Establishing special clinics for TGW, PWID in NSACP and in selected STD clinics
2.4.6	Establishing and scaling up sexual health services

Strategic Direction 2.5 - Scale up HIV and Tuberculosis (TB) service collaboration

Rationale

Tuberculosis is the second most common opportunistic infection (OI) among PLHIV in Sri Lanka (reference). The NSACP has been working in partnership with the National Programme for Tuberculosis and Chronic Chest Diseases for more than two decades. According to the guideline of management of HIV-TB co- infection, all persons who are diagnosed with TB are offered HIV testing and the positives are referred to the respective STD clinics. All PLHIV undergo screenings for active TB at the booking visits to HIV care services and in follow-up visits using four symptoms-based screening[15]. Isoniazid (INH) is provided after excluding active TB infection. TB co-infected persons are treated according to the National ART national guidelines.

However, 2019 and 2020 data reveal that compliance with these guidelines is low – for example, out of 36 HIV TB co-infected persons in 2019, only 15 received ART (41.6%) and only one received co-trimoxazole preventive therapy (CPT). 2020 data show similar results. Interoperability of the National NPTCCD health management system and the NSACP/SIM unit management system should be ensured which will help in tracking continuum of care.

Priority actions that need to be undertaken include:

Strategic Direction 2.5	**Scale up HIV and Tuberculosis (TB) service collaboration**
2.5.1	Strengthen collaboration with NPTCCD and NSACP for diagnosis treatment and care of HIV and TB at all Chest clinics and STD clinics.
2.5.2	Ensure all HIV-TB co-infected patients are on appropriate treatment regimens for both infections
2.5.3	Scale up provision of IPT from ART centers

[15] A guide to HIV care services and management of opportunistic infections, NSACP 2022

3.6 Strategy: 03 Strategic Information Management System

The strategic objective: Generating strategic information for policy development, programme management and monitoring and evaluation.

The strategic objective 03 - designates under four strategic directions.

SD 3.1	HIV and STI Surveillance
SD 3.2	Programme monitoring and evaluation
SD 3.3	HIV/AIDS and STI Research
SD 3.4	Knowledge management

Rationale

At the central level, the SIM unit which was established in 2005 is responsible for strategic information management of the NSACP. As the nodal unit it handles all the STI/HIV related data of interventions carried out by government agencies, NGO/CBO/CSO and communities and the private sector. The primary responsibility of the SIM unit is the implementation of the National STI/HIV/AIDS monitoring and evaluation plan. The SIM unit is empowered with good data governance, security, privacy and confidentiality. To perform these duties, the current NSP recognize the need to strengthen the SIM unit with appropriate infrastructure and financial and human resources to collect, collated and analyse data to generate useful evidence on emerging epidemiological patterns and service achievements and gaps for policy and programme planning and monitoring and evaluation.

The paper based data collection system is being converted to electronic databases with the financial support of the GFATM. This transition has taken into account the importance of health data governance, interoperability, unique identifiers, data security, privacy and confidentiality, and data access only for authorized individuals.

The Electronic Information Management System (EIMS) collects patient related data and provide data for surveillance as well as comprehensive STI/HIV patient management. The current surveillance system of the NSACP include 1) HIV sentinel surveillance (HSS) 2) Integrated Biological and Behavioural Surveillance (IBBS) 3) HIV and STI case reporting 4) AIDS death surveillance. Population Size Estimation of Key Populations is done parallel to the IBBS. HIV Epidemic Estimation is undertaken annually in collaboration with UNAIDS. STI related data are collected from STD clinics and routed through the SIM unit of the NSACP. HIV case reporting is from both public and private HIV testing laboratories. The SIM unit systems are trying to track continuum of care for individuals accessing HIV care services to identify testing and treatment outcomes, develop cascade indicators for each KP group and collect data on AIDS deaths.

The PMIS was established to provide information on the full range of outreach activities (e.g., HIV/STI prevention, HIV/STI testing, community-based out-reach services, mobile clinics, drop-in centres, and prison programmes). The information system built into the virtual reaching of KPs online reservation application named “know4sure.lk.” is the other database which has been recently added to the data collection system.

In addition, programme related data from other institutions related to STI/HIV from maternal and child health programme of the Family Health Bureau on prevention of mother to child transmission of HIV and syphilis, National Blood Transfusion Service and private sector laboratories are also channelled to the SIM unit.

The data collected from these different sources are collated, analysed and data thus generated is evidence based and used for policy development, programme planning and monitoring and evaluation, address accountability and improve performance and meet various national and international reporting needs.

The current NSP recognise the need to integrate these two data systems to generate data for policy development, programme monitoring and evaluation and management and optimize interventions according to specified timelines as they are essentially fundamental requirements to guide the national response.

The current NSP is promoting a "M&E Culture" in the NSACP and district STD clinics and the NGO/CBO/CSO and communities by capacity building to use such data for decision making in planning and monitor and evaluate the national and sub national level epidemics. In parallel, there is a need to ensure infrastructure development including availability of hardware, access to internet facilities, maintaining data back-up systems as per the government regulations and the necessity to have service/maintenance agreements /MOUs, developing specific and standardized definitions and data validation methods, development of guidelines/protocols, regular supervision, to sustain the systems. The current NSP calls to strengthen the LIMS and make arrangements to link it to EIMS and also promote community led monitoring (CLM) to assess client satisfaction. The SIM unit procurements to be included in the NSACP, Procurement and Supply Chain Management system.

In order to add value to the data generated by programme implementation the current NSP is drawing attention to establish a Research unit in the NSACP with a Research Committee consisting of representation from key stakeholders to identify the research needs to add value to the data generated by the above mentioned systems.

The NSP will also support the population based surveys such as Demographic and Health Survey and Sri Lanka Population and Housing Census conducted by the Department of Census and Statistics. The NSP will also address a creation of a knowledge management strategy for NSACP which will strengthen evidence-based programming. Knowledge management encompasses four components:

- Knowledge creation – Regular, Systematic analysis of data and bringing out knowledge products such as reports, bulletins, articles and scientific papers
- Knowledge collection and storage – Electronic capture and recording of knowledge products in a systematic manner for easy reference and use
- Knowledge sharing - Dissemination and communication of knowledge products to stakeholders from time to time
- Knowledge translation – Use of data for programmatic actions and decision making

Priority actions that need to be undertaken include:

Strategic Direction 3.1	**Sustain HIV and STI Surveillance**
Major activities	
3.1.1.	Design, develop Plans for both HSS and IBBS with timelines to conduct HSS and IBBS periodically
3.1.2.	Design, develop a plan to continue Population Size Estimation of KP in parallel with the IBBS
3.1.3.	Continue annual HIV estimation and projections in collaboration with UNAIDS.
3.1.4.	Strengthen mortality surveillance by conducting regular review of AIDS death data and improving AIDS death notification to NSACP
3.1.5.	Integrate HIV drug resistance surveillance to EIMS
3.1.6	Strengthen district level EIMS and PMIS databases for STIs and ensure identified indicators are constructed.
3.1.7	Strengthen STI surveillance (1) ensuring separate reporting and analysis of Hepatitis B and C, (2) establishing a mechanism via which private sector hospitals and clinics can report STI cases in a timely fashion, and (3) establishing a data sharing and collaboration between NSACP and Epidemiology unit of the Ministry Health
Strategic Direction 3.2	**Continue Programme monitoring and evaluation**
Major activities	

3.2.1	Ensure functioning of all digital platforms; EIMS, PIMS and know4sure.lk in all the STD clinics in the country through a database located centrally with differential access at local/district level
3.2.2.	Establish Community Led Monitoring and link the data base to PIMS
3.2.3.	Strengthen Laboratory Information Management System and ensure interoperability
3.2.4	Ensure Data quality of EIMS / PIMS services
3.2.5.	Link the different information systems currently functioning to a common database across all service delivery points/units that allow integrated information pathways to support a comprehensive evaluation framework.
3.2.6.	Data dissemination in a timely manner for national and international reporting e.g GAM, SDG
Strategic Direction 3.3	**HIV/AIDS/STI Research**
Major activities	
3.3.1.	Create the research culture in the NSACP and district STD Clinics
Strategic Direction 3.4	**Knowledge Management**
Major activities	
3.4.1	Develop a Knowledge Management Strategy

3.7 Strategy 04: Health Systems Strengthening

Strategic Objective: Strengthen health systems to provide an efficient and effective HIV/STI response

The strategic objective 04 designates under six main strategic directions;

SO 4.1	Strengthen Leadership and Governance Structure
SO 4.2	Infrastructure Development
SO 4.3	Coordination, Human Resources, Training and Capacity Building
SO 4.4	Diagnostics, Medicines, and Other Supplies
SO 4.5	Strengthening Integrated Service Delivery.
SO 4.6	Programme Funding, Transition, and Sustainability

Throughout the HIV epidemic, investments have been made by domestic and donor funding to strengthen the national health system and community systems. Infrastructure development, capacity building of workforces, establishment of electronic data management systems are some areas which have been advanced to make health system effective and efficient to respond to HIV/AIDS and ensure health services are accessible and available to those in need of services.

In the changing scenario of the HIV/AIDS epidemic, there is a necessity to review the current National HIV/AIDS Policy (2011) and update with new policy directions highlighting social contracting services for KP groups to streamline expanded HIV testing services and linkages to treatment and care provision, and strengthen procurement and supply chain management of diagnostics, medicine and commodities.

The current NSP is focusing on a public health and human rights-based approach by giving priority to concerns such as universal health coverage, gender equality and health related rights such as accessibility, availability, acceptability and quality of services (AAAQ) and

human rights related principle of non-discriminatory, participatory and accountability.

Prevention related service delivery models have been described in SD-1, service delivery related to treatment and health information systems are described in SD 2 and SD-3 respectively.

This section addresses the other three building blocks of health systems strengthening.

Strategic Direction: 4.1 - Strengthening Leadership and Governance Structure

Achievement of the goal and objectives of this National Strategic Plan requires a well-functioning and responsive health system. The national response to prevention and control of STI/HIV is spearheaded by the NSACP of the Ministry of Health together with the district level STD clinics, other health sector, non-health public sector, private sector and several NGO, CBO, CSO and community stakeholders.

The National AIDS Committee (NAC), chaired by the Secretary of the MoH, is the supreme body which monitors the national response and provides a platform for multi-sectoral engagement and discussion on all activities related to HIV/STIs and is accountable to the Hon Minister of Health.

The current NSP calls for strengthening of the NAC with high level representation from each ministry engaged in the national response. The NAC will be restructured with a new TOR and as the Secretary of the NAC, the roles and responsibilities of the Director NSACP will also be formulated towards good governance. The coordinators of the NSACP will work according to a TOR and coordinate all activities under the specific areas allocated to them and conduct effective M&E according to the National STT/HIV M&E Plan. The progress of each unit will be monitored and evaluated at senior management meetings. Inputs from the District and Provincial AIDS Committees will be taken up for discussion at these meetings and feedback will be provided. The DAC shall report to the PAC and PAC shall be reporting to the NAC

Currently the GFATM related activities are monitored by the oversight committee and the CCM. The current NSP proposes to appoint an interim oversight committee for a period of 2 years after GFATM ceases to function as the principle donor and then hand over the

responsibility of M&E of the national response to the NAC as the country coordination mechanism.

During the last few years, the MoH has worked in partnership with NGO, CBO, CSO, KPs, PLHIVs in the true spirit of community involvement to optimize the delivery of combination prevention packages for key populations given the nature of operations of KP groups e.g. being hidden and not seeking HIV/STI care services compounded by stigma and discrimination in healthcare settings and self-stigma. The NSP is addressing the issue of establishing a social contracting system with a finance model for civil society to be meaningfully engaged in the national response once the donor funding cease to operate. This is discussed in SD 1.1.

The NSACP will engage all stakeholders in the national response and will pay particular attention in seeking the support of other health and non-health sectors to integrate HIV prevention in their respective policies and programmes. The NSP identifies the need to plan for regular programme reviews to identify strengths and weaknesses to improve the progress.

Rationale

Priority actions that need to be undertaken include:

Strategic Direction 4.1	**Strengthening Leadership and Governance Structure**
Major activities	
4.1.1	Update the National HIV/AIDS policy with new evidences including the required legal and policy statements for purchase of services from civil society organizations.
4.1.2	Robust Monitoring and Evaluation using National M &E plan
4.1.3	Strengthen planning, coordination
4.1.4	Establish a social contracting system for KP interventions

Strategic direction: 4.2 - Infrastructure development

Rationale

The central STD clinic, National Reference Laboratory and the District STD clinics with its own supporting laboratory services are the back-bone of patient care for STI/HIV prevention and control. The service delivery consists of both facility and community outreach. Clinical services are provided on a daily basis from 8am to 4pm and in the **central STD clinic around 75 patients** are provided with STI/HIV care. At the district level around 41patients are seen daily in high populace districts and 05 in low populace districts.

With the introduction of new guidelines, protocols, new technologies and increasing clinic attendees the geographical spaces in clinics and laboratories and work forces need expanding. Lack of transport facilities hinders conducting out-reach mobile clinics and transporting clinical specimens to other centers including the NSACP. These challenges have to be met to improve the quality of services.

Priority actions that need to be undertaken include:

Strategic Direction 4.2	**Infrastructure Development**
Major activities	
4.2.1	Develop a comprehensive infrastructure Master Plan for the NSACP including district clinics

Strategic Direction: 4.3 - Coordination, Human Resources, Training and Capacity Building

Rationale

The service delivery of prevention and control of HIV is the mandate of the NSACP and its district clinics. Most of the district STD Clinics are under the provincial council administration but the technical guidance is provided by the central level. The Infectious Diseases Hospital (IDH) supports the NSACP as an ART center and in providing in patient care.

Regarding staffing, although there has been an effort to ensure designated staff to all sites, shortcomings persist and mismatches between needs and placements are observed in several locations where positions have not been filled. New staff positions are needed to reflect changes in service delivery models. Lack of administrative staff in some of the programmatic areas of NSACP and lack of data management staff in STD clinics hamper efficient functioning. In order to be able to manage the workload efficiently, staffing requirements and gaps need to be looked into and filled.

The current NSP identifies the need to train new recruits of all categories of staff according to a plan to ensure they have correct knowledge on STI/HIV and the skills to perform their respective roles. Training will address patient centered care, gender sensitive and rights-based approach to ensure that the service providers own attitudes and misconceptions about HIV/AIDS should not be a barrier in providing care to girls and women, boys and men and gender diverse groups. Refresher training should be conducted on a regular basis. Consideration should be given to using online or virtual versus face-to-face training as a method of convenience to district level participants and a cost effective method. However, didactic training should be complemented by virtual and on-site **mentoring** in order to improve the effectiveness of training/capacity building efforts. Development of a joint supervision-mentoring protocol is one possibility for facilitating continuous quality improvement.

Priority actions that need to be undertaken include:

Strategic Direction 4.3	**Coordination, Human Resources, Training and Capacity Building**
Major activities	
4.3.1.	Develop a HR Master Plan for all categories of staff covering all service delivery areas of prevention and control of STI/HIV/ AIDS at the NSACP and district STD clinics.
4.3.2	Develop a capacity building plan to ensure trained staff are available for clinical care and laboratory services
4.3.3	Strengthen capacity of public health preventive service providers to support prevention and control of HIV/STI.
4.3.4	Develop capacity of CSO/KP led organizations to engage in policy development, advocacy, and confidential good quality service delivery, management of strategic information, budgeting and negotiation skills for funding.
4.3.5.	Enhance quality related to prevention, diagnosis and treatment and care

Strategic Direction: 4.4 - Laboratories, Medicines, and Other Supplies

Rationale

The laboratory system plays a supportive role in management of STI/HIV patients by performing baseline assessments and follow up of immunological, virologic tests, haematology and biochemical tests and diagnosis of co-morbidities. The NRL in addition to providing screening and diagnosis of HIV infection is geared to conduct key STI related investigations. The NSP calls to strengthen these technologies and platforms used to monitor and diagnose HIV/STI to ensure reliability and accuracy of results. The NSP

identifies the need to establish a Laboratory Information Management System (LIMS) and link it to the EMIS. The NSP recognizes the need to accelerate the HIV DR system and finalize the guidelines, SOPs and protocols and data collection system (This is addressed in SD-2)

The procurement orders for STI management drugs, health commodities are done annually through an on –line system of the Medical Supplies Division by the NSACP and the respective district clinics. The ART drugs, laboratory items: equipment, test kits, reagents and preventive health devices e.g. condoms and lubricants are also ordered through this platform and it worked efficiently without creating stock-outs until the Covid 19 pandemic disrupted the process and the country's economic crisis added an extra blow to the smooth functioning of the system.

The NSACP has introduced innovations such as PrEP, PEPSE. The post exposure prophylaxis (PEP) for occupational exposure will be continued. Drugs are now procured with GFATM funds due to the current economic crisis. The national ART guideline was changed to adapt the WHO recommendation of including dolutegravir as a first line drug to be combined with tenofovir and emtricitabine/lamivudine also caused some disruptions in the procurement supply chain. Therefore, the current NSP calls for a comprehensive review of the procurement process by analyzing the supply chain process to identify reasons for delays and ways to overcome them. Careful forecasting exercises, placing orders at the correct time to prevent shortages of supplies along with requests to suppliers for a longer shelf life of kits and reagents is also required.

Priority actions that need to be undertaken include:

Strategic Direction 4.4	Diagnostics, Medicines, and Other Supplies
Major Activities	
4.4.1	Strengthen the Laboratory Information Management System to capture data from NRL and district STD clinic laboratories.
4.4.2	Ensure availability of an uninterrupted supply of affordable, quality equipment and consumables including laboratory, medicines, and other supplies
4.4.3	Ensure Quality assurance and accreditation of laboratories
4.4.4	Improve storage capacity and transport

Strategic Direction: 4.5 - Strengthening Integrated Service Delivery

Rationale

Health service provision in the country was decentralized in 1987 following a constitutional amendment. Despite placing the programmes under the provincial and district level health administration in the periphery, as a practical matter the programme continued to function primarily under central technical direction and guidance. Thus, integration at district level was not complete and continues to face obstacles in delivery of services. Central STD clinic is directly under the central government and majority of district STD clinics are placed under the Provincial health system. However, integration with the rest of the curative and preventive institutions under central or provincial health authorities is not structurally aligned. The central STD clinic does not have a hospital affiliated to it to obtain needed services to the patients. Some of the district STD clinics, which are under the provincial health system, have to deal with the major hospitals under the central health ministry and other STD clinics may have to deal with hospitals under provincial authorities to obtain supportive services.

Structurally STD clinics functions independently from the hospital setup without direct structural/official link. Hence, the supportive services needed from the hospitals to the STD clinics are made through an ad hoc arrangement and not through a systematic and

structurally cohesive arrangements. Further, the preventive arm of the Sri Lankan health system with 354 health units (Medical Officer of Health) are directly administered by the provincial system. A major focus of NSACP is prevention of STI/HIV at community level which is not completely integrated to the primary care prevention system.

Commitment, support, and resource allocation across different provinces is observed to be varying. Therefore, true integration of STI/HIV service delivery at local level is far from the reality preventing a one-stop delivery mechanism for STI/HIV. With this situation, it is important to strategically direct institutionalizing the integrated service delivery in respect to STI/HIV prevention and care.

Priority actions that need to be undertaken include:

Strategic Direction 4.5	**Strengthening Integrated Service Delivery**
Major activities	
4.5.1	Strengthen planning, implementation, coordination, M&E of other health service systems which support STI/HIV services
4.5.2	Strengthen collaboration of Strategic Information Management unit and other central level health systems, provincial and district health system and private sector

Strategic Direction: 4.6 - Programme Funding, Transition, and Sustainability

Rationale

The domestic funding by the Government of Sri Lanka for the NSACP has increased over the years. Domestic funding was mainly for payment of government employee's salaries, infrastructure and equipment maintenance and transport and payment of peer educators of

five districts with the commencement of passage towards transition. As Sri Lanka graduated to an upper-middle-income country, most bilateral and multilateral donors closed their health-related programmes in the country by 2019. The GFATM support continued and the 2025-2027-year cycle grant was approved. In the meantime, Sri Lanka agreed to a stepwise transition from GFATM to government funding with a complete transition by 2028.

However, successive macroeconomic problems resulted in the country's reclassification as a lower-middle-income country by the start of 2021. This economic crisis precipitated by the covid-19 pandemic has limited the Government's ability to mobilize funding for the HIV/STI response, and the GFATM provided an emergency allocation of funds in 2021 and 2022 to support procurement of ARVs and other supplies.

The timeline of the transition away from external donor support depends largely on factors outside the control of Sri Lanka's HIV/STI stakeholders. Given the country's current economic situation, the NSACP expects to continue receiving GFATM support during the 2025-2027 grant allocation periods. If Sri Lanka is able to recover from its economic crisis and realign its transition efforts with the previous timeline for full transition by 2028, then 2025-2027 grant will provide funding solely for transition activities. If the country does not reach upper-middle-income status by 2025, however, then the GFATM is unlikely to require full transition before 2030. In either scenario, some transition is to be expected during each GFATM grant period. Although Sri Lanka may require increased external funding in the short-term to ensure that HIV/STI programming continues uninterrupted in spite of the national economic crisis, this NSP aims to identify strategies and activities that will ensure that the country makes continued, incremental progress toward a full transition, since the beginning in the first year of the strategic plan.

Successful transition and sustainable programming in Sri Lanka will require enhanced coordination of the country's HIV/STI stakeholders in addition to systems for marshalling the financial investments that public, private, and international funders make. As noted in SD 4.1, the government must immediately begin revitalizing the NAC so that it is fully operational before the transition from GFATM funding is complete. The Government of Sri Lanka needs to resume funding all procurement of HIV/STI medicines, consumables,

and laboratory supplies, infrastructure and human resource development as soon as the country emerges from its economic crisis. Therefore, this NSP is aiming to put in place several mechanisms such as Procurement Supply Chain, Infrastructure and human resource plans, capacity building plans and a road map to formalize the social contracting system which was initiated in 2019 to scale up the coverage of KP interventions.

Continuing to secure public financing for the NGOs/CBOs that provide services for KPs remains vital to maintaining the success of the HIV/STI response, and the district-by-district approach for transitioning from GFATM to Government funding for these NGOs/CBOs allows for some flexibility based on the shifting national budget. Towards this end, the current NSP is giving priority to reviewing how meaningfully civil society has been in the national response and its added value in terms of its operational and technical capacity. Costs for service delivery of civil society organizations bourn by the central government and provincial expenditure, involvement in planning and decision making and strengths in advocacy.

Over the duration of the NSP, the NSACP needs to prioritize programming based on the local HIV burden as highlighted in strategic direction 1 on developing district level plans so that “high intensity” areas receive the entire range of prevention and treatment services while low burden areas may receive only some prevention services that are micro-planned to be appropriate for the local context. There is the potential that, as Sri Lanka recovers from its economic crisis, the government may have increased fiscal space because of tax code changes and efficiency measures implemented to stem the crisis, which will facilitate resource mobilization for the HIV/STI programme over the long term.

Priority actions that need to be undertaken include:

Strategic Direction 4.6	Programme Funding, Transition, and Sustainability
Major activities	
4.6.1	Map the civil society organizations district-wise and develop a tool to assess its capacity, needs and gaps in delivering targeted KP interventions.
4.6.2	systematically asses the cost and cost effectiveness of services delivered by CSO and STD clinics
4.6.3	Develop a capacity building plan to enhance the KP led organizations to effectively participate in national policy development, decision making, monitoring and evaluation.
4.6.4.	Recruit a senior independent financial sustainability advisor on contract basis till the transition plan is approved by GoSL and GFATM
4.6.5	Establish a NGO/CBO accreditation system for KP interventions

3.8 Strategy 05: Supportive Environment

Strategic Objective: Creating a supportive environment to reduce stigma and discrimination

The strategic objective 05 designates under four main strategic directions;

SD 5.1 Create an enabling legal environment by removing punitive and discriminatory laws and policies which are barriers for HIV/STI prevention and control.
SD 5.2 Strengthen policies to address stigma and discrimination among selected government ministries and institutions
SD 5.3 Promote responsible media reporting on HIV/AIDS to advance health promotion, human rights and right to health.

Rationale

The success of the national strategy is dependent on the presence of a social, cultural, legal and policy environment that encourages people living with HIV and KPs to support the interventions undertaken by the government and benefit by the services offered to them. The GoSL is fully committed to eliminate all forms of stigma and discrimination against HIV/AIDS and to ensure the full enjoyment of all human rights and fundamental freedoms by PLHIV and members of KP groups. The NSACP has provided them with opportunities to be involved effectively in policy, planning and implementation of interventions which have had positive outcomes such as participating in policy and programme development dialogues, increasing the coverage of reach and HIV testing services, development of the national strategic plan and programme reviews and developing partnerships in providing care and support.

Stigma and discrimination towards HIV/AIDS is a worldwide phenomenon. The Constitution of the Democratic Socialist Republic of Sri Lanka clearly outlines that every person irrespective of race, religion, place of birth, sex is to be equally treated. There are laws, policies and regulations and programmes that are put in place to provide a supportive environment. The National AIDS Policy, The National HIV/AIDS Policy in the World of Work, National Condom Strategy, National Communication Strategy on Control and Prevention of STI/HIV/AIDS are some policies and strategies which were developed to combat stigma and discrimination. A Legal and Ethical subcommittee was established under the National AIDS Committee and is chaired by a legal professional.

On the other hand, there are also aged old laws which have become barriers which have led to social exclusion, difficulty in accessing health and social services for PLHIV and KPS. The Sri Lanka constitution along with a number of supportive laws, policies, regulations, strategies, and programmes provide a supportive and conducive environment for PLHIV, KPs to enjoy their rights.

Since the beginning of the epidemic, the GOSL has taken steps to combat stigma especially in healthcare settings and in media reporting. The current NSP, identifies the need to remove the punitive laws which are barriers for HIV prevention and control and will

continue to support creating an enabling environment by advocating to revise some of the laws and regulations such as the Penal Code, Vagrancy Ordinance, to ensure that all areas support positive health outcomes and they do not compound stigma and discrimination and social exclusion.

However, there is another aspect to stigma which is internal stigma and the recent stigma report shows a high degree of internal stigma among PLHIV and the current NSP is taking note of it to strengthen comprehensive counselling among PLHIV and KP groups of the nature of the health system in Sri Lanka with associated long waiting times to consult a doctor, collect medicines, non-availability of tests and drugs etc which are common features to all patronizing services in a non-fee levying system. The current NSP is including stigma and discrimination, human rights, ethical professional practices, gender equality in pre-service and in-service training of healthcare providers, training of government teachers and other training courses conducted by non-health ministries such as Ministry of Labour, Ministry of Youth and Sports, Ministry of Women's Affairs, Ministry of Plantations, Sri Lanka Police, Faculty of Law and Law Colleges. The NSP is addressing the issues within the STD clinics by introducing a structured training programme and a Grievance Redress mechanism.

Priority actions that need to be undertaken include:

Strategic Direction 5.1	**Create an enabling legal environment by removing punitive and discriminatory laws and policies which are barriers for HIV/STI prevention and control**
Major Activities	
5.1.1	Advocacy to amendment laws that criminalize KPs such as vagrancy ordinance, brothel ordinance, penal code 365, 365a.
Strategic Direction 5.2	**Combating stigma and discrimination among selected government ministries and institutions**
Major Activities	
5.2.1.	Advocacy to reduce stigma and discrimination in all relevant government institutions such as education, labor and institutions such as National Child Protection Authority and the Sri Lanka Police.
5.2.2.	Include human rights, right to health, HIV/AIDS and the negative effects of stigma and discrimination to the national response in pre-service and in service training programmes of Ministry of Health
5.2.3.	Include HIV/AIDS and the effects of punitive laws on the national response in relevant curricula
Strategic Direction 5.3	**Responsible media reporting on HIV/AIDS to advance health promotion, human rights and right to health**
Major Activities	
5.3.1	Create a group of media personnel as change agents.

Annexures

Activity Plan

Indicator frame work

Costed Activity Plan

REFERENCES

1. Ministry of Health. Annual Health Bulletin: 2020

2. The Parliament. The Constitution Government of Democratic Republic of Sri Lanka.1978.

3. United Nations Development Programme. Human Development Report, 2015.

https://www.undp.org › files › files › migration

4. Department of Census & Statistics. Census of Population and Housing 2011

5. Ministry of Health. National STD/AIDS Control Programme. Annual Report 2021.

6. The Parliament. The Constitution Government of Democratic Republic of Sri Lanka.1978

7. Ministry of Health. The National STD/AIDS Control Programme. SIM Unit Data.

8. Ministry of Health. National STD/AIDS Control Programme. Annual Report 2021

10. Ministry of Health. The family Health Bureau, Annual Report 2019

12. The parliament. The Constitution of Democratic Socialist Republic of Sri Lanka.

13. Ministry of Health. National STD/AIDS Control Programme. Annual Report 2020

14. Ministry of Health. National STD/AIDS Control Programme. Annual Report 2021.

ACTIVITY PLAN – NSP 2023-2030

Strategy 1: Prevention			
Strategic Direction	Major Activity	Sub Activity	Responsibility
1.1 Prevention of transmission of HIV/ Hepatitis /STI among Key Population (KP) groups (FSW, MSM, TG, PWUD/PWID, BB, and prison inmates)	1.1.1 Accelerating coverage and quality of on-going delivery of SHP through physical and virtual out reach	Map the district level hot spots and the compositions with the support of the NGO/CSO and STD clinic staff, STD clinic attendees, MOH and team to recruit more clients	
		Scale up different approaches such as KP targeted mobile outreach clinics, virtual outreach, workplace programmes,	
		Develop appropriate guidelines and SOP to deliver the Sexual Health Package	
		Use up to date, target group specific IEC material in the SHP and other interventions	
		Capacity building of healthcare providers, CBO/CSO involved in delivering the SH package (physical and virtual approaches) relevant to their respective roles and responsibilities to reach out FSW, MSM, TG, PWID and Beach Boys	
		Conduct monthly meetings to review the progress based on the appropriate indicators included in the district Plan (selected from the National M&E Plan)	
		Strengthen district AIDS Committees and report the progress to the National AIDS Committee	
	1.1.2 Increase the coverage and quality of community based programme for people who inject drugs (PWID).	Advocacy to MoH and other relevant stakeholders on scaling up PWID interventions	
		Consultative meeting to Identify the districts / geographical areas to introduce the PWID programme based on	

		epidemiology and estimate the number of PWID to be reached in each district	
		Develop district plans for implementation of PWID interventions (size estimation, procurement and supply of diagnostics, pharmaceuticals, health product and other commodities, M &E)	
		Consultative meetings with healthcare providers to introduce the mechanisms of evidence based pharmacological interventions for PWID.	
		Develop guidelines / protocols for PWID interventions	
		Collaborate with National Dangerous Drug Control Board to scale up interventions	
		Capacity building of service providers in STD clinic and CBO in implementing the interventions including community clinics	
	1.1.3 Strengthen HIV/STI/ prevention services in prisons.	Advocacy for prison authority for an institutionalized sustainable and robust HIV/STI prevention program in prisons twice a year.	
		Develop a HIV prevention and control plan identifying the approximate numbers to be reached, number of HIV tests needed, number of peer educators needed, number of prison officers to be trained etc.	
		Develop a training plan for training prison officers and peer educators.	
		Conduct capacity building programmes twice a year.	
		Review the training module every 2 years and update it.	
		Ensure all antenatal prison inmate mothers are screened for HIV and syphilis and ensure positive mothers are managed as per the National PMTCT guidelines.	
		Ensure availability of peer led preventive measures including health commodities in prison as in the community	
		M&E indicator results to be submitted to NAC	

	1.1.4 Scale up coverage and quality of PrEP, PEP and PEPSE services to reach different KP groups.	Develop a Retrospective cascade to understand the dynamics of the PrEP biomedical model.	
		Estimate the annual number of MSM, TG, FSW who need PrEP, occupational PEP and PEPSE and the annual quantities should be ordered with STD drugs using the MSD e-platform for domestic funding.	
		Update the PrEP, PEP and PEPSE guideline and protocol	
		Develop capacity of stakeholders in demand generation and linkages to PrEP services	
		Regular training for all STD clinic staff on PrEP, PEP and PEPSE services	
		Train the General Practitioners on linkage to PrEP	
		Conduct a needs assessment to increase community PrEP outlets.	
		Strengthen web based data management system in PrEP, PEP, PEPSE offering institutions.	
		Develop a M&E tool for PrEP, PEP and PEPSE services	
	1.1.5 Develop a "Road Map" to formalize the social contracting system	Assess the current model with the support of an international expert to identify the interventions, NGO/CSO to be contracted based on capacity to deliver services, and unit costs.	
		Identify the policy and legal requirements necessary to purchase HIV services from civil society organizations.	
		Establish a lobby group to sensitize the government policy makers on the need of a social contracting system and funding from other donors	
Strategic Direction	Major Activity	Sub Activity	Responsibility
	1.2.1 Strengthen HIV prevention programme to cover the migrant's complete journey (pre-departure,	Advocacy to Sri Lanka Bureau of Foreign Employment, to continue the internalized HIV prevention and control programmes using a plan which cover the migrant's complete journey.	1

1.2 Prevention of transmission of HIV/STI among vulnerable groups; migrant workers, armed forces, and tourist industry workers.	settling in the host country, departure from host country, integration to mother country, society and family) through strong collaboration with Sri Lanka Bureau of Foreign Employment SLBFE.	District HIV Prevention and Control Plans to include the HIV prevention and control Plan for migrants.	2
		Map district wise job agencies, testing centers, NGO/CSO working for migrant workers with their respective roles and responsibilities and develop capacities.	3
		SLBFE, to be represented at the district/ provincial AIDS Committees and NAC	4
		Representative from Association of foreign employment agencies, NGOs working for migrants to be represented in the district/provincial AIDS committees.	5
		Update the training curriculum for pre departure training at SLBFE. It should include Human rights aspects, gender issues such as gender based violence, effective complaint system.	6
		Sensitization programmes for registered foreign employment agencies and GAMCA laboratory staff by the district STD clinic staff on HIV related issues and importance of HIV testing data sharing.	7
		Establish a referral system from district level foreign employment agencies / laboratories to the district STD clinics if any testing samples e.g. HIV, hepatitis B&C are positive. Develop protocols in collaboration with the MLTs of the agency labs.	8
		NSACP / MoH, ministry of foreign affairs and Ministry of Foreign Employment to advocate with GCC countries to improve migrant worker health (How migrant workers can access HIV/STI services in host countries etc).	9
		Develop a tool for M&E and conduct biannual meetings with SLBFE to assess the progress	10

	1.2.2 Develop new information sharing methods through social media / virtual platforms / Mobile Apps on HIV/STI prevention as a method of enhancing knowledge during the stay in the host country	Consultative meetings to identify the contents for these platforms (risk assessment, access to services, negotiation skills for safer sexual practices)	
		Procure a communication organization to develop the app	
	1.2.3 Establish a structured service system in which returning migrant workers are offered HIV/STI counselling and testing facilities integrated into existing health service package	Initiate and scale up providing comprehensive health package for migrant workers in collaboration with MoH and district/ provincial health authorities	
		Advocacy for health and non-health (divisional secretariat) sectors to refer migrant returnees to obtain comprehensive health package	
		Train health staff in counseling and testing for HIV and referral to the district STD clinic	
	1.2.4 Reach out to men and women and adolescent girls and boys left behind.	Advocacy to district and divisional secretariats to expand the data base on migrants to include other family members left behind	
		District STD clinics to liaise with the divisional secretariat to develop a data base of migrant's and their families and extract disaggregated data by sex, age, employment, school education.	
		District STD clinics to collaborate with MOH, district and divisional secretariat and Sri Lanka police to develop a package of interventions to promote and safe guard sexual health including HIV/AIDS among migrant's left behind families	
		District STD clinics to build the capacity of the stakeholders to implement the sexual health package for migrant's left behind families	

	1.2.5 Establish a functioning system to receive HIV testing data related to out-bound migrants from private laboratories to NSACP	Advocacy meetings with Ministry of health / private health sector regulatory council, Ministry of Foreign Affairs, Attorney General's Department SLBFE for data management including a policy and a legal environment.	
		Advocacy / awareness for private sector laboratory network to strengthen the cooperation on data sharing of migrants HIV testing.	
		Include private sector HIV testing as an agenda item in the NAC	
	1.2.6 Develop a STI/HIV prevention programme for internal migrants. with community participation and involvement of property developers, contractors of super highways, Municipal Council and Pradeshiya Saba officials	Desk review with recent publications	
		Key informant interviews in relevant areas/district	
		Review Registration lists in municipal councils and local governments	
	1.2.7 Support to continue internalize HIV prevention programmes in tri-forces	Conduct advocacy and update the implementation plan annually	1
		Optimize the HIV/AIDS Prevention and Control programme or tri-forces.	2
		Capacity building to establish a peer led model of HIV prevention activities	3
		Support to update guidelines, protocols and procurement of test kits	4
		Establish a functioning system to obtain data on HIV testing by the tri forces to NSACP	5
		Conduct M&E meetings every six months	6
	1.2.8 Develop an evidence based programme to prevent	Conduct a KAP survey and situation analysis and provide inputs in structuring the proposed plan.	

	transmission of HIV among tourist industry workers.	Advocacy with the Sri Lanka Institute of Tourism and Hotel Management, Tourist Guide Association and other private sector tourism institutions	
		Develop a National Plan with an M&E component for Prevention and Control of HIV/AIDS in the Tourist Industry.	
		Advocacy with International Labour Organization (ILO) for partnership	
		Conduct M&E every six months	
	1.2.9 Conduct epidemiological surveys to identify other vulnerable populations	discuss with academia on survey methods	
Strategic Direction	Major Activity	Sub Activity	Responsibility
1.3 Prevention of transmission of HIV/STI among general population including youth (15-24 years)	1.3.1 Strengthen the collaboration between the existing public health system (NCD, Mental Health and Women's Health services) and integrate HIV/STI prevention activities at district and provincial level to reach men and women, adolescent boys and girls.	Meetings with the relevant sectors to identify the service points for integration and methods	
		Develop IEC material to incorporate into the existing training programmes for primary healthcare providers (eg, MO-MCH, MO-NCD and MO-MH etc…)	
	1.3.2 Support FHB to integrate age appropriate comprehensive sexuality		

	education (CSE) into the public school curriculum		
	1.3.3 Support FHB in addressing HIV/STI in Youvun Piyasa (Adolescent and Youth friendly Health services center) for adolescents and Mithuru Piyasa for survivors of gender based violence	Develop a close partnership with the FHB / National Programme Managers for Yowun Piyasa (AYFHS) and Mithuru Piyasa for service integration	
		Collaborate with youth organizations and youth clubs to sensitize them on STI/HIV	
		Collaborate with FHB to implement the HIV/STI component in Yowun Piyasa (AYFHS) and Mithuru Piyasa	
		Update the STI/HIV related components in management guidelines of Yowun Piyasa (AYFHS) and Mithuru Piyasa	
		NSACP to obtain data required from Yowun Piyasa (AYFHS) and Mithuru Piyasa on HIV/STI	
		Refer women, girls and boys subjected to SGBV to STD services based on the FHB guidelines	
		Introduce the green village concept and get youth involved and gradually introduce SRH including HIV	
	1.3.4 Capacity building of youth educators of Ministry of Youth in communicating HIV/STI knowledge	NSACP to participate in capacity building programmes conducted by FHB for Youth Educators of the Ministry of Youth Affairs.	
		Conduct TOT for ministry of youth affaires and Internalize comprehensive sexual health education in respective youth centers	
	1.3.5 Strengthen multi-sectoral approach with relevant stake holders to address SRH issues scientifically (education, youth affairs, sports, Media and work places)	Establish a group of experts using available policy briefs developed by UNFPA to lobby to strengthen age appropriate comprehensive Sexuality Education (CSE) in to the school curriculum and higher education institutions including universities and vocational training centers (VCT).	
		Advocacy to relevant ministries (Ministry of youth affairs and sports / ministry of media) on importance of	

		comprehensive sexual health education and to internalize training/awareness programs on HIV/STIs and SRH for youths and in work places	
		Provide technical support the Family Planning Association in the on-going interventions for out of school youth through youth camps	
		Collaborate with the Ministry of Media to provide space in radio and television channels to include SRH issues including HIV/AIDS e.g. morning TV shows	
		Conduct TOT and internalize comprehensive sexual health education, HIV prevention and control activities in work places	
	1.3.6 Integrate STI/HIV Prevention into University system with the support of University Grants Commission.	Advocacy to Ministry of higher education/ UGC on importance of comprehensive sexual health education and to internalize training/awareness programs on HIV/STIs and SRH for students of higher education institutions and vocational training centers	
		Develop an E-learning platform to deliver SRH knowledge to university students to follow over a period of six months since recruitment and apply for a certificate after passing an on-line test.	
		Sensitize university medical officers and staff on STI/HIV prevention, treatment and available services	
	1.3.7 Integrate STI/HIV Prevention into medical school curriculum and to intern medical officers.	Consultative meetings to develop medical school curriculum with HIV/STI prevention activities in the Medicine, Obstetrics and gynecology, pediatric and Community Medicine streams	
		Provide access to the e-learning platform which is planned for universities	
		Consultative meetings to develop training material on prevention and control of HIV/STI for the induction training programmes of intern medical officers	

	1.3.8 Strengthen the collaboration with the National Child Protection Authority to educate the officers to have accurate knowledge on STI/HIV/AIDS including risks and vulnerabilities and policies and laws	Capacity building of child protection officers in SRH to support the public health staff to address sexual health issues of abused children and their families.	
		Annual review with NCPA to assess the progress and to identify gaps	
	1.3.9 Establish a helpline/hotline to provide SRH counselling for general population including women and youth	Advocate with the Ministry of Telecommunication to obtain a specific number (similar to Women's Affairs Ministry obtained a number for SGBV).	
		Develop a plan to implement the helpline/hot line interventions	
		Market the availability of the hotline through NGOs, social organizations, ministries, district and divisional secretariats	
		Collaborate with FHB for capacity building medical officers of the Mithuru piyasa help line. in HIV/STI and availability of services	
		Advocate with the Ministry of Women's Affairs and train SGBV hotline service providers in HIV/STI basic facts and availability of services	
	1.3.10 Increase the use of virtual platforms and social media for sexual health education among young people	Develop Youth-friendly virtual platforms/ social media platforms on promotion of safe sexual practices and prevention of HIV/STIs	
		Develop videos messages for promotion of safe sexual practices and prevention of HIV/STIs	
		Expand social marketing for virtual platforms	
Strategic Direction	Major Activity	Sub Activity	Responsibility
	1.4.1 Strengthen collaboration between NBTS and NSACP	Involve in capacity building of NBTS staff on counselling, and referral to care for HIV/STI/ Hepatitis B & C	
		Support development of training modules	

1.4 Strengthen collaboration with National Blood Transfusion Services to ensure all blood and blood products prepared for transfusion are screened for HIV/syphilis/ hepatitis B & C		Support NBTS to advocate directorate of private health sector development / Private Health Sector Regulatory Council to register all private blood banks	
		Support NBTS to estimate HIV, hepatitis B&C test kits and timely submission of procurement orders to avoid stock out situations.	
	1.4.2 Awareness programmes to focus on sustaining non-remuneration donations and HIV risk free donations to sustain a safe blood supply to the country	Develop messages to the public on non-remuneration donations which keeps a safe blood supply to the nation	
		Include safe blood messages in mass media campaigns on regular basis	
	1.4.3 Ensure the NBTS data base on HIV testing is shared with the NSACP and NSACP uses such data to manage the index case for continuum of HIV care and treatment of syphilis	Develop a mechanism for NBTS data base of HIV screening positive patients inclusive of donor screening risk profile to be shared with NSACP/ SIM unit data base	
		Regular monitoring of NBTS data base on HIV testing is used effectively for index case testing and linking to HIV care and treatment of syphilis	
Strategic Direction	Major Activity	Sub Activity	Responsibility
1.5 Prevention of mother to child transmission of HIV, syphilis and hepatitis	1.5.1 Support FHB sustain universal screening of antenatal mothers for HIV and syphilis	Support FHB to increase coverage and quality of preconception care package and antenatal care package for prevention of STI /HIV	
		NSACP to be involved with capacity building of the pre conception service and antenatal care package for primary healthcare workers.	
		Antenatal screening for syphilis and HIV to be completed at booking Visit	
		Advocacy for implementation of point of care DUO test of HIV and syphilis	
		Advocacy for retesting STI/HIV for high risk pregnant mothers	

		Strengthen EMTCT Steering committee at national level	
	1.5.2 Develop capacity of STD clinic staff to identify and reduce the unmet family planning needs of KP and the HIV infected cohort.	Increase availability of family planning services within the STD clinic	
		Develop capacity of STD clinic staff on FP methods	
	1.5.3 Ensure all HIV infected pregnant mothers are initiated on ART according to national guidelines and their new-borns managed according to guidelines	Update PMTCT management guidelines regularly with neonatal screening protocols	
	1.5.4 Provide nutrition and social support for HIV infected mothers and families	Link mothers to PLHIV organizations with their consent	
	1.5.5 Introduce screening for hep B &C for high risk antenatal mothers and develop a screening protocols	Advocacy for MoH / FHB and academia	
		Develop guidelines / protocols	
		Introduce point of care testing	
	1.5.6 Strengthen the PMTCT data sharing with FHB and generate data to improve coverage and case management.	Coordinate with FHB to share data on HIV and syphilis screening	
		analyze antenatal screening data coverage and appropriate dis-aggregations	

Strategy 2: Diagnostic, treatment and care			
Strategic Direction	Major Activity	Sub Activity	Responsibility
2.1 Provide quality HIV diagnostic services	2.1.1 Strengthen differentiated HIV testing services/approaches	Promote demand generation for HIV testing among KPs, vulnerable groups, youth, general population, using out-reach activities, digital, social media, mass media.	1
		Develop a training programme and a module to enhance provider initiated HIV testing at STD clinics and hospital based testing	2
		Strengthen implementation HIV self-testing (HST) and RDT island wide	3
		Develop a training module and a training programme to strengthen counselling skills of healthcare providers, peer educators and out-reach workers to link those testing positive to STD clinics to initiate ART as early as possible.	4
		Ensure annual estimations of test kits / reagents are done accurately and requirements are uploaded to the MSD online system on time for placing procurement orders	5
		Advocacy for stakeholders who conduct HIV testing services to develop M&E system (e.g. tri-forces, GAMCA centers, private hospitals, private sector laboratories.	6
		Analyze data of people who have not been linked to services by age, sex, district level and make individual plans to reach them.	7
		Strengthen Public Private partnerships for laboratory services	8
	2.1.2 HIV confirmation by using the national three tests algorithm to reduce turnaround time	Educate STD clinic staff and CSO staff on HIV testing three test algorithm	
		Refresher training of MLTs on use of three tests	
		Ensure accurate estimates are made for RDT 2 and 3 tests and distributed to district clinics	
		Regular monitoring of use of three test algorithm.	

	2.1.3 Optimize use of CD4 and Viral Load testing as a point of care tests after a needs assessment	Conduct a needs assessment of point of care CD4 and VL testing requirements and supply accordingly	
		Ensure accurate estimates are made for CD4 tests and viral load test kits, reagents and other accessories	
	2.1.4 Ensure availability of diagnostic tests for management of opportunistic infections	Update guidelines regularly	
		Identify the common opportunistic infections and investigations required and estimate the quantities for tests, reagents and medicines.	
		Develop unit costs for each test to assure sustainability of testing.	
		Conduct a needs assessment and identify potential STD clinics where such testing facilities could be newly introduced.	
	2.1.5 Strengthen quality assurance of HIV testing through national reference laboratory.	Appoint a working group to develop tools to assess laboratory quality	
		National and international training in quality assurance competencies	
		Develop SOPs and QSPs	
		Accreditation of NRL in quality assurance	
		Improve district STD clinic laboratories in a phased manner to accreditation level	
		Accreditation of NRL& sustain the status by internal audits, annual assessments by SLAB, QA workshops, consultative meetings for reviewing QM (Quality management), SOP& QSPs (Quality system procedures)	
	2.1.6 Ensure drug resistance surveillance for HIV	Appoint an expert committee to identify Early Warning Indicators (EWI), monitor EWI, the progress of surveillance of pre-treatment HIV drug resistance (PDR) in populations initiating ART, surveillance of acquired HIV drug resistance (ADR) in populations receiving ART, assess the annual drug resistance testing estimations (reference – WHO HIV drug resistance surveillance guidance 2015)	

		Develop a National Strategic Plan for HIV DR testing and include in it a plan for Infrastructure development of NRL for HIV drug resistance testing with the support of an international expert, human resource capacity, training, and diagnostics.	
	2.1.7 Ensure availability of hematological, biochemical tests for the management of PLHIV	Make accurate annual estimates for tests and reagents and upload the MSD online system to place the procurement orders	
		Identify diagnostic equipment for hematological and bio-chemical testing for the NSACP and selected STD clinics with a high burden of HIV cases based on a needs assessment	
		Calculate unit costs for required tests (e.g. full blood count, LFT, Serum creatinine etc)	
		Conduct a needs assessment and identify potential STD clinics where such testing facilities could be newly introduced	
	2.1.8 Ensure sustainability of HIV DNA PCR testing for early infant diagnosis (EID)	Quantify the test kits required and upload the MSD online system to place procurement orders	
	2.1.9 Develop and update HIV testing guidelines and SOPs accordingly	Conduct consultative meetings	
	2.1.10 Accreditation of NRL and other testing sites		
	2.1.11 adequate training of staff and supportive supervision		
Strategic Direction	Major Activity	Sub Activity	Responsibility
		Conduct a needs assessment on upgrading district STD laboratories and identify laboratories which have a high work	

2.2 Provide quality STI diagnostic services	2.2.1 Ensure STI tests (smear tests, culture) are available in each STD clinic	load with a view to introduce automated systems, GeneXpert systems and other point of care systems	
		Develop SOP for laboratory tests	
		Estimate kits and reagents for identified tests	
		Conduct routine monitoring of tests	
		Ensure availability of infrastructure for HIV/ STI testing facilities island wide on need basis	
		Introduce point of care molecular testing for STI following a feasibility study.	
	2.2.2 Upgrade all STD laboratories to the required standard for accreditation and offering quality services	Quality improvement workshops for capacity building	
		Onsite evaluation	
		Establish proficiency testing in STD clinics	
	2.2.3 Introduce HPV DNA testing at NRL and other STD clinics in phase manner	Collaborate with FHB to test all PLHIV women for HPV DNA	
		Make annual estimates for DNA test kits and reagents	
Strategic Direction	Major Activity	Sub Activity	Responsibility
2.3 Sustained and equitable access to quality, person centered treatment and care facilities to improve the well-being for all people living with HIV	2.3.1 Ensure provision of comprehensive package of interventions including ART on the basis of "treat all" policy	Develop a comprehensive differentiated service delivery package to be implemented in a phased-out manner	
		Develop / update guidelines/protocols to provide quality services to PLHIV	
		Capacity building (preservice/in-service trainings) based on the guidelines develop by the NSACP for health care staff at STD clinics to maintain standard care services for PLHIV.	
		Identify determinants of defaulting for ART and take measures to overcome	
		Develop private public partnership ART services adhering to national guidelines through standard protocols.	

		Comprehensive Monitoring & Evaluation of advance HIV disease management	
		Identify gaps in pediatric HIV case management and arrange special training, resource allocation to improve the identified gaps	
		Strengthen social support for PLHIV (e,g, education / job opportunities)	
		Expand use of partner notification (tracing)/index case HIV testing among all diagnosed HIV cases	
		Sensitize communities on the need to scale up partner testing	
		Update and streamline the referral system and strengthen the linkages to other specialties including palliative care and other supportive systems	
		Identify limitations for universal access to services and develop systems to mitigate the barriers	
	2.3.2 Generate strategic information on treatment and care to ensure all diagnosed cases are linked to treatment, retained in care and have achieved sustained viral suppression.	Scale up implementation of EIMS to get real time data for better patient management within the continuum of care.	
		Analyze ART cascade by KP groups	
		Conduct regular AIDS death review and analyze data for action	
		Include treatment successes in the NSACP Data Dashboard to be used as a message to broadcast to public at large	
Strategic Direction	Major Activity	Sub Activity	Responsibility
2.4 Increase coverage and quality of sexual health and STI treatment and care	2.4.1 Develop a comprehensive STI prevention and treatment package	Develop / update guideline/SOPs to improve quality sexual health and STI care	
		Capacity building of health staff in STD clinics in implementing comprehensive package	
		Strengthen standardize contact tracing and defaulter tracing for STI	
	2.4.2 Create a conducive clinic environment for accessibility	capacity building of staff in gender sensitive and response care	

	and acceptability of STD clinic services for all clients, including KP and youth population	Introduce a client feedback system in all STD clinics	
		Establishing KP friendly/ youth friendly clinics	
	2.4.3 Increase demand generation for STI services	Engage online communication platforms and social media apps like grinder, Facebook, tinder	
		Expand the package of know4sure.lk platform	
	2.4.4 Ensure periodical drug resistance surveillance for selected STIs (e.g …….)	Capacity building of MLTs in resistance surveillance of STIs	
	2.4.5 Establishing special clinics for TGW, PWID in NSACP and in selected STD clinics	Conduct need assessment to identify STD clinics	
		Conduct discussion with college of psychiatry, directorate of mental health, MoH, provincial & health authority and other stake holders	
		Develop a Road map to further sustainability of interventions	
	2.4.6 Establishing and scaling up sexual health services	Optimize provision of sexual health and family planning services for all STD clinic attendees including KP	
Strategic Direction	Major Activity	Sub Activity	Responsibility
2.5 Scale up HIV and Tuberculosis (TB) service collaboration	2.5.1 Strengthen collaboration with NPTCCD and NSACP for diagnosis treatment and care of HIV and TB at all Chest clinics and STD clinics.	Ensure all PLHIV are referred for TB screening and all TB patients are screened for HIV according to national guidelines	
		Conduct webinars to update the knowledge on policies/guidelines/ protocols on testing, treatments care of HIV/TB co-infected patients for the health staff in all Chest clinics and STD clinics	
		Conduct joint biannual review meetings at district level and at national level to assess progress and the gaps within the HIV and TB services	
		Conduct clinical audits to improve the quality of services	

	2.5.2 Ensure comprehensive management of HIV-TB co infection	Update guidelines / standard operating procedure (SOP) on treatment and care of HIV/TB co-infected patients	
		Capacity building of health staff at Chest clinics	
	2.5.3 Scale up provision of IPT from ART centers	Update IPT guidelines regularly	
		Establish a mechanism to dispense IPT from ART centers	
		Assess the progress to identify gaps at joint review meetings at district level and at national level (As per in 2.5.1)	
Strategy 3: Strategic Information Management System			
Strategic Direction	Major Activity	Sub Activity	Responsibility
3.1 Sustain HIV and STI Surveillance	3.1.1 Design, develop Plans for both HSS and IBBS with time-lines to conduct HSS and IBBS periodically	Identify teams for HSS and IBBS and develop TORs	
		Develop training guides and conduct capacity building of team members on dates prior to the planned dates	
		Estimate the number of tests and the types of tests and make arrangements to procure test kits and other accessories required for testing	
		Ensure data collection, analysis and generated data are in keeping with identified indicators and disseminate data.	
		Include the test kits and other commodities required in the NSACP-PSM Plan.	
		Ensure data is useful to track the epidemic, for size estimation, projections and M&E and reporting for international data collection systems	

		Cost both the HSS and IBBS and allocate domestic funds or explore donor funding	
	3.1.2 Design, develop a plan to continue Population Size Estimation of KP in parallel with the IBBS	Design and develop a costed plan and allocate funds from domestic funding and explore donor funding.	
		Cost the PSE plan and allocate domestic funds or explore donor funding	
	3.1.3 Continue annual HIV estimation and projections in collaboration with UNAIDS.	Develop a costed plan and allocate funds from domestic funding and explore donor funding	
	3.1.4 Strengthen mortality surveillance by conducting regular review of AIDS death data and improving AIDS death notification to NSACP	NSACP to liaise more closely with PLHIV organizations to report AIDS related deaths.	
		Hospital staff training programmes to include categorizing cause of death and immediate cause of death.	
		Sensitize Registrar General Office staff on collection of data related to AIDS from death certificates.	
	3.1.5 Integrate HIV drug resistance surveillance to EIMS	Consultative meeting to identify HIV drug resistance related indicators for M&E and reporting	
	3.1.6 Strengthen district level EIMS and PMIS data bases for STIs and ensure identified indicators are constructed.	Ensure continuous help on Internet and hardware, network to STD clinics	
		Provide continuous technical support to STD clinic staff on hardware and software support	
		Update software as and when necessary	
	3.1.7 Strengthen STI surveillance (1) ensuring separate reporting and analysis of Hepatitis B and C, (2) establishing a mechanism via which private sector hospitals and clinics can report STI cases in a timely fashion, and	Ensure PIMS captures data on Hepatitis B & C among PWID targeted in the community programme	
		Advocacy for directorate of private health sector development / Private Hospital Regulatory Council	
		Identify the type of data and indicators which should be shared with the Epidemiology Unit for Hepatitis B&C	

	(3) establishing a data sharing and collaboration between NSACP and Epidemiology unit of the Ministry Health		
Strategic Direction	Major Activity	Sub Activity	Responsibility
3.2 Continue Programme monitoring and evaluation	3.2.1 Ensure functioning of all digital platforms; EIMS, PIMS and know4sure.lk in all the STD clinics in the country through a database located centrally with differential access at local/district level	Annual consultative meeting to update and maintain HIV/STI indicators to assess the progress and identify unmet needs.	
		Ensure district and national level bi annual review of the HIV/STI programme using standard formats and indicators to assess the progress and challenges	
		Develop a Plan for infrastructure Development of SIM unit to maintain high quality web based data management systems	
		Develop infrastructure requirements for district STD Clinics e.g. hardware required for the data platforms	
		develop a mechanism to alert stock outs /excess stocks of Diagnostics, Medicines, and Other Supplies through the EIMS	
		Ensure data backup systems are in place	
		Ensure MOUs/contracts/maintenance agreements are available for equipment	
		Ensure agreements with RDHS to allocate funds from provincial budget to update and maintain the system.	
	3.2.2 Establish Community Led Monitoring and link the data base to PIMS	Monitoring client feedback on a regular basis using community-led monitoring (CLM) approaches to assess access barriers to HIV prevention programmes by key and vulnerable populations and programme coverage	
	3.2.3 Strengthen Laboratory Information Management	Ensure the data base is able to generate data for STI/HIV case management and to fulfil reporting indicators	

	System (LIMS) and ensure interoperability	Update the laboratory module of EIMS of to have a satisfactory LIMS.	
	3.2.4 Ensure Data quality of EIMS / PIMS services	Develop guidelines/ SOPs for each system	
		Develop a Training Plan and update training modules for capacity building of service providers to collect accurate and timely data which is validated to ensure data quality including analytical capacity	
		Develop a supervision guide and a costed plan to enhance data quality management by frequent supervision by SIM unit	
	3.2.5 Link the different information systems currently functioning to a common database across all service delivery points/units that allow integrated information pathways to support a comprehensive evaluation framework.	Obtain International technical assistance (ITA) to develop the interoperability of systems	
	3.2.6 Data dissemination in a timely manner for national and international reporting e.g. GAM, SDG	Develop and maintain built-in dashboards regularly with updated, data generated from EMIS and PMIS to report on National and International Indicators e.g. GAM, UA, SDG	
		Ensure district STD clinics, NGO/CSO are provided with "action orientated" feedback on data submitted to SIM unit every quarter	
Strategic Direction	Major Activity	Sub Activity	Responsibility
3.3 HIV/AIDS/STI Research	3.3.1 Create the research culture in the NSACP and district STD Clinics	Establish a Research Unit and a Research Committee	
		Identify Research areas	
		Encourage clinical audits, operational research, and qualitative research on SRH issues by inviting guest speakers for Continuous Medical Education	

		Conduct conference/s for STD staff and community stakeholders using the STI/HIV related data findings on population surveys such as Demographic and Health Survey (DHS) and Sri Lanka Population and Housing Census conducted by the Department of Census and Statistics	
Strategic Direction	Major Activity	Sub Activity	Responsibility
3.4 Knowledge Management	3.4.1 Develop a Knowledge Management Strategy	Appoint a committee and identify the interventions for the strategy and develop a strategic plan.	
Strategy 4: Health System Strengthening			
Strategy	Major Activity	Sub Activity	Responsibility
4.1 Strengthening Leadership and Governance Structure	4.1.1 Update the National HIV/AIDS policy with new evidences including the required legal and policy statements for purchase of services from civil society organizations.	Consultative meetings to review and update the policy	
	4.1.2 Robust Monitoring and Evaluation using National HIV/STI M & E plan	Develop a comprehensive supervision plan for central and district level programme implementation with appropriate tools	
		Regular M& E meeting of programme coordinators	
		Conduct quarterly review meetings with NSACP staff and higher officers other departments /institutions	
	4.1.3 Strengthen planning, coordination	Appoint unit coordinators at NSACP and develop TORs which include provision of technical expertise and liaison with provincial and district administration.	
		Strengthen the National AIDS Committee with TORs and re-appoint sub-committees including a finance sub committee	
		Ensure provincial and district AIDS committees are functioning according to the TOR and reporting to the NAC	

		Develop district HIV/STI plan based on the district level epidemic to increase the coverage and quality of preventive, laboratory and curative services with M&E component aligning with the National Strategic Plan.	
		Appoint an Oversight Committee with technical experts, CSO representatives to review the progress as per the National HIV/AIDS Monitoring & Evaluation Plan and submit a synthesized report to the NAC.	
		Include voices of civil society organizations and PLHIV	
	4.1.4 Establish a social contracting system Social contracting for KP interventions	Consultative meetings to develop a "Road Map" to establish a social contracting system with the assistance of MoF, Treasury which also includes a legal and policy framework to enable purchase of HIV services from CSO.	
		Lobby the social contracting system in NAC	
Strategic Direction	Major Activity	Sub Activity	Responsibility
4.2 Infrastructure Development	4.2.1 Develop a comprehensive infrastructure Master Plan for the NSACP including district clinics	Develop an infrastructure plan for the NSACP and separate plans for district STD clinics based on the needs, available resources after agreement with the provincial health authorities	
		Submission of a costed plan to Ministry of Health / provincial health authority	
Strategic Direction	Major Activity	Sub Activity	Responsibility
4.3 Coordination, Human Resources, Training and Capacity Building	4.3.1 Develop a HR Master Plan for all categories of staff covering all service delivery areas of prevention and control of HIV/STI at the NSACP and district STD clinics.	Consultative meetings	
		Plan cadre projection and identify cadre positions for the NSACP and district STD clinics	
		Submission of planned cadre positions to the MoH/ provincial secretory.	
	4.3.2 Develop a capacity building plan to ensure trained	Develop curriculum and training modules for training of different staff categories / capacity building in consultation with curriculum developers	

	staff are available for clinical care and laboratory services	Conduct pre service/ in services capacity building workshops / training / refresher training for health staff to ensure all health staff are regular training according to their job task.	
		Enhance capacity building on HIV/STIs, availability of services, methods of referrals for staff of private sector health institutions.	
		Establish a distance learning system for capacity building of STD clinic staff	
		Develop a Quality Performance Evaluation Tool for each category of staff	
	4.3.3 Strengthen capacity of public health preventive service providers to support prevention and control of HIV/STI.	Integrate STI/HIV prevention and control to all categories of prevention staff curricula with the support of the directorate of ET&R	
		Establish a distance learning system for capacity building of public health staff	
	4.3.4 Develop capacity of CSO/KP led organizations to engage in policy development, advocacy, and good quality community led service delivery, management of strategic information, budgeting and negotiation skills for funding.	Develop training module for training / capacity building	
		develop a costed plan for capacity building of CSO, KP groups at district level	
		Conduct capacity building workshops / training for CSO/KP groups at district level	
		Develop a new community led mentoring model to supplement didactic training	
		Create an accreditation system for outreach workers and CSOs providing services.	
		Use robust self-assessment tools to monitor the NGO/CBO/CSO performance, to demonstrate self-capacity improvement	
Strategic Direction	Major Activity	Sub Activity	Responsibility
4.4 Diagnostics, Medicines, and Other Supplies	4.4.1 Strengthen the Laboratory Information Management System to	Expand the LIMS to capture all the STD clinic, from government and private sector	

	capture data from NRL and district STD clinic laboratories.		
	4.4.2 Ensure availability of an uninterrupted supply of affordable, quality equipment and consumables including laboratory, medicines, and other supplies	Develop a Procurement Supply Management Chain Plan for laboratory diagnostics, lab reagents, medicines, consumables and preventive commodities such as condoms and lubricants	
		Conduct a gap analysis to identify bottlenecks to enhance procurement from international and local suppliers of medicines, equipment, etc	
		International technical assistance (ITA) for capacity building and training in the effective use of tools for procurement and supply management	
		Train relevant staff in delivering an uninterrupted supply of HIV-related commodities	
		Develop a contingency procurement process for use in urgent/emergency situations requiring fast resupply of provisions (e.g., in under two months)	
		Establish an expert committee for estimating Diagnostics, Medicines, and Other Supplies (ART, drugs for OI, etc…) in a timely manner to provide data for the procurement process	
		Strengthen the collaborations with neighboring countries to establish regular procurement of medicines that have low use/demand in Sri Lanka by pooling the volume within each shipment and lowering each country's prices.	
		Create a local purchasing vote for diagnostics medicines and health products	
	4.4.3 Ensure Quality assurance and accreditation of laboratories	**Sub activities refer 2.1**	
	4.4.4 Improve storage capacity and transport		
Strategic Direction	Major Activity	Sub Activity	Responsibility

4.5 Strengthening Integrated Service Delivery	4.5.1 Strengthen planning, implementation, coordination, M&E of other health service systems which support STI/HIV services	Develop TORs for provincial and district AIDS committees including all stakeholders.	
		Identify district focal point for HIV/ STI at the office of the Regional Director of Health Services (RDHS office)	
		Strengthen coordination with programme managers at RDHS office (CCP, RE, MO/MCH, MO/Epidemiology, MO/ planning etc..) and Medical Officers of Health (MOH)	
		Advocate with hospital management in supporting STD clinics for its smooth functioning including laboratory testing facilities	
		Enhance collaboration with the non-health government sector, private health sector as a service provider for knowledge sharing, data sharing and linking laboratory services to treatment and care.	
	4.5.2 Strengthen collaboration of Strategic Information Management unit and other central level health systems, provincial and district health system and private sector	Data sharing with other health facilities (FHB, etc..) and other stakeholders on prevention interventions and relevant epidemiological data.	
		Develop a data collection format and share with private sector hospitals	
		Liaise with the directorate of private Health Sector development for capacity building /awareness of health staff of private health institutions and data management.	
Strategic Direction	Major Activity	Sub Activity	Responsibility
4.6 Programme Funding, Transition, and Sustainability	4.6.1 Map the civil society organizations district –wise and develop a tool to assess its capacity, needs and gaps in delivering targeted KP interventions.	Consultative meeting to develop the map and tools	
		Obtain International Technical Assistance (ITA)	
	4.6.2 systematically asses the cost and cost effectiveness of	consultative meetings to assess the cost, develop unit costs for service delivery of interventions undertaken by the civil society organizations and KPS and STD clinic service	

	services delivered by CSO and STD clinics	consultative meetings with international expert support to determine cost effectiveness of services implemented by CSO/KPs to use this information as a marketing tool to obtain support for social contracting	
		Develop a costed Action Plan with unit costs	
	4.6.3 Develop a capacity building plan to enhance the KP led organizations to effectively participate in national policy development, decision making, monitoring and evaluation.	Develop a transition plan for GF activities	
		Develop a costed performance sustainability plan	
	4.6.4 Recruit a senior independent financial sustainability advisor on contract basis till the transition plan is approved by GoSL and GF	Cost effectiveness and efficiency analysis of KP services	
		Develop the TOR	
		Allocate funds	
		Ensure that adequate financial resources are allocated for individual HIV/STI services and mobilized according to the costed activity plan.	
	4.6.5 Establish a NGO/CBO accreditation system for KP interventions	Consultative meetings to develop accreditation system for KP intervention	
Strategy 5: Supportive environment			
Strategic Direction	Major Activity	Sub Activity	Responsibility
5.1 Create an enabling legal environment by removing punitive and discriminatory laws and policies which are barriers for HIV/STI prevention and control.	5.1.1 Advocacy to amendment laws that criminalize KPs such as vagrancy ordinance, brothel ordinance, penal code 365, 365a.	Meetings with the Attorney General's Department, Human Rights Commission, Legal Aid Commission	
		Establish a group of activists consisting of lawyers, medical officers, NGOs representing KPs, PLHIV and other activists	

Strategic Direction	Major Activity	Sub Activity	Responsibility
5.2 Combating stigma and discrimination among selected government ministries and institutions	5.2.1 Advocacy to reduce stigma and discrimination in all relevant government institutions such as education, labor and institutions such as National Child Protection Authority and the Sri Lanka Police.	Conduct advocacy meetings with the hierarchy of the selected ministries and institutions.	
		Prepare a plan to conduct awareness programmes for all relevant officers	
	5.2.2 Include human rights, right to health, HIV/AIDS and the negative effects of stigma and discrimination to the national response in pre-service and in service training programmes of Ministry of Health.	NSACP together with relevant groups to prepare a curriculum for selected ministries based on their respective roles e.g. Ministry of Education- rejection of school admissions based on HIV status, confidentiality of HIV status of children	
	5.2.3 Include HIV/AIDS and the effects of punitive laws on the national response in relevant curricula	Law College and Faculty of Law - Consultative meetings to develop a curriculum on basic facts of HIV/AIDS, legal milieu, 95-95-95 targets, stigma on condom, diverse sexual groups availability of ART which leads to "treatment as prevention to be introduced.	
		Police Training curricula (recruitment and promotional)- Consultative meetings to develop a curriculum on basic facts of HIV/AIDS, legal milieu, 95-95-95 targets, stigma on condom, diverse sexual groups availability of ART which leads to "treatment as prevention" to be included.	
		Train the trainers according to the curriculum	

		Advocate to include a question on HIV/AIDS and Human Rights and gender related discrimination at each examination. If there are any practical's such as OSPE's (objective structured practical evaluation) to include HIV/AIDS	
Strategic Direction	Major Activity	Sub Activity	Responsibility
5.3 Responsible media reporting on HIV/AIDS to advance health promotion, human rights and right to health	5.3.1 Create a group of media personnel as change agents.		