COUNTRY REPORT – SRI LANKA

ON FOLLOW UP TO THE DECLARATION ON COMMITMENT ON HIV/AIDS (UNGASS)

Reporting Period: January 2006- December 2007

Status of the epidemic.

Sri Lanka remains one of the few countries in the region with a low level HIV epidemic despite sharing some of the conditions such as sex work , networks of men who have sex with

men and large population of heroin users .In addition, many infections that have been identified are associated with overseas work..

It is apparent that some important vulnerability factors are absent or low-level in Sri Lanka. High literacy rates, relatively high status of women and good access to health care services and low STI prevalence all act to protect individuals and communities against HIV infection. On the other hand, conditions of higher vulnerability include conflict, high mobility of military, internally displaced persons, and separation of spouses related to overseas employment. Moreover, new economic developments such as the expansion of internal free trade zones, and broad social changes, such as the increasing migration of young adults from rural areas to large urban centers, could result in expansion of societal vulnerability factors. Returning migrant workers have been increasingly detected to be infected however will be epidemiologically important only if they are able to seed local networks that could sustain transmission.

HIV epidemic potential in Sri Lanka s not yet well understood, however there is a low probability that Sri Lanka will experience a large generalized epidemic. Experts based this assessment on the observations that despite the likely repeated introduction of HIV from out-migrants and in-migrants the HIV epidemic has remained very low in the general population and high-risk sub-populations other Asian countries have not experienced large-scale generalized epidemics, and Sri Lanka does not appear to have sexual behaviour patterns that are more conducive to widespread HIV transmission than elsewhere. Instead its believed two patterns of HIV epidemics, truncated persistently low level epidemic or a concentrated epidemic may emerge in Sri Lanka.

Truncated (persistently low level) epidemics – In circumstances where sexual and drug-using behaviours and networks cannot sustain local transmission, the spread of HIV is highly dependent on the movement of individuals to and from other locations where the HIV prevalence is higher. This could include out-migrants who are exposed to higher levels of HIV risk at their destination, or visitors from elsewhere who have sexual relationships with local residents. In Sri Lanka there is some evidence that this pattern of transmission is occurring. For example, HIV testing data indicates that more than 40% of women who have tested positive for HIV are international migrants. However, these data overstate the importance of this pattern of transmission since many of these out-migrant workers require HIV screening prior to departure so they are highly over-represented in HIV testing data. Moreover, it is not clear how many of these women have acquired HIV infection abroad, and how many have acquired HIV within Sri Lanka. It is important to note that unless those who acquire HIV infection abroad or from a foreign visitor are connected to local sexual or drug-injecting networks, the local HIV epidemic will remain truncated at a very low HIV prevalence

Concentrated epidemics – A concentrated HIV epidemic will occur where there are substantial enough high-risk behavioural patterns and networks to initiate and sustain local transmission within high-risk sub-populations (e.g. female sex workers, high risk men who have sex with men and injecting drug users). Expansion to the wider population occurs through the sexual partners of these groups (bridge populations). The ultimate extent of

concentrated epidemics will be determined by the size of the high-risk sub-populations and their sexual behaviours, including their number of sexual partners, concurrency patterns in sexual partnerships, types of sexual contacts, the prevalence of other sexually transmitted diseases that amplify HIV transmissibility, and condom use.

The recently conducted Behavioral surveillance confirms that the bridge populations such as transport workers, men working in factories are at low risk due to low partner change & fewer concurrent partnerships, low commercial sex and male to male sex, majority engaging in abstinence or safer sex & regular partnerships while MSM & beach boys (who frequent with tourists and engage in commercial sex) are practising unsafe sex with frequent partner change and relatively low condom use. Sex workers seem to be protected with low STIs , high condom use and low number of partners. Injecting drug use seems to be low even among drug users and networking of injectors is rare.

However the actual sizes of these populations are lacking and it’s likely that there will be substantial geographic heterogeneity in the distribution of these groups and in the epidemic potential. Moreover, the demographic, social and economic situation in Sri Lanka is changing, and these changes could increase the size and distribution of these sub-populations, thus altering the epidemic potential.

PREAMBLE

At the UN general assembly Special session on HIV /AIDS in June 2001 Sri Lanka was one of the 189 participating countries which committed themselves to a comprehensive programme to fight HIV/AIDS adopting a declaration of commitment and participated in the follow-up sessions pledging the government support.

The Declaration of commitment reflects global consensus on a comprehensive framework to achieve the millennium development goals of halting and beginning to reverse the HIV /AIDS epidemic by 2015.It calls for careful monitoring of progress in implementing agreed on commitments and United Nations General Secretary to issue progress reports annually on core indicators to measure the progress in implementing the declaration of commitment, Sri Lanka was one of the 103 member states which submitted national reports to UNAIDS based on the original core indicators in 2003 and subsequently in 2005 on the progress made .

Sri Lanka received the information regarding the report preparation very late and there fore had only a short time frame for finalisation. The process to prepare the report was done through UNAIDS and its partners ,and the national STD/AIDS control programme (NSACP) ministry of health in accordance with procedures provided for reporting. A local external consultant was contracted by the UNAIDS and a coordinator based at the NSACP facilitated the data collection for part A of the National composite policy index Questionnaire (NCPI)from the government partners while UNAIDS facilitated collection of information to the part B of NCPI from civil society. A meeting to educate civil society on UNGASS reporting was held .A team of experts from the national programme assisted data collection analysis & reporting process. Key informants to be interviewed identified for each area and data gathered through desk reviews & interviews. Much of the data needed was available in the format required for the report in existing reporting system of the NSACP and from the surveys (behavioural surveillance) carried out during the period. Some data needed special surveys and obtaining financial data on actual expenditures at national and sub national level and from donors, other agencies on the new format has been a failure as most of the information was not available in the required format and the reluctance of other partners to submit reports and due to constraints in time.
The draft report was discussed at a stakeholder meeting representing civil society, PLWHA NGOs ,CBOs and government partners to arrive at a consensus .
With the development of the new management information system of the NSACP comprising a project tracking format , a patient management information system and a website and the much needed monitoring and evaluation unit generating data & reporting will be easier in the future. The relevant UNGASS indicators are incorporated in the M&E indicator framework and an annual report on the progress will be published.

Attention

The UNGASS National Programme and Behaviour Indicators to be reported & relevant to Sri Lanka were selected by a panel of experts, which are also incorporated in the National M&E framework considering the low prevalence status and are reported using the CRIS format.

For the first time Sri Lanka attempted reporting the indicators using CRIS reporting system. Majority of UNGASS indicators & universal access indicators are incorporated in to the National Indicator Frame work which is relevant to Sri Lanka in the low prevalence situation and feasible to collect .The MIS is on trial for the computation of the indicators which would help to provide information required for the UNGASS Declaration of Commitment document.

When the data was not available or not in the format for CRIs, explanatory notes are given on the narrative report The proposed research strategy will include the surveys that will collect the indicator data, along with epidemiological, social & behavioural and operational research to evaluate quality of programme efforts.

1 **TABLE OF CONTENTS**

ACRONYMS

NSACP -	**National STD/AIDS Control Programme**
NAC	**National AIDS Committee**
NHAPP	**National HIV/AIDS Prevention Project**
NBTS	**National Blood Transfusion Services**
NTB	**National Tuberculosis Programme**
FHB	**Family Health Bureau**
HEB	**Health Education Bureau**
MLTs	**Medical Laboratory Technicians**
ANC	**Antenatal clinics**
NIE	**National Institute of Education**
MOH	**Ministry of Health**
MOHs	**Medical officer of Health**
STIs	**Sexually transmitted Infections**
MOSTD.	**Medical officer sexually transmission disease**
NGOs	**Non governmental organisations**
PLWHA	**People living with HIV**
SLFEB	**Sri Lanka foreign Employment bureau**
NDDCB	**National dangerous drug control board**
MOMCH	**Medical officer of Health**
PHI	**Public Health Inspector**
PHN	**Public Health Nurse**
MARP	**Most At Risk Population**
MSM	**Men having Sex with Men**
FSW	**Female Sex Worker**
IDU	**Injecting Drug User**

STATUS AT A GLANCE

I Status of the epidemic.

Sri Lanka remains one of the few countries in the region with a low level HIV epidemic despite sharing some of the conditions such as sex work, networks of men who have sex with men and large population of heroin users .In addition, many infections that have been identified are associated with overseas work..

It is apparent that some important vulnerability factors are absent or low-level in Sri Lanka. High literacy rates, relatively high status of women and good access to health care services and low STI prevalence all act to protect individuals and communities against HIV infection. On the other hand, conditions of higher vulnerability include conflict, high mobility of military, internally displaced persons, and separation of spouses related to overseas employment. Moreover, new economic developments such as the expansion of internal free trade zones, and broad social changes, such as the increasing migration of young adults from rural areas to large urban centers, could result in expansion of societal vulnerability factors. Returning migrant workers have been increasingly detected to be infected however will be epidemiologically important only if they are able to seed local networks that could sustain transmission.

HIV epidemic potential in Sri Lanka s not yet well understood however there is a low probability that Sri Lanka will experience a large generalized epidemic. Experts based this assessment on the observations that despite the likely repeated introduction of HIV from out-migrants and in-migrants the HIV epidemic has remained very low in the general population and high-risk sub-populations other Asian countries have not experienced large-scale generalized epidemics, and Sri Lanka does not appear to have sexual behaviour patterns that are more conducive to widespread HIV transmission than elsewhere. Instead its believed two patterns of HIV epidemics, truncated persistently low level epidemic or a concentrated epidemic may emerge in Sri Lanka.

Truncated (persistently low level) epidemics – In circumstances where sexual and drug-using behaviours and networks cannot sustain local transmission, the spread of HIV is highly dependent on the movement of individuals to and from other locations where the HIV prevalence is higher. This could include out-migrants who are exposed to higher levels of HIV risk at their destination, or visitors from elsewhere who have sexual relationships with local residents. In Sri Lanka there is some evidence that this pattern of transmission is occurring. For example, HIV testing data indicates that more than 40% of women who have tested positive for HIV are international migrants. However, these data overstate the

importance of this pattern of transmission since many of these out-migrant workers require HIV screening prior to departure so they are highly over-represented in HIV testing data. Moreover, it is not clear how many of these women have acquired HIV infection abroad, and how many have acquired HIV within Sri Lanka. It is important to note that unless those who acquire HIV infection abroad or from a foreign visitor are connected to local sexual or drug-injecting networks, the local HIV epidemic will remain truncated at a very low HIV prevalence

Concentrated epidemics – A concentrated HIV epidemic will occur where there are substantial enough high-risk behavioural patterns and networks to initiate and sustain local transmission within high-risk sub-populations (e.g. female sex workers, high risk men who have sex with men and injecting drug users). Expansion to the wider population occurs through the sexual partners of these groups (bridge populations). The ultimate extent of concentrated epidemics will be determined by the size of the high-risk sub-populations and their sexual behaviours, including their number of sexual partners, concurrency patterns in sexual partnerships, types of sexual contacts, the prevalence of other sexually transmitted diseases that amplify HIV transmissibility, and condom use.

The recently conducted Behavioral surveillance confirms that the bridge populations such as transport workers, men working in factories are at low risk due to low partner change & fewer concurrent partnerships, low commercial sex and male to male sex, majority engaging in abstinence or safer sex & regular partnerships while MSM & beach boys (who frequent with tourists and engage in commercial sex) are practising unsafe sex with frequent partner change and relatively low condom use. Sex workers seem to be protected with low STIs , high condom use and low number of partners. Injecting drug use seems to be low even among drug users and networking of injectors is rare.

However the actual sizes of these populations are lacking and it’s likely that there will be substantial geographic heterogeneity in the distribution of these groups and in the epidemic potential. Moreover, the demographic, social and economic situation in Sri Lanka is changing, and these changes could increase the size and distribution of these sub-populations, thus altering the epidemic potential.

NATIONAL COMMITMENT AND ACTION INDICATORS	
Expenditures	
	1. AIDS spending ,by category and funding source in **(2007)** Government spending on AIDS. **US$ 1.705911.17 (1.7million)** International agencies (UNFPA&WHO) Development Partners WB
Policy Development and Implementation Status	
	2. National Composite Policy Index **80% mean score 4**
NATIONAL PROGRAMME INDICATORS	
	3. **% of donated blood units screened for HIV in a quality assured manner** - 42.07% in public sector
	4. % of adult & children with advanced HIV infection receiving ARV therapy in 2006 - 9.62%%
	4 % of adult & children with advanced HIV infection receiving ARV therapy in 2007 - 13.79 %
	5 % of HIV + pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT -3.92% (2006)*
	6 % of estimated HIV positive incident TB cases that received treatment for TB & HIV (not reported)
	7 % men & women aged 15-49 who received an HIV test in the last 12 months and who know their results - 0.24 % *****
	8 % most at risk populations (Sex workers) who received an HIV test in the last 12 months and who know their results - 42.6%
	8 % most at risk populations (MSM) who received an HIV test in the last 12 months and who know their results – 13.58%

Key : ***** *No data available. See explanatory notes*
******** *Limited data available. See explanatory notes*

NATIONAL PROGRAMME INDICATORS	
	9 % most at risk populations reached with prevention programmes* not reported
	10.% orphans and vulnerable children aged 0-17 whose households** received free basic external support in caring for the child
	11 %of schools that provided life skills based education in the last Academic year *
Knowledge and Behaviour Indicators	
	12 Current school attendance among orphans and non-orphans aged 10-14 * *Not reported as not applicable in the low prevalent situation*
	13 % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission 7.9******
	14 % of most at risk populations (sex workers) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission - 9.96%
	14 % of most at risk populations (MSM) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission - 19.87%
	15. % of young women and men who have had sexual intercourse before the age of 15** - 2.5 % *should be interpreted with caution*
	16. % of women and men aged 15-49 who have had sex with more than one partner in the last 12 months 1.64% **
	17 % of women and men aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual exposure **
	18 .% of female and male sex workers reporting the use of a condom with their most recent client ** 89.3%

Key : ***** *No data available. See explanatory notes*
***** ***** *Limited data available. See explanatory notes*

Knowledge and Behaviour Indicators	
	19 % of men reporting use of a condom the last time they had anal sex with a male partner - 60.9%
	20 .% of injecting drug users reporting the use of a condom the last time they had sexual exposure ** ***(not applicable to Sri Lanka at present)***
	21 .% of injecting drug users reporting the use of sterile injecting equipment the last time they injected** ***(not applicable to Sri Lanka at present)***
Sri lanka remains	
	22. % of young women and men aged 15-24 who are HIV infected ***** **not applicable in low prevalence epidemic**
	23 % of most at risk populations (sex workers) who are HIV infected 0.2%,disaggregated by age 0% prevalence among below 25 yrs
	24. .% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy 63.6%
	25 % of infants born to HIV infected mothers who are infected ***** **modelled**

Key : ***** *No data available. See explanatory notes*
***** ***** *Limited data available. See explanatory notes for each policy indicator.*

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC (2006-2007)

Two decades since the detection of the first HIV infection in Sri Lanka, a cumulative total of 957 HIV infections and 266 AIDS cases have been detected in the country. There has been a steady increase in the number of reported cases over the years, in part due to the increase in HIV testing facilities (Figure 1). To date, 172 persons have died of AIDS. The male to female ratio of the reported HIV/AIDS cases is 1.3:1 So far, 30 children have been infected with the virus as a result of vertical transmission from their mothers. Perinatal transmission accounts for 3.1% (30 cases) of the reported cases. Majority of the people affected are within the 30-39 year age group. HIV positives are reported from all the provinces, majority from the western province (60%) and central province (8%). Injecting drug use is at present not reported as a problem in the country. Asia harm reduction network estimates 240,000opiate users in the country while National Dangerous Drugs Control Board estimates 40,000 as heroin users and 20,000 cannabis users. Among heroin users 1- 2% are estimated to be injecting. According to recent research findings 0.2% of the drug users are injecting. To date 2 drug users are reported to be infected with HIV since the first case reported in 2004.However there are no cases of HIV transmission reported through sharing of injecting equipment. There are two major sources of information on burden of HIV infection in the country.

Those include;

1. From the reported HIV cases
2. Trend information through the HIV Sentinel Surveillance

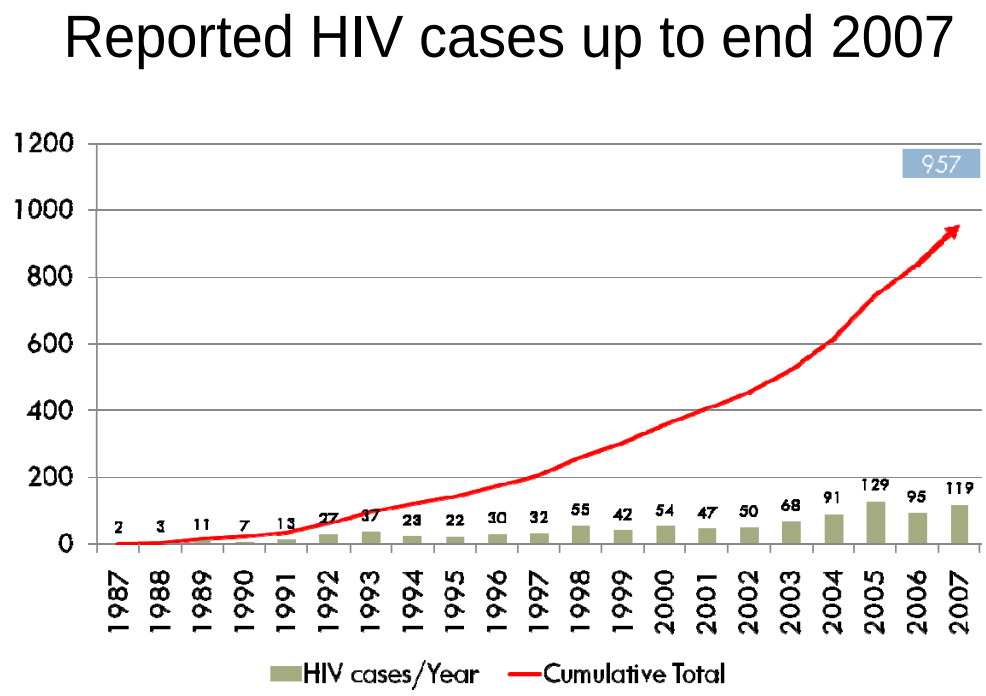
Even though HIV is not a notifiable disease in Sri Lanka , all the confirmatory tests for HIV is done only at the National reference laboratory at NSACP. From the laboratory, coded data on HIV positive people are sent for the surveillance purposes.

Table 1: Country situation- reported HIV/AIDS cases as of end 2006 - 2007.

Cumulative HIV cases	Cumulative HIV cases		Cumulative AIDS cases	Cumulative AIDS deaths	Male : female ratio of HIV
	male	female			
*838	487	351	226	155	1.4 :1
**957	552	405	266	172	1.3:1

*(Source – NSACP 2007) * end 2006 **end 2007*

Sri Lanka is considered a low prevalence country for HIV/AIDS but at high risk for a potential epidemic due to several reasons. Those reasons include emerging sexually active youth population (17-19% of the total population of 18.3 million in 2010) , increasing commercial sex (BSS mapping estimates 6000 sex workers compared to previous estimates of 30, 000),an open economy leading to large industrial zones with an estimated work force consisting of young people of over 100,000 , external migrants(annually nearly 180,000, mainly women to the middle eastern countries),and large contingents of armed forces personnel consequent to the civil war in the North and East for nearly two decades and child exploitation and abuse.



.

Since 1993, the national STD/AIDS programme has been conducting annual HIV sero-surveillance among various sentinel populations. In 2006 drug users in rehabilitation camps in southern and western provinces were included in the survey. Inclusion of MSM as a sentinel group in future is under consideration.

In 2006, a total of 7092 blood specimens were tested from patients with sexually transmitted infections (STIs), female sex workers (FSW), tuberculosis (TB), and military personnel; of these, only 12 specimens were HIV-positive –8 out 2216 (0.36%) STD patients, 2 out of 1216 (0.16%) FSW, 1 out of 1332 (0.08%) TB patients and 1 out of 432 (0.23%) drug users. Thus,

even among the high-risk groups, the HIV prevalence well below 1%. No data available for MSM .

Table 2 – HIV Sero –Sentinel surveillance 2005 -2006

Sentinel groups	**No. tested**	**No. positive**	**Prevalence**
Sex workers	1214	2	0.16
STD clinic attendees	2127	8	0.37
Diagnosed TB patients	1332	1	0.07
Service personnel (military)	400	0	0
Pre employment screening	696	0	0
Drug users	432		0.2
Total	**7092**	**12**	

(Source – NSACP 2006)

There was no major change in trend and the low prevalence status of the country prevails. The prevalence among young people 15-24 years was Zero in most of the sentinel groups. (Table-)

Table 3: HIV Sentinel Surveillance 2006 (age desegregation)

Sentinel Groups	**No tested**		**No. Positive**		**Prevalence Rate**	
	<25 years	**>25years**	**<25 years**	**>25 years**	**<25 years**	**>25 years**
Female sex workers	318	896	0	2	0	0.2
STD clinic attendees	564	1644	1	7	0.2	0.4
Diagnosed TB patients	219	1112	0	1	0	0.1
Service personnel (Military)	144	1056	0	0	0	0
Pre-employment category	269	427	0	0	0	0
Drug users	77	354	0	1	0	0.3

(Source – NSACP 2006)

Table 4: HIV Sentinel Surveillance 2007 Western Province data (disaggregated by age)

Sentinel Groups	No. tested		No. Positive		Prevalence Rate	
	<25 years	>25years	<25 years	>25 years	<25 years	>25 years
Female sex workers	118	303	0	0	0	0
STD clinic attendees	179	476	0	1	0	0.2
Diagnosed TB patients	16	210	0	0	0	0
Service personnel (Military)	37	363	0	0	0	0
Pre-employment	-	-	-	-	-	-
Drug users	36	198	0	1	0	0.5

Analysis of data from 2007 is complete only in the western province which has 5 sentinel sites.A single drug user among 404 (0.5%) and a STI clinic attendee among 655 (0.2%) were found to be positive.

Each year a large number of blood units are screened for HIV. Over the years, the HIV sero – positivity has ranged from a low of less than 1 per 100 000 population to a maximum of 5 per 100 000 population. Cumulatively, of a 251,187 blood units tested for HIV in 2006, (0.04%) were positive. *(Source – NSACP)* There was no major change in trend and the low prevalence status of the country prevails.

Antenatal clinic attendees as a sentinel group in the annual HIV sero-sentinel surveillance was discontinued in 1996 as advised by the WHO since repeated surveys yielded zero prevalence. The NSACP had been carrying out unlinked anonymous screening of VDRL samples of antenatal clinic attendees from two premier maternity hospitals in Colombo between 2000 and 2005, of 103,731 pregnant women tested in the two large hospitals in Colombo, only 6 (0.01%) were positive with little fluctuation from year-to-year.

Analysis of ANC data on mothers who were tested for HIV for PMTCT in a pilot project found a single mother positive in 2006 and none in 2007. (Table 5)

Table 5 – Prevalence of HIV among antenatal clinic attendees at the two premier maternity Hospitals in Colombo and pilot project at Gampaha

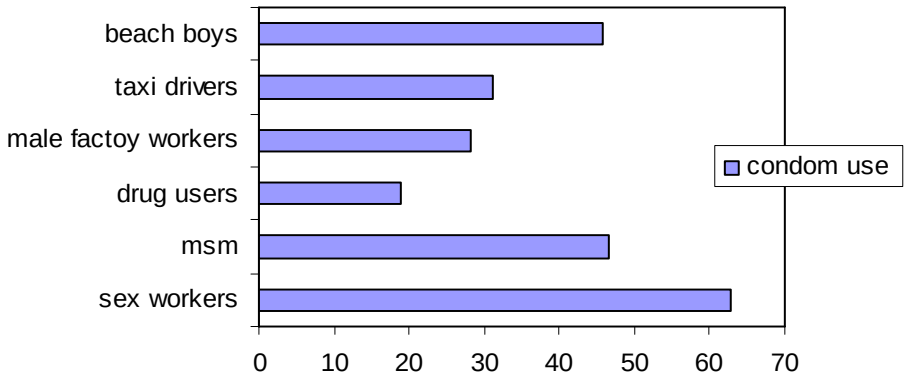
Year	Number of VDRL samples screened	Number positive	%
2003	20,286	1	0.01
2004*	14,529	2	0.01
2005**	< 2000	0	

2006**	800	1
2007**	2105	0

(*The number of samples for VDRL received at the reference laboratory of NSACP in 2004 - 2005 declined as the maternity hospitals commenced testing their own samples).
**PMTCT pilot project in from 2004-2007 conducted in western province and central province yielded a single positive in 2006.

In 2006, the first behavioural surveillance survey (BSS) was conducted among a representative sample of sex workers, men who have sex with men (MSM), factory workers, three wheel drivers, beach boys and drug users.
Key findings of BSS were: proportion of men buying commercial sex ranged from 1.1% among factory workers to 12.2% among three wheel drivers and 15.5% among drug users; 0.8% of factory workers and 5.5% of drug users reported having male-to-male sex in the past year. Consistent condom use varied from a low of 46% % among MSM with non regular partners to 80% among factory workers with commercial sex workers.

Pattern of consistent condom use among vulnerable populations



Source BSS 2006-2007 NSACP

HIV prevalence at a glance

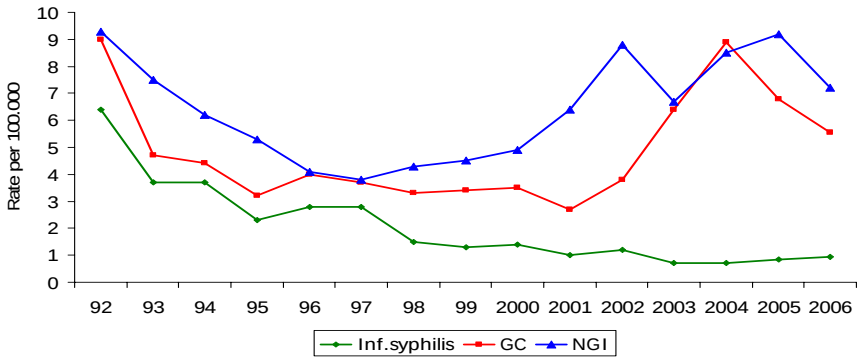
% of young people 15-24 years of age who are HIV infected **– 0% prevalence in 2007**

% Most at risk population infected –well below 1% .

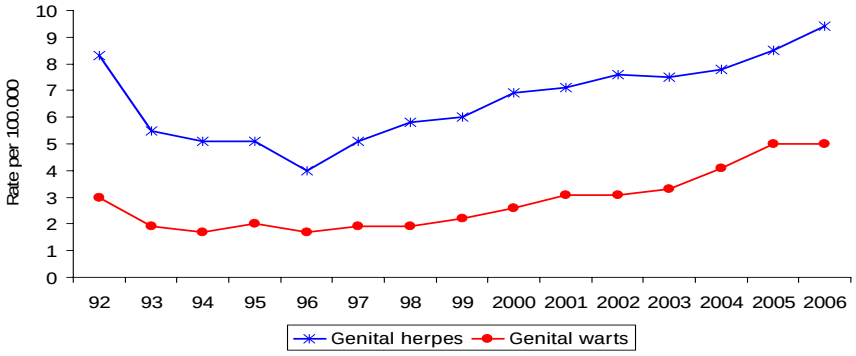
% of infants born to HIV infected mothers who are infected – no data available.
30 babies are infected through PMTCT to date.

Sri Lanka has a very strong network of STI Clinics Island wide which offers a comprehensive service package for the management of STIs. An analysis of the trends in data on reported sexually transmitted infections shows that while bacterial STIs have declined over the years, there is an increase in viral STIs.

Trend of selected bacterial STDs 1992-2006



Trend of selected viral STDs 1992-2006



III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC.

1. National commitment and action

The Government of Sri Lanka (GOSL) has responded to HIV/AIDs since early1980s and the strategic response of the GOSL to the threat of HIV/AIDS has been the early adoption of a multi -sectoral approach which encompass partnerships, policy development capacity building and utilisation of resources of the partner sectors.
The GOSL is fully committed to the prevention and control of HIV/AIDS and over the years has recognised HIV/AIDS as a developmental issue with social and health implications and given priority to prevention and control activities.

The National AIDs Council formed in 2006 is the highest governing body chaired by His Excellency the president with relevant ministers as members .The National AIDs Committee (NAC) formed in 1988 is the policy formulating body of the Ministry of Health on HIV/AIDS and oversees implementation of the response and chaired by the secretary for the ministry of health care & nutrition (MOH) ,with other ministerial secretaries , donors , civil society including Non governmental organisation NGOs/ Community based organisations CBOs People living with HIV/AIDS (PLWHA)and private sector as members.

The National STD/AIDS Control Programme (NSACP), which comes under the purview of the Ministry of Health, is spearheading the national response with all other stakeholders such as non- health state sectors, non governmental organizations, business community, people living with HIV in its multi sectoral approach. The three one principle guides the national response, one multi sectoral strategy, one national comprehensive strategy and one HIV/ AIDS monitoring & evaluation framework. The head quarters of the NSACP are located in Colombo with the central STI clinic & national reference laboratory for HIV/STIs. The NSACP carry out both prevention and curative functions. The key component areas are surveillance, STI management and care, prevention of mother to child transmission, laboratory support including infection control, HIV care and support, Information education and communication (IEC) Behavioral change communication (BCC), Voluntary counselling and testing (VCT),policy and programme management, training and research.

NSACP provides preventive and curative services for STIs and HIV through a network of 26 STI clinics island wide manned by a trained MO trained in /STD. Clinical services for STI are high quality and well organized. Clinics are well equipped and have adequate supplies of condoms and essential medicines. Stock outs of some laboratory reagents were reported, however recently.

With the devolution of the health services the administrative powers lie with the provincial authorities and the NSACP provides technical guidance and oversees implementing preventive services through STI clinics in collaboration with the provincial health services. STD clinic staffs are very active in the community conducting awareness and risk reduction trainings for a range of groups from intermediate to low risk together with provincial medical officers of health (MOH). These include military (those passing through transit camps,

peace keepers en route to overseas deployment), 3-wheel drivers, domestic workers en route to Middle East, school children, teachers, community groups (e.g.: funeral committee), etc.

Within the health sector the key institutions providing HIV/AIDS related services are Family health bureau - (PMTCT) Health education bureau , national blood transfusion service (NBTS) , National TB programme , Curative services of Ministry of health .
The other government sectors responding to the national response are education (school based life skills education) ,labour , prisons , national dangerous drug control board , defence, fisheries tourism , Social Services & national child protection authority , national youth council .Media & Broadcasting, External Resources, Ministry of foreign employment and Policy planning and Implementation. Public Administration, Provincial Councils and Home Affairs.
Non-governmental Organisations and Community based organisations and the private sector are the other stakeholders for the national response , mainly by raising awareness among general population at large and subpopulations with lower risk .Few NGOs are engaged in community care for those affected by HIV and targeted interventions for most at risk populations .
The first Medium Term Plan (MTPI) and the National AIDS Committee (NAC) was formed in 1988 and was followed by the MTP II in 1994, the formation of the UN Theme Group in 1996 and the National Integrated Work Plan in 1998.

Few development partners support the national response .The strategic plan for 2002-2006 was implemented by the NSACP mainly through the National HIV Prevention Project (NHAPP) launched in 2003 using a multi sectoral approach for a period of five years funded by a WB grant of 12 million US$ to the ministry of health. The grant was utilized for HIV/ AIDS prevention and care, purchase of ARV, strengthening surveillance, TB control, safe blood and waste management, institutional strengthening, and capacity building.

Global fund (GFATM) will support prevention services in schools and plantations and committed to support purchase of ARV from 2008 onwards. USAID the only bilateral donor assisting prevention has been providing technical assistance to CBOs , UN theme group formed in 1996 has been providing technical assistance including some funds for programme management (UNAIDS), surveillance (WHO) PMTCT & sexual health education for adolescents (UNFPA &UNICEF), HIV prevention in workplace (ILO) food support to AIDs affected families (WFP).

An external review was carried out in 2006 to evaluate the national response over the 2003-2006 and to make recommendations for formulating the strategic plan for the next five years. Several reviews were conducted by the WB in 2006 & 2007 to evaluate the progress of work by the NHAPP & a revised project implementation plan for year 2007-2008 has been developed with the objective of strengthening the NSACP in implementing the new strategic plan by engaging consultancies to develop a national strategy for advocacy, communication, research, care and treatment for HIV, M&E and size estimation of risk groups.

The national strategic plan (NSP) for the 2007-2011 was prepared during 2007 with participation of all relevant stakeholders with the Goal to maintain the low HIV prevalence in

the country and provide care and support for those infected and affected. It intended to enhance programme efficiency in its ongoing BCC activities, re-focus the programme on most at risk populations (MARP), and move towards greater integration of HIV-related activities with other health , sectoral and civil society activities. The NSP has identified key strategic areas and the relevant interventions and cost. Production of plan of operations building "bottom-up" from districts to provinces and provinces to the national level will be the next step which translate strategic directions laid out in the NSP into a work plan and a budget.

Political commitment

- His Excellency the President chairs the National AIDs council a higher governance body formed in 2006 to provide direction to all sectors through their line ministries and take decisions on controversial issues. H.E.the president issues statements on World AIDS day and monitors the progress of work done on HIV/AIDS during health sector reviews. His Excellency the President was the Chief Guest at the 8th ICAAP held in 2007 .A high level ministers forum was organised by the ministers of Health & Labour at the 8th ICAAP on reproductive /sexual health HIV/AIDS integration. Sri Lanka politicians actively involved in the Parliamentarians for Global Action programme against AIDS.
- AIDS in the Workplace activities are being evaluated by the minister of Labour regularly and the minister of Foreign Employment is actively involved in planning HIV prevention programmes of the Foreign Employment Bureau targeting international migrants and their families. New legislations protecting right and welfare of overseas employees are being introduced with support from employing country, securing minimum wages and health facilities.
- Laws and policies are in preventing young married women under the age of 35 seeking employment overseas to prevent child abuse and family disruption was a step in the right direction.

Progress in implementation of the national strategic plan - 2006-2007.

Prevention

Prevention activities were conducted through NGOs, sectors, provincial authorities, International NGO (INGO) and private sector with support from donor agencies.
The project implementation plan of NHAPP was revised as recommended following the WB mission review in 2006 to focus more on interventions for high risk groups (CSWs, MSM, drug users, etc) as it was noted that majority of the NGOs and sectors were only creating awareness among general population & low risk populations . The sectoral plans were revised to conduct BCC programs, base line surveys to gather information to develop appropriate interventions, training peer leaders to reach the target populations and continue advocacy for support from higher officials. Awarding contracts to NGOs to deliver a service package to MARP was expedited.

MARP were targeted through sectors (as evident by programmes in prison, for fishermen and external migrants) and NGOs (sex workers , drug users , internal migrants) and some provincial programmes . Capacity building of the NGOs and sectors to meet the targets was given due attention.

The format of the prevention programmes moved away from IEC to behaviour development for low risk groups and BCC for MARP. More peer lead interventions to reach target population were designed than mass education programmes. The communication strategy which is being finalised will ensure development of standard, quality, target group specific, messages at the central level .
Most recently in 2007 the NSACP has obtained additional support through the Global fund for AIDS/TB/Malaria (GFATM round 6) .This fund will further strengthen and fill in some gaps in prevention, care and support programs for HIV. The key areas covered here are a program which covers 1300 schools in 10 selected districts, Plantation workers in Tamil speaking plantations in 5 districts for increasing condom use and strengthening voluntary counselling and testing, support for ARV, reagents and a program that builds provincial level teams that will be responsible for implementing prevention programs in the provinces and districts.

Involvement of Provincial Health Authorities

Provincial Work plans have been developed with technical assistance by NSACP to include HIV /AIDS prevention activities in the provinces in line with the National Programme objectives. The provincial health authorities collaborate with the STD clinics, other sectors and NGOs in their provinces in implementing these activities.

Regular meeting of provincial AIDS committees are held assisted by NSACP staff for monitoring the activities carried through other sectors and NGOs.
The provincial programmes were focussed on reducing stigma in health care settings by increasing awareness of health staff on HIV transmission & prevention , promoting standard precautions /Universal precautions among HCW , capacity building on VCT and sensitisation of the health staff on ART and comprehensive care for HIV .MO/STD continued to be the focal point providing technical support.

A summary of WB funded activities conducted by the NHAPP in 2006-2007 are given below.

Involvement of NGO/CBOs

Sub projects – small scale behaviour change interventions were carried out through 26 NGO/CBOs contracted during the second round in 2005 -2006 who successfully completed the first round of subprojects. Target groups were drug users, transport workers, sex workers, factory workers, estate population, internally displaced, youth etc. The activities were closely monitored by the provincial authorities, provincial AIDS committees, and 2 regional facilitators of the NHAPP. It was found that targeting high risk /vulnerable groups through NGOs were not adequate as only 3 NGOs out of the 26 engaged in targeted interventions addressed sex workers, 2 on drug users and none on MSM and the coverage was very low. It

was evident that very few NGOs are willing to work with difficult to reach groups in spite of capacity building on BCC, VCT, and M&E etc.

Subcontracts -Large contracts

6 NGOs were selected to provide interventions to sex workers, drug users and factory workers in 2007. Some have completed baseline surveys and some have used the results of the BSS to plan interventions. The project is ongoing, and peer out reach, BCC, VCT, condom promotion and linking with STD services are the key activities identified.

Sectors

Although 13 sectors were involved in the beginning in 2004-2005 in the first round, Prison, military, foreign employment bureau, labour and fisheries sectors were continuing to address high risk groups and were continued to be funded through WB till end 2007. The disbursement Of funds by other sectors were low A focal point for HIV prevention has been identified in almost all the sectors to liaise with the NSACP through the sectoral coordinator at NHAPP . Condom promotion (condom dispensers were installed in officers mess in military , condoms made available to prisoners on discharge and in the wards in the prisons hospital) and VCT, BCC, screening for STIs, HIV/ AIDS education incorporated in to the training curricular, are the activities internalised in to sectoral programmes. Some sectors have mainstreamed preventive activities and have allocated own funds for these activities clearing doubts on sustainability of the projects.

Involvements of other sectors on HIV/AIDS Prevention

The 13 government sectors continue to work for prevention of HIV / STD /AIDS with technical assistance from NSACP and financial support of the NHAPP with additional resources made available through from the UN agencies (National Dangerous Drug Control Board , National Institute of Education , Labour, Child protection authority) .Owing to the interest and commitment generated by NHAPP/ NSACP new sectors are getting involved in the national response .

- **Uniformed services:** (Army, Navy, Air force and Police): Awareness and advocacy programmes were continued in 2006 and specific IEC material produced. Existing counselling centres function as VCT centres with trained counsellors in the Army ,Navy and Air force camps. Peer leaders were trained. Condom promotion and distribution are in built in to the sectoral programme 30994800 condoms were distributed in 2006 & 18403200 in 2007. Nearly 80 condom dispensing boxes were installed in the camps. HIV prevention activities have been limited in 2007 due to escalation of the conflict situation in the country. However, advocacy programmes and awareness programmes for all three forces are continuing and condom distribution activities are sustained. Link with the STI clinics for referrals for STIs continued, however patients may be seeking treatment in the private sector.

  A KAP study was carried out in 2006 among Air Force personal and in 2007 among Sri Lanka Army soldiers.

- **National Youth Services Council** : Guidelines for training peer educators were completed and peer outreach is being carried out through youth clubs on life skill based HIV prevention. Nearly 16,000 youth were reached in 2006.

- **National Institute for Education (NIE):** Curricula for teaching HIV/AIDS and reproductive health education in schools and teacher training modules have been revised giving attention to concentrate in school education than informal education by NGOs /Medical officers and several organisations in the past. Ongoing activities to develop adequate material for the teachers to teach life skills based education in reproductive health (2 life skills per each area) will be supported by the NSACP.

- **Worker Education Division of Labour Department:** HIV /AIDS awareness in the working place especially in garment factories, plantation sector & industrial zones are being carried out.

- **National Dangerous Drug Control Board (NDDCB) :**
  In the revised national policy on prevention & control of drug abuse launched in June 2006 under the "preventing use of drugs & reducing adverse consequences of drug abuse" its stated that drug prevention programmes will include HIV/AIDS prevention components and encourage voluntary testing .It also states that epidemiological ,social & scientific research on all aspects of drug abuse is encouraged .It also recognized that treatment and rehabilitation of drug dependents need different types of treatment and encourage provision of treatment acceptable to government via treatment services (residential or community based). Medical interventions are combined with counselling & provide with- in remand, prisons and correctional facilities with equity, screening for Hepatitis B&C ,TB and STIs also will be carried out.
  A focal point has been appointed to deal with HIV/AIDS issues & collaborates with the NSACP in planning & implementing targeted interventions, estimations & research and surveillance on drug abuse .Director NSACP is among the many stakeholders, government and NGO dealing with drug abuse**.**
  Promoting Voluntary Counselling and testing for HIV and other STDs through peer educators and rehabilitate drug users are some activities carried out by NDDCB through 4 residential centres and an out reach programme for drug dependents. 2738 persons island wide received treatment in 2006.58% in government facilities. 0.7% by NGOs .41% in prisons, majority (96%) receiving institutional care and were heroin addicts among whom (69%) inhaled, while 0.5% injected. No harm reduction (needle exchange programmes) are in place as it was not felt counter productive in low prevalent situations & methadone substitution is not permitted. NDDCB supported NSACP in conducting sentinel surveillance among drug users in the rehabilitation canters since 2006. A drug user was found to be HIV positive among 427 surveyed in the sentinel survey in 2006.

- **Fisheries Ministry**: One of the objectives of the Fisheries Social Development Division is the prevention of the HIV/AIDS in the Island wide fishing community HIV prevention activities are incorporated into fisheries cooperative societies and are carried out through fisheries field officers of the relevant division. Advocacy and awareness programmes for ministry officials were conducted to sensitise them on vulnerability of the fishing

population to HIV/AIDS as the commitment of the hierarchy for prevention programmes was very low initially..A baseline survey was completed to assess the vulnerability of fisher folk and their families. Training of peer leaders is being carried out. Monitoring and evaluation of HIV prevention activities is the responsibility of social development division.

- **Sri Lanka Foreign Employment Bureau:** (SLFEB) Pre departure awareness on HIV/AIDS and skills building to face vulnerable situations while overseas was commenced in 2005 for female migrants to minimize vulnerability to HIV infection as a pilot project. This was later extended to include spouses and families .Since the pilot project was successful it has been extended to the balance 34 training centres in the country. Videos, handouts are prepared for this activity. A hand out to promote voluntary testing on return to the island will be distributed at the immigration & emigration desks **.**An advocacy programme for foreign employment job agency officials was conducted to inform them of the necessity to educate migrants and maintaining confidentiality and quality of HIV testing.

- **Department of Labour:** Several policy level actions have been taken. A workshop was held to incorporate the ILO code of conduct on AIDs in the work place programmes. A tripartite agreement was signed between the Ministry of Labour, employer's federation and workers organizations. NSACP and ILO have facilitated this process and some sectors are now internalising prevention of HIV/AIDS into their routine training protocols.

- **Department of Prisons:** Advocacy programmes were successful in generating interest & commitment of the high commissioner & prison officials integrating HIV prevention in to the prisons . Skill based HIV prevention education has been incorporated in to the training curriculum of new recruit prison officers. HIV prevention activities are included in to the duties of prison welfare officers. Training module were developed and training of peer leaders (prisoners) are being carried out by welfare officers

  Comprehensive clinical care for prisoners are in place with 16 doctors and 14 nurses facilitated by recent upgrading of the STI clinic and the laboratory to offer onsite testing, which is a major achievements and training of medical officers in syndromic management of STIs & counselling . 3 prisoners were found to be HIV positive over the years and 2 were foreigners who were deported**.**

  Prisoners have access to IEC materials in their wards (rooms) and Library. Prisoners participated in World AIDs day programmes in 2006-7 by producing drama and song on AIDs & poster competition attended by Hon Minister of Health and higher officials' Condoms are made available in the prison hospital & the clinic and distributed when released for family leave every 6 months. Despite overcrowding recreational facilities and income-generating activities for inmates are in place in the main prison in Colombo There are places of worship for 4 major religions. Female prisoners with infants are accommodated in a special unit and a pre-school for children under-five.
  Specialized programme for drug dependent prisoners are conducted by the NDDCB& NGOS.

- **National Child protection authority :** The drop-in canters established by the NCPA in 2004 were not reaching those most at risk or most vulnerable children as expected. Those who attended were mainly to engage in recreational activities after school until their parent's returns, or from poor families. The children who were deprived of parental care or living on the streets were not accessing these centres and the project was not funded in 2007. NCPA is committed to preventing child abuse and have engaged in a mass media campaign and providing a hotline for assistance in this respect.

Private sector organizations in the national response

A Business coalition has been established following the 8th ICAAP and the Standard Chartered Bank is giving the leadership to this collective and 39 business enterprises have been enlisted into the coalition

Sex workers outreach

Due to the illegal nature of the sex trade it is extremely difficult to reach out to sex workers. A group of health care providers have been trained to go out in to the field and meet with sex workers, brothel house workers and associated persons to educate them on the need for control and prevention of STD/HIV. As such around 250 sex workers have been reached in the capital city and 18 peers have been trained for out reach. The peer educators are referring colleagues for STD check up and voluntary counselling and testing. This project is funded by UNFPA

Information ,Education and Communication (IEC)

The national AIDs poliy has identified IECas aA Communication Agency has been contracted to develop a Mass Media Campaign and Condom Social Marketing under the supervision and with the technical assistance of the NSACP to increase HIV and STD awareness and bring about a behavioural change among vulnerable groups and general population to reduce stigma and adopt safe behaviours however, this failed to achieve the desired goals and was discontinued.

Awareness programmes are conducted by NSACP with the assistance of provincial health authorities by trained staff in the STD clinics and public health staff, and provide technical assistance for NGOS, CBOs, religious organisations, other sectors, private sector and PLWHA . A communication strategy was developed in 2007 with international expert assistance funded by UNFPA to guide developing target specific IEC material, to deliver uniform messages as it was evident from the BSS that there are gaps in knowledge on HIV transmission and prevention.
An advocacy strategy to support creating an enabling environment to implement prevention programmes was developed in 2006 & many advocacy programmes were conducted to sensitize political leaders, religious and community leaders, judiciary, provincial authorities

and sectors. Steps are being taken to develop a detailed advocacy & policy strategy aiming at policy change
(prevent sex worker arrests, facilitate condom promotion in prisons, and prevent discriminating drug users and MSM) and is a priority area in the new NSP.

A Media Forum has been established in 2005.
Regular meeting are held chaired by the director HEB, with the participation of representatives, sectors & NGOs and health. 6 media seminars were held in 2006 and 15 media seminars in 2007 various issues related to HIV/AIDs were addressed including women empowerment, responsible media reporting, reducing stigma, health promotion.
Award for the best population journalist was given in 2005.NSACP has recognised the role of media as a very good method of dissemination of information on HIV & AIDS as reported by Behavioral surveillance , however responsible media reporting is encouraged respecting the rights of PLWHA for confidentiality & anonymity. Violators will have to pay compensation to the affected PLWHA.

ILO/USDOL HIV/AIDS Workplace Education Programme

The ILO in partnership with the Ministry of Labour Relations and Manpower (MOLRMP) is implementing a HIV/AIDS Workplace Education Programme since May 2005, with the objectives of reducing employment related stigma and discrimination and reducing risk behaviours among workers. The project has a behaviour change communication (BCC) component which is targeting nearly 7000 workers in 14 workplaces (5 hotels, 5 estates and 4 manufacture sector factories) and also has a capacity building component to enable partners from Employers' Organisations, Trade Unions and the MOLRMP to integrate HIV/AIDS education in their programmes. The project approach is based on the *ILO Code of Practice on HIV/AIDS and the World of Work.* HIV/AIDS Committees have been established in all workplaces and they are trained to implement HIV/AIDS prevention programmes, provide care & support and to develop HIV/AIDS Workplace Policies. In addition Trainers and Peer Educators have been trained to create awareness and conduct BCC programmes. Thirteen workplaces have adopted Workplace HIV/AIDS Policies and have a workplace HIV prevention programmes in place.
At national level the project trained Trainers selected from the tripartite constituents, viz: MOLRMP, Trade Unions and the Employers Organisations. The tripartite constituents were provided assistance to design and sign a National Tripartite Declaration on Prevention of HIV/AIDS in Workplaces and also the Trade Unions to draft a Joint Trade Union Policy.
The project attempts to change risky behaviours among migrant workers (both external & internal) in collaboration with the Sri Lanka Bureau of Foreign Employment (SLBFE), Trade Unions and the Board of Investment.
Capacity of Lanka plus has been increased by training peer leaders and increasing communication capacity of PLWHA. Active participation of members of Lanka plus is encouraged in all project activities which has helped to reduce employment related stigma & discrimination.

Blood Safety

The goal of the national blood policy is to transfuse infection free blood to all through non remunerative voluntary blood donations.. All blood donations are non remunerative but there is substantial levels of replacement donations. In Colombo replacement donations account for 8% and the national figure is 37%. Over the years there is a definite declining trend in the percentage of replacement donations while the total number of donations per year has increased from around 207 000 units in 2005 to 246752 in 2006.The donors who come in as replacement donors are turned back in many instances after counselling them about voluntary donation and they are used to recruit voluntary donors. A donor registry is maintained by the NBTS and MIS & M&E systems are being set up with WB assistance.
World blood day for 2006 & 2007 were celebrated ceremonially in order to improve voluntary in house blood donations.

All blood units collected are screened for HIV, syphilis and hepatitis B. Hepatitis C testing is performed in Colombo and will be island wide from January 2007. Blood is also tested for malaria, but there are often delays as the slides are read by AMC. HIV testing is done using ELISA. Blood units that test positive are destroyed and a sample sent to the central STD laboratory for confirmation. If confirmed, the donors are contacted by the central STD clinic for follow up.
The central blood bank and larger regional blood banks participate in an external quality assurance program run by the National Reference Laboratory in Melbourne and Thailand.

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

Good progress is being made towards achieving 100% voluntary donations. It appears that some doctors and nurses outside the transfusion service are not aware of this policy. Smaller blood banks participate in external quality assurance program but do not practice standard operational procedures but this problem will disappear once testing is 'centralised' to Colombo and 5 regional blood banks practising standard operational procedures in the future.

STD Services

Sri Lanka has a well-established network of STD clinics at district level manned by both specialist and non-specialist medical officers and public health staff – usually a Public Health Inspector (PHI) and a Public Health Nurse (PHN) who have both clinic and prevention functions.. STD management Guidelines are followed in all the clinics to provide high quality clinical services for STIs. A comprehensive package is offered and the clinics are well equipped and have adequate supplies of condoms and essential medicines and laboratory facilities. 339552 condoms were distributed through STI clinics in 2006, & 182256 in 2007. Consultant Venereologists and MOs working in STD clinics are trained to manage the routine care of PLHA including routine ART follow-up visits.

STD clinic attendance is increasing following recent activities to raise awareness of STIs and HIV within communities. NGOs working with sex workers / MSM/drug users collaborates well with the local STD clinic team and makes regular contact and refer risk groups for STI services. PHI and PHN provide important outreach work including STI contract tracing and visits to sex work venues, and reach other high-risk populations with the support of NGOs.

PMTCT in Sri Lanka

An opting out and an opting in pilot projects are on going. In the opting out project 4200 samples have been tested and only one antenatal mother was found to be positive. She was provided with the comprehensive management package. None have become positive in the opt- in project.

A working group was formed and a four prong strategy was adopted giving high emphasis on the first two prongs with Family Health bureau .Guidelines for PMTCT is to be finalised in 2008.The screening of pregnant mothers offering VCT to all is not cost effective in the current low prevalent situation, therefore screening of high risk mothers and opt in approach is favoured. Policy on ART to provide all mothers with ART free of charge in all public sectors exists. The drugs are registered for treatment of mother and baby. Breast feeding policy is in place encouraging formula feeding and exclusive breast feeding for the first 4 months in the event of in adequate facilities for formula feeding. 2 mothers were provided with ART for PMTCT during 2006-2007.

The training of health care workers on PMTCT have been conducted especially on stigma & discrimination covering the major maternity hospitals, children hospital in Colombo and will be extended to teaching hospitals in the provinces. A team of health staff including obstetricians, paediatricians, nursing sisters labour room staff, public health midwives and laboratory staff, were sent overseas for training on PMTCT in 2007. A team of obstetricians in the leading maternity hospitals in the country have been identified to provide comprehensive care to HIV positive pregnant mothers in collaboration with Venereologists of NSACP. To date a cumulative number of 30 babies were found to be infected through MTCT.

Treatment and Care:

Treatment and care of PLWA has been integrated in to prevention programme as a comprehensive approach to combat the epidemic. The care and support component has been strengthened by providing ARV for eligible people living with HIV in the public sector free of charge since 2004.The number of patients requiring ARV is increasing at a rate of approximately 30- 50 annually. It is a challenge to continue to provide ARV in the future as already an increase of people seeking care is noted probably due to availability of treatment (quarterly statistics NSACP)

The achievements so far in establishing the ARV programme are development of National treatment guidelines and drug policy ,Improving diagnostic facilities in the reference laboratory for diagnosing opportunistic infections, Institutional strengthening of Infectious disease hospital to provide care and treatment to AIDS patients in a patient friendly environment, Capacity building of health staff in the major institutions in the public sector , covering the National hospital ,obstetric units in 2 large maternity hospitals, National Eye

hospital and the leading paediatric hospital. All these activities were supported by the World Bank with necessary funds. Training programmes are currently being conducted, on treatment and care of HIV patients, counselling and infection control with emphasis on reducing stigma & discrimination towards positive people in health care settings.

Policy and Guidelines on HIV care

National AIDS policy under section one states that all HIV positive persons and AIDS patients shall have access to Government health services equally with other persons for treatment . Government accepts the right of infected persons to have access to treatment. HIV/AIDS patients will have the right to treatment as much as any other person in Sri Lanka. All drugs available in the government hospitals free of charge will be equally accessible to HIV/AIDS patients HIV Guidelines for ART and comprehensive care has been available since 2005 and will be up dated next year. Guidelines for management of Paediatric AIDs and for PMTCT are yet to be done, and HIV/TB guidelines are in the draft form and will be finalized during early 2008
National policy/ protocol for PEP is to provide PEP to all health care workers free of charge.. Recently the guidelines for disposal of dead bodies were updated and a new circular issued by the Ministry of Health .(2007)

Antiretroviral therapy (ART)

Since public provision of free ART began in November 2004, a total of 112 eligible persons were receiving ART by end 2007(adults and children) according to national guidelines. Provision of ARV was commenced at the central STI clinic and at present expanded services to Colombo North, Colombo South, and Kandy STI clinics. Due to the prevailing conflict situation in the north & east the services could not be extended to Jaffna as planned in the first phase of scaling up. Attention is being paid to scale up services gradually to the other provinces as well. The facilities for investigations for follow-up and monitoring the disease progress and response to therapy such as CD4 & Viral load tests are available at the central STD clinic In the immediate future these tests will be done only at the central STD laboratory because of small number of HIV/AIDs patients attending these clinics. It will not be cost effective to establish testing facilities in the peripheral clinics .Alternatively blood samples for CD4 are sent to the reference laboratory in the central STD clinic Drugs are issued to patients from the central STD clinic pharmacy and a quota of drugs for patients attending provincial clinics will be issued in advance from the central pharmacy. The facilities for treating patients for opportunistic infections and for comprehensive management of STIs are available in all the STD clinics.

WB/IDA project provided the financial assistance to procure ARV for HIV/AIDS patients at the inception of the comprehensive care and treatment programme and will be continued till June 2008. Average cost per an adult patient for ARV is Rs 8375 and it varies from 2274 to Rs 16024. It should be mentioned that these prices subjected to all tariff, duty, and other taxes imposed by the government. Funds from the 6th round of GFATM will be utilized to purchase ARV from latter half of 2008.

The cumulative number of patients registered at the central STD clinic was 275 at the beginning of 2006 .49 new HIV infected adults (25 Males and 24 females) were registered during year 2006'and 33 eligible patients commenced on ARV combination therapy during the same period. The cumulative number who were alive and on ART at the beginning of January 2007 was 69. During 2007, 67 new patients (36 males and 31 females) were enrolled and 44 eligible patients (22 males & 22 females) commenced ARV, of whom 6 have died .Cumulative number of adults on ART as end 2007 was 107.Six children are on ART at present a 50% increase from last year. Total number of patients who were changed to second line treatment was 5. At present there are about 391 HIV positives registered in the HIV clinic at the central STD clinic (NSACP)

According to the estimates carried out by the national working group in 2007, ART need for adults & children in 2006 were 706 and 776 in 2007. Accordingly coverage of ART for adults and children in 2006 was 9.6% and increased to 13.7% in 2007.
Patients are monitored using 6 monthly CD4 counts and viral load when it is available. HIV drug resistance testing is not available in Sri Lanka and it is recommended that close monitoring of adherence & compliance to treatment should be carried out to prevent development of drug resistance .Monitoring of CD 4 counts & viral load to detect treatment failure and as an early warning of drug resistance among patients on ART is also recommended in the absence of drug resistance testing. 63% patients were alive and on treatment continuously for 12 months during 2006-2007.

Capacity building

Over 700 health staff have been trained in clinical care , infection control since 2005.In 2007 sensitization programmes for health care workers in teaching hospitals in Colombo were commenced and will be scaled up to provinces next year aimed at providing facts on ART , adherence to treatment etc. and reducing stigma towards PWHA in the health care setting. This two-day WS on comprehensive care and treatment program (CCTP) has paid dividends among HCWs who committed to provide care for HIV/AIDS patients. It was evident that stigma and discrimination towards these patients were minimized significantly.

Care & Support

Patients who were having economic difficulties were provided nutritional support in a form of a food basket weighing 65 Kg on monthly basis with assistance from WFP since 2007. Palliative care is provided in all government hospitals including IDH .Community and Home based care is still in its infancy, very few Care groups /NGOs are engaged in providing support to PLWHA .Lanka + and "positive hope "PLWHA network provides psychological support. A three wheeler was provided to Lanka + by WB grant as logistic support in 2007 for PLWHA. Another NGO -salvation Army has a wider net work and make home visits, train family members in home based care. Nest looks after 2 orphans who are on ART. The burden of care of orphans still lie with the extended families and relatives and is an issue to be addressed in the new strategic plan by supporting care groups and engaging religious organisations in community based care with careful planning not to divulge identities and increase stigma.

Voluntary Counselling and Testing –VCT

In the National HIV/AIDS Policy, section 3.5 states that voluntary counselling and testing will be promoted. There are 26 administrative districts in Sri Lanka and a STD clinic with laboratory facilities has been established in each district. Of the 26 public STD laboratories offering HIV testing, 13 perform testing onsite, 3 send samples to the national reference laboratory and 10 send to another STI or hospital laboratory. According to the national STD guidelines, testing for HIV is encouraged for persons attending STD clinics where verbal consent is obtained prior to testing. On average around 400 persons seek services only for VCT at the central STD clinic, annually. All were found to be HIV negative in 2006 & 2007.

Systems are in place for access to HIV testing and counselling throughout the healthcare system. Doctors and nurses have been trained in HIV counselling by the NSACP. The current two day comprehensive care and treatment programme give an exposure to principles of counselling to health care workers .National counselling guidelines developed in 2003 were translated in to Tamil. A draft national VCT plan has been prepared for consensus on specific counselling training needs addressing specific populations (general population, high risk groups, and estate populations) and including refresher training programs.

Establishing standalone VCT centres for those who are not willing to attend STI clinics were explored over the years. Few NGOS conduct counselling services but do not provide on site testing and refers / bring persons to STI clinics. A pilot project will be carried out on feasibility of integrating VCT in to the health education units in the out patient departments of the hospitals with a trained counsellor in 2008. 20 Tamil speaking counsellors (Assistant medical practitioners) will be trained as a first step to establish VCT centres in the estate sector.
Around 30 private laboratories offer HIV testing in Colombo but data is not available on the volume of testing performed in these laboratories. However, it is known that HIV testing in these settings takes place in the absence of VCT.

HIV/TB co-infection

Sentinel surveillance carried out since 1993 screened TB patients and prevalence of HIV among TB patients were low .Of 1331 TB patients tested in 2006 survey only 1 tested positive with a sero prevalence of 0.1%. At the moment TB/HIV co infection is not a significant health issue in Sri Lanka. No policy /guidelines exist on HIV testing of TB patients. Given the strong evidence showing a very low prevalence of HIV in TB patients Its felt that offering VCT to all TB patients (universally) is not counter productive and cost effective and need to be targeted.

All patients newly diagnosed with HIV are referred to chest clinic for TB screening .TB patients when suspected of having HIV ,clinical suggestion blood is tested for HIV or referred to STI clinic for VCT. A need for a formal mechanism for collaboration between HIV &TB National programmes was highlighted in the NSP 2007.M&E systems of both programmes have HIV/TB indicators in place to monitor the dual epidemic and is a starting point for collaboration.

Knowledge and behaviors

The Key findings of BSS among 6 sub populations surveyed are given below. Nearly 7000 respondents were interviewed with an overall response rate of 90-95%.Trend of behaviours will be seen in the repeated rounds with exposure to planned interventions . The current information may be taken as baseline .

Knowledge about HIV transmission

The Respondents surveyed had heard about HIV from a range of sources, most often TV, newspapers, family and friends, health services and school.
Knowledge about HIV prevention was quite low across all groups .While most knew that HIV was sexually transmitted, over 50% of the respondents incorrectly identified HIV as being transmitted by mosquito bites, over a third of respondents did not know that condoms provided protection from HIV and a majority felt that someone with HIV could not look healthy, Redesigning BCC programmes to address the gaps in knowledge is recommended.

When disaggregated by age (below 25yrs and over 25 yrs) overall knowledge on HIV transmission and prevention (UNGASS indicator) was ranging from 8-11.7% among three wheeler drivers , 6.1%-12.5% among drug users, 10-13% among factory workers , 18% -21% among beach boys and 17% -21% among MSM ;Knowledge among Sex workers ranged from 6%-14% among different categories surprisingly street sex workers were more knowledgeable than karaoke &casino girls. Knowledge was. relatively higher, albeit low, among Beach Boys and MSM;

Knowledge on STIs

While most were aware of STIs, over 80%-90% few had ever had symptoms of STIs, particularly in the previous 12 months. Knowledge of asymptomatic STIs was low ranging among taxi drivers (30%) factory workers 25% drug users 25.4%, beach boys higher 46% 7 & MSM 54%. Sex workers too were unaware of asymptomatic nature of STIs (36 %)

Attitude towards PLWHA

Attitude to those with HIV and AIDS were extremely negative. Over half of all respondents would not want to work or live in the same house with someone with HIV, and a third did not think a student with HIV should be allowed to attend school. The attitudes of MSM to those with HIV were quite stigmatizing: 39.7% would not work with someone who

had HIV, 50.2% would not live in the same house as an HIV-positive person and only 75.5% said that a healthy student with HIV should be allowed to continue their schooling.

However a majority responded positively to the question about caring for a sick relative with HIV. Prejudices may at least partly be caused by incorrect knowledge and misperceptions about HIV. Education messages that focus on providing education about how HIV is transmitted correcting erroneous beliefs that HIV can be contracted through living, going to school or working with someone who is HIV-positive & the importance of treating people with HIV with dignity.

HIV Testing

Levels of HIV testing were low overall, with the exception of MSM ever tested (20.9%) and in particular sex workers. (53.4%) of the sex workers surveyed had been ever tested for HIV making this the group witch by far the highest rate of testing in the survey and most had done so voluntarily. Almost all had been tested at a government hospital clinic .10% Drug users and less than 1% of factory workers had been ever tested for HIV. Government hospitals were the most utilized sites for HIV testing, with some groups being tested at STI clinics and private clinics. Those who had been tested majority tended to have done so in the previous year.

Sexual behaviour ,Type & number of partners & condom use

Sexual behaviour varied considerably between groups, with some groups showing worrying levels of risk for HIV due to unprotected sex with casual and regular sexual partners, both male–male and male–female. There were other groups who either had no sexual partners or one partner only, although condom use amongst monogamous respondents was extremely low. Condom use in commercial sex is higher than with other partners,

Mean number of partners varied from a low single partner among female factory workers to 2 among males, 3 among taxi drivers, 2-4 among drug users, 7 among beach boys &11 among MSM. Beach boys had high rates of partner change with both males and females, local and foreign while MSM had fewer partners compared to in the region. Sex workers on average had 3 clients per last day worked.

Table below summarise rates of condom use over the 12-month period for each of the groups according to different types of partners.

Summary of condom use for vaginal intercourse 'every time' in the previous 12 months by each group, with regular, non-regular and commercial partners

	Regular partners 'used a condom every time'	Non-regular partners 'used a condom every	Commercial partners 'used a condom every

	Freq (%)	time' Freq (%)	time' Freq (%)
Three-wheel drivers	2.3	31.2	64.8
Drug users (male)	1.1	18.8	47.4
Drug users (female)	0.0	9.1	50.0
FTZ Factory workers (male)	4.4	28.3	81.8

Consistent condom use in the previous 12 months: with paying clients and non-paying partners of female sex workers

	Paying clients 'used a condom every time' Freq (%)	Non-paying partners 'used a condom every time' Freq (%)
Brothel	62.9	9.8
Massage parlour	70.4	4.2
Street	81.9	11.7
Karaoke	62.5	2.4
Casino	39.4	4.8

Table 1: Summary of condom use for vaginal intercourse 'every time' in the previous 12 months: with regular and non-regular female partners of beach boys and MSM

	Regular partners 'used a condom every time' Freq (%)	Non-regular partners 'used a condom every time' Freq (%)
Beach boys	4.8	47.2
MSM	18.2	36.1

Table 2: Summary of condom use for male-to-male anal intercourse 'every time' in the previous 12 months: with regular and non-regular partners of beach boys and MSM

	Regular	Non-regular partners 'used a condom every

	partners 'used a condom every time' Freq (%)	time' Freq (%)
Beach boys	21.6	45.9
MSM	25.9	46.5

Sexual behavior among the populations

Factory workers

Total of 1288 factory workers, males and females were recruited for the survey and over half of the male factory workers (49.3%) had had sexual intercourse in the year prior to the survey; 29% of the female factory workers had had sexual intercourse in the year prior to the survey. Abstinence was common among the group.

Of those factory workers who had had sex in the previous 12 months, 71.1% of women had had sex with a regular partner compared with 46.2% of men. Of those factory workers who had had sex in the previous 12 months, very few (7.6% of men and 0.4% of women) had had sex with casual partners. Fourteen male factory workers had paid for sex in the previous 12 months and only one female factory worker had been paid for sex during that period.

Condom use in the previous 12 months among male factory workers was low with regular partners (4.4%), higher with casual partners (28.3%) and very high with commercial partners (81.8%).Female factory workers' condom use with both regular and casual partners in the previous 12 months was almost non-existent.

Three-wheel drivers

A large number of three wheeler drivers (1444) participated in the survey. Most three-wheel drivers (88.7%) had had sexual intercourse in the 12 months prior to the survey, a fifth with casual partners. Condom use was low with regular partners (2.4% always used condoms), higher with casual partners (31.2% always used condoms) and higher still with commercial partners (64.8% used condoms). A similar pattern emerged with each type of partner on the most recent occasion that the drivers had had sex.
A very small percentage (0.8%) had had anal intercourse with a man in the previous 12 months.

Drug users

779 drug users were interviewed Two-thirds (65.2%) of male drug users had had sexual intercourse in the previous 12 months, 49.7% with a regular female partner, 27.3% with a casual female partner and 15.6% with a female sex worker. Condom use among male drug

users at each occasion of vaginal intercourse in the previous 12 months was extremely low with regular partners (1.1%), higher with casual partners (18.8%) and higher still with commercial partners (47.4%).

Beach boys

553 beach boys were studied and by far the group at highest risk with diversity of partners men and women foreign and local and engaged in commercial sex. 81% of beach boys had had vaginal intercourse with a woman in the year prior to the survey. 45.4% had had anal intercourse with a man in the previous 12 months. In the previous 12 months, over half of the beach boys had had a regular female partner and 70.7% had had casual female partners.18.5% had had anal intercourse with a regular male partner in the previous 12 months, 41% had had anal intercourse with a casual male partner and 44.5% had engaged in anal intercourse with a foreign male partner.

Condom use in the previous 12 months with regular female partners was very low (4.8% always used a condom); 47.2% always used a condom with casual female partners.

Condom use was higher on the most recent occasion, 11.3% with regular female partners and 71.4% with casual female partners.21.6% had always used a condom for anal intercourse with regular male partners in the previous 12 months, 45.9% with casual partners. Across the sample Beach Boys had sexual intercourse with more non-regular female partners than regular partners, there were high levels of male–male anal intercourse amongst beach boys. Two-thirds had ever had male sexual partners with 60% (almost all those sexual intercourse with ‘foreign’ than ‘local’ female partners. who had had sex with a man) having had anal intercourse.

Forty-five per cent had had anal intercourse with a man in the 12 months prior to the survey. Condom use on the most recent occasion of anal intercourse with a man was higher, 39.6% with regular partners and 68.8% with casual partners.

Men who have sex with men (MSM)

92.4% of MSM among the 300 surveyed had had anal intercourse in the previous 12 months, 67.5% with a regular male partner and 80.9% with a casual male partner.

Condom use in the previous 12 months during sex with men was low; 25.9% had always used condoms with regular male partners and 46.5% had always used condoms with casual male partners. Almost a quarter of the sample (23.0%) had had sexual intercourse with a woman in that period, 14.7% with a regular female partner and 12.2% with a casual female partner.

While constant condom use in the previous 12 months was low with female partners, it was the highest of all groups with regular partners (18.2%) and 36.1% with casual partners.

Female sex workers sexual behaviour

Around 1094 female sex workers were surveyed. Almost all of the brothel and street sex workers had had sexual intercourse in the previous 12 months (99.3% and 99% respectively) but fewer of the karaoke (85.1%), casino (87.5%) and massage parlour workers (72.1%).Very few massage parlour workers (15.1%) had had vaginal or anal intercourse with paying clients in the previous 12 months. The vast majority of other types of sex workers had had anal or vaginal intercourse with clients. Condom use with clients 'every time' in the previous 12 months was dependent on the type of sex worker; 39.4% of casino workers, 62.9% and 62.5% of brothel and casino workers, respectively, 70.4% of massage parlour workers and 81.9% of street workers had used a condom every time during this period. The condom use among a selected group of sex workers were 65% in 2005 showing an increasing trend .

In the previous 12 months 74.4% of all sex workers had faced some difficulties getting clients to use condoms. Overall, 90.5% of sex workers had used a condom with their most recent paying client and this varied only slightly between the different types of sex workers.

The major reason for sex workers not using condoms at the most recent sexual occasion was that clients objected. Half of all sex workers who had had sex with clients had also had sex with non-paying partners. These sex workers had low rates of condom use with non-paying clients; around 10% used a condom 'every time' .Around 11% of all sex workers had been forced to have sex in the previous 12 months. Street workers, in particular, faced harassment from police for carrying condoms (33.2% in the previous 12 months).

Drug use among the populations surveyed.

Apart from the drug user group, few respondents used drugs; The most used drug was cannabis, followed by heroin and injecting drug use was practically non-existent. 4 three wheeler drivers ever injected and only 2 sex workers ever injected more a year ago. drug users mostly used heroin (94.7%) and cannabis (85.1%).34 (4.4% of) drug users had injected in the previous 12 months while 14% had ever injected Sharing needles was common, with 42.3% of injectors having shared a needle used by someone else and 51.1% having shared their used needle with someone else.

Injecting drug users: safe injecting and sexual practices

Since there were only twelve drug users who had injected drugs in the last twelve months and who had also had sexual intercourse in the same period, the percentage for this indictor must be treated as unreliable. The percentage of injecting drug users who had avoided sharing needles and had used condoms in the last twelve months was 33.3% (4/12). Please note that this UNGASS indicator is usually based on a shorter time period, of about one month, compared with the twelve months used here.

Although the percentage may be unreliable because of small numbers of injecting drug users, the result nonetheless suggests that health promoting behaviours around injecting drugs is

likely to be low in this population. Of the minority who did inject drugs, needle-sharing was common and condom use was low.

As such, there is a risk that HIV could be transmitted very quickly through injecting drug user groups. Targeted interventions for drug users should emphasise the importance of practising safe sex, as well as safe drug using practices in preventing HIV transmission. Education focussed on methods of safe sex, including the use and provision of condoms, should be a priority.
Harm reduction programmes for those who inject drugs may be an important option to consider. Continuous checks on the drug using behaviours of this population are a priority.

Capacity building & infrastructure

Institutional Strengthening;

The IDA/WB funds were utilized to upgrade the STD clinics / TB clinics and wards and all the clinics are manned by trained medical officers. Most of the planned civil works including refurbishment and new constructions of STD clinics (4) and TB clinics (28 chest clinics/wards) refurbishment of reference laboratory has been completed. Newly refurbished training centre at the NHAPP is being utilized for training since 2006. Almost all the STD clinics are equipped with computers, communication facilities and vehicles.

Capacity building: Donor funding is also utilized for capacity building of service delivery persons in both government and civil society. Local training has been provided in the areas of counselling BCC, post exposure prophylaxis (PEP) including infection control , PMTCT , HIV care and treatment, surveillance, laboratory training, M&E including management information system (MIS) , syndromes management and in service training of medical officers of STD .
International training was supported by many donors including PMTCT (WB&WHO,UNICEF) surveillance & estimations (WHO/UNAIDS), M&E & programme planning (WHO),VCT &BCC (WHO/WB) ,HIV care and support (WHO) .Teams in-turn conducted training of trainers in the respective areas.

Policy reviews

The revised National AIDs Policy emphasizes respect for the rights of people at risk or for living with HIV.Improved the policy statements such as non discrimination for MSM & sex work .and protecting human rights of PLWHA - right to marry, disclosing HIV status to partners, access to treatment & information., On positive prevention -legal implication for purposely transmitting HIV to partners protecting rights of partners.

A policy statement emphasises need to target high risk groups in HIV prevention primarily in the low prevalence state, while continue addressing general population prevention strategies.
A special mention is made on preventing discrimination and protecting rights of MSM, Sex workers and prisoners.

The National Policy was ratified by all partners in the response including PLWHA.
Policy on private health sector - implemented, regarding standards for safe delivery of health care, infection control etc.
A review of National policy and Laws is proposed to support the implementation of National AIDS Policy in HIV prevention.

Strengthening Surveillance Systems

Sero-surveillance is carried out annually according to WHO guidelines among STI clinic attendees, sex workers, TB patients, military and drug users. Attempt to include MSM in the year 2006 and 2007 surveys did not succeed and will be surveyed from 2008 with the support of MSM networks & NGOs.

A Behavioral surveillance system was established and the first ever behavioural surveillance has been conducted from 2006-2007 among six subpopulations including female commercial sex workers, men who have sex with men, drug users, beach boys, transport workers and male and female factory workers interviewing over 7000 participants. This is an important mile tone achieved by the NSACP.

A surveillance advisory committee was set up and a pre surveillance assessment a qualitative study was conducted in 2004-2005 prior to BSS .The Pre surveillance assessment conducted helped in the planning of BSS in selecting subpopulations to be surveyed, developing operational definitions of the sub populations, mapping to identify key locations where the risk populations found and developing the sampling frame, identify key informants for the target groups and timing of interviews, selection of interviewers, place and time of interviews etc in implementing the field survey. Construction workers, sex workers, factory workers, fisherman, army personnel, and three wheel drivers were the populations surveyed with mapping of the locations.

A long process of planning the BSS commenced in 2006 January overseen by an expert planning committee following international guidelines including selection of risk populations and geographical locations , mapping , sampling strategies and sampling sizes for each of the populations , training of interviewers , developing study instruments , ethical clearance and data analysis. The FHI BSS questionnaires were adopted to suit the local situation. It was evident from the mapping exercise that previous size estimates for sex worker population was an over estimate.

The results of the BSS were shared at many forums; the ICAPP held in August 2007 and were used in strategic planning and estimation of PLWA. Further dissemination of the findings is planned in the year 2008 among implementing partners and risk groups. Capacity building of NSACP staff and universities were done aimed at taking over the BSS from the external agency and carry over the BSS in the future every two years. A series of qualitative surveys are being planned to compliment BSS findings and will be conducted among selected high risk populations in the early 2008.Replanning of BSS commenced since mid 2007 the

methodology has been revised, and the tools are being updated and will be made available for researchers to be used in the behavioural research in the future.

With the evidence over the years of continued low HIV prevalence even among the high risk groups and supported by behavioural surveillance the option of conducting sero- surveys every two years is being considered. Integrated biological and behavioural surveillance will be a future option to strengthen second generation surveillance.

STI surveillance :is limited to routine data on STIs among STD clinic attendees through the network of 26 STI clinics and screening of syphilis among pregnant mothers attending ANC. Over 10,000 episodes of STIs are treated annually. Attendance is through referrals, or voluntary. Facilities for etiological diagnosis of STIs (*Gonorrhoea , Chlamydia , Herpes simples virus (HSV* etc) are limited to central STI clinic and few other peripheral clinics. The incidence of bacterial STIs *(Syphilis,Chancroid*) are in the decline over the past 3 years and viral STIs (HSV, Genital warts) show an increasing trend. Incidence of Gonorrhoea (GC) has shown to increase in the recent past and emerging drug resistance to GC is of concern. *Non gonococcal cervicitis / urethritis* are the commonest diagnosed bacterial STI, followed by *candidiasis.* Herpes remains the commonest viral STI among the attendees.

Sri Lanka has an efficient public health system to deliver MCH care, 90% of pregnant women seek ANC care and 99% of deliveries take place in the hospitals. The coverage of VDRL /RPR is 69% in 2006 and 93% in 2007.It should e noted that the denominator changed in 2007(from number of pregnant mothers under care to number of deliveries reported by the public health mid wife., which reduced the denominator) Prevalence of syphilis among ANC mothers is 0.25% (*Source Family Health bureau).*

Ad-hoc community prevalence surveys on STIs and STI syndromes compliment routine data which has shown very low STI prevalence of *gonorrhoea ,Chlamydia ,trichomoniasis* & *syphilis* among general population and risk groups in 2007 .One of the obstacles to conduct community STI surveys has been the non availability of diagnostics / field tests such as urine PCR .WB funds were utilised to refurbish the laboratories, procurement of test kits, reagents and equipment during 2006-2007 to strengthen diagnosis of STIs. STI surveillance among high risk groups (MSM, sex workers, IVDU) need to be strengthened. Analysis of STIs among sex workers attending central STI clinic from January to December revealed very low incidence of syphilis 11/396, and no cases of *gonorrhoea* among the attendees.
NSACP reference laboratory participate in quality assurance programs and monitoring Drug resistance for gonorrhoea (GASP).

AIDS mortality and HIV incidence surveillance need to be established in the future to strengthen the second generation surveillance.

Research

Guidelines for recommending research grants for funds were developed in 2007 by the research coordinator adopted from existing guidelines of national research foundations and research bodies with attention to ethics, relevancy to program objectives etc .Steps are being

taken to develop a comprehensive research strategy with external assistance to identify research needs, practising ethics in research especially among vulnerable & marginalised populations utilizing WB funds.

Series of workshops will be held to identify research needs for the future. Research studies on community prevalence of STIs, operational research on quality of services in the STI clinics, drug resistance patterns for GC & Chlamydia were completed and research awards assessing stigma, PMTCT, epidemiological study MSM are being evaluated NSACP provided technical assistance in developing research protocols and research tools for sectors post graduate students private agencies etc in the field of HIV/AIDS. The following research were carried out in 2006/2007, a KAP survey among air force & army personnel and community survey on drug users.

Monitoring and Evaluation

M&E is identified as a priority in the strategic plan 2007-2011.External review recommendation for establishing a strategic information unit is being implemented and a M&E unit will be operational in early 2008 with strengthened system of surveillance and research . A consultancy was engaged in 2007 to develop the M&E plan and is in place. National draft M& E frame work has been developed, with set of National core indicators, incorporating relevant UNGASS & UNIVERSAL ACCESS indicators. Dedicated staff identified to the M&E unit and capacity building of staff has been commenced.
NSACP web site is in place linked to the ministry of health and the National strategic plan, with goals and objectives, surveillance reports; external review report, update on HIV situation, where STI services are available, and FAQ on HIV/AIDs are available for public view.

A Comprehensive Patient management information system for STI & HIV with links to pharmacy, laboratory and administration is in place at the centre and is expected to function from January 2008.Web based Project & programme monitoring & tracking system is in operation for monitoring the prevention activities carried out by sectoral , NGO & provincial authorities. First round of Behavioral surveillance has been completed and rich information on risk behaviors, gaps in knowledge on HIV prevention and transmission , taking up and availability of services ,exposure to intervention and source of information are available for programme & strategic planning .

Currently WB grant is utilised for Capacity building of staff, procurement of equipment and communications, but a funding source need to be identified as M&E generally get low priority for funding.

Involvement of UN theme group

UN agencies are supporting the country AIDS response through technical assistance and small grants. A Joint UN team for AIDs formed recently meets regularly and is functioning well. A joint UN Implementation and Support Plan (ISP) were developed for 2006. The next plan linked to the 2007-2011 NSP will be developed soon.

The areas supported by UN agencies are as follows: (FAO/WFP: HIV awareness raising among farmers, ILO: plantation sector, hotel sector and manufacturing sector, IOM: internal migrants and Tsunami-affected communities, UNDP: women leaders and positive network, UNFPA: young people UNICEF: life skill training for young people, prevention of mother-to-child transmission (PMTCT) and paediatric AIDS, UNHCR: internally displaced people and returning overseas workers, UNODC: drug users, especially injecting drug users, World Bank: funding of the NHAPP,WHO: support surveillance , VCT,M&E ,STI care, syndromic management of STIs , UNAIDS: programme planning &M&E.

V Best Practices

Sri Lanka has an established network of public sector STI clinics covering the entire island with qualified medical officers (post graduate diploma and MD in Venereology), providing comprehensive management of STI/HIV/AIDS (treatment and care, counselling, health education, condom promotion), ART in order to improve survival and quality of life of patients as well as prevention services. These clinics are supported by good public health system at grass root level and by a large number of allopathic and indigenous private healthcare providers who provide care and support to the community. There is also close cooperation between NGOs and CBOs (community based organisations) with the STI clinic staff.

Sri Lanka was one of the first South Asian countries to reform its blood banks to prevent HIV transmission within the health system. Screening of donor blood for HIV antibodies was started in 1987 by the NSACP in collaboration with the National Blood Transfusion Service (NBTS). The Ministry of Health made screening of all donor blood and blood products mandatory. The National Blood Centre in Colombo and 54 regional blood banks distributed throughout the country screen donor blood on site for HIV, hepatitis B, syphilis and malaria before transfusion. Screening for hepatitis C is also carried out in Colombo and some regional blood banks. The reported number HIV infections transmitted through transfused blood is extremely low (2 of 957 since 1987) (*Source NSACP*)
All donors are interviewed individually and are required to sign a donor declaration form prior to blood collection. The donor declaration form allows for self-deferral. In Sri Lanka, the NBTS has employed the policy of confidential after-donation reporting of HIV positives with subsequent destruction of blood units. Voluntary donation is encouraged and currently around 75% of all NBTS supplies come from voluntary blood donations. In Colombo, 90% of donations are voluntary.

Guidelines on appropriate use of blood have been circulated to all healthcare institutions in the public and private sector. The National Blood Policy and the blood transfusion act have been enacted. A Private Medical Institutions Bill that incorporates legislative powers to the Ministry of Health to regulate public and private sector blood banks has also been approved by Parliament.

VI. Major Challenges Faced and remedial Actions Needed To Achieve the Goals and Targets

Data collection plan (2008 reporting)	**2005**	**2006**	**2007**
Household surveys DHS		x	x
Health facility surveys	Clinical audits	x NSACP	
School based surveys		X*	
Workplace surveys		x ILO/NSACP	
Desk review			**x**
BSS		x NSACP/ UNSW**	**x**
Other special surveys		x	**x**

* Not done ** (UNSW -University of New South Wales -Australia)

Some of the constraints identified in 2005 such as delay in awarding consultancies was a major draw back , and vercame by the commitment of the new administrative staff at NHAPP supported by the NSACP and political commitment .As a result a firm was contracted in early 2006 and Behavioural surveillance survey was completed in 2007. Lack of sectoral policy and commitment by administrators continued to hamper sectoral programmes but the untiring effort and commitment of sectoral coordinator and strong advocacy programmes to the officials at the highest level with the support of relevant sectoral ministers brought about the desired attitudinal changes. Simplified procedures for procurements and disbursements helped smooth functioning of planned activities. Frequent changing of project managers lead to confusion and dissatisfaction among the staff, and the decision to appoint director NSACP to manage the project was a step in the right direction. NSACP continued to give technical support.

V Support Required From Country's Development Partners

Greater commitment and coordination among donors towards the national efforts by aligning with the National strategic plan with provision of technical support for key programme areas & necessary funds will strengthen the government, A UN joint mechanism is in place since 2006 as described earlier and it is expected the donor agencies respect state decisions and be supportive to implement the strategic plans.

VI Monitoring and Evaluation Environment

Monitoring and evaluation is in-built in to the implementation strategies of the NSACP. The National AIDs Commitee under the chairmanship of the Secretary, Health reviews overall progress of activities In addition, the select subcommittees review activities relevant to each broad programme area. Both internal and external reviews of the programme are conducted and the recommendations are taken into consideration when formulating National Strategic plans. The 2006 external review and mid term reviews helped in shaping the new NSP.

Overall monitoring and evaluation has been strengthened with the construction of a data base (Programme Management Information System). A functional M&E unit will be in place by

January 2008 with the surveillance focal point as the head of the M&E unit. The unit will be supported by surveillance and research forming a Strategic Information Unit

The funds for M &E from 2008 onwards need to be secured.
Technical assistance for M &E is needed for expanding the MIS to district level, supporting maintenance and upgrading of hardware and software, capacity building of programme officers in M &E through regional training and local training .Setting up CRIS to complement the current programme information system is an option.

UNGASS INDICATORS

NATIONAL COMMITMENT AND ACTION - INDICATORS

1. Amount Of National Funds Spent On HIV/AIDS

Government funds

The national health account system was established in year 2002. However the system has not been functioning efficiently and currently information on health accounts are only available up to year 2004. The allocation of the health budget for prevention has increased from 8% to 10% since 2005.
Funds for HIV/AIDS prevention and control activities are committed by the government and donor agencies. Allocations from the government consolidated fund covers infrastructure and recurrent expenditures (physical facilities, drugs, other consumables, logistic support, office utility, petrol local staff mission) and salaries of health staff at central and provincial levels. There is no disaggregating of consolidated funds for expenditure on HIV/ AIDS as distinct from STD services.

Some proportion of monies allocated annually for curative services is also expended for the in -ward care of HIV/AIDS patients ,however no specific allocation is made due to the small number of affected patients at present.
Following devolution of power to the provinces, the earlier vertical NSACP has been decentralised and individual provinces are responsible for implementing HIV/AIDS related activities with technical resource from the centre. The decentralised health budget is a common budget that does not identify a separate allocation for STD/HIV/AIDS. Considerable variation exists therefore in prioritising HIV/AIDS related activities and in allocations and utilisation of funds at provincial level.

In 2007 a total of Rs 44061110.25 was allocated to the Central STD Clinic for infrastructure costs and salaries, an increase of more than 20% from the previous year's allocation. These monies were spent for: salaries and emoluments Rs. 36, 62452212.00, Transport Rs. 284 377.00, overheads and maintenance Rs. 545731945 and Miscellaneous Rs. 1694891.68.

WB has been the principle donor with the IDA/World Bank grant of approximately 12 million US dollars (with US$9.6 million grant) for the period 2003-2007.
As of May 2006, US$5.1 million of this grant had been disbursed. As of September 2007
Of the grant approximately a total of Rs 109908831.00 was spent in 2007 to expand STD/HIV AIDS prevention and care services in all the programme areas at the national level inclusive of programme planning ,IEC, BCC ,counselling and surveillance , Infrastructure development, Laboratory development , blood safety, strengthening TB program , waste management , Prevention of peri-natal transmission and training .

Counterpart funds to international funds

The total amount of government funds allocated to the NASCP in 2005 to cover operational cost and supplies as a counterpart funding to international funds (mostly for the World Bank project) is estimated at US$500,000. It was revealed that 87% of this government counterpart fund was spent in 2005, compared with 39% of external grant funds.
The allocation from the Government (counter part funds) for the WB project in the year 2007 nearly Rs **31190105.00 was** spent .It was revealed that 100% of the government counter part fund was spent in 2007 .
NSACP received donor funds from few UN agencies in the year 2007. Of the UNFPA grant Rs 142243.00 was spent for a CSW intervention project and from the allocation received from WHO Rs 1068505.00 was spent for VCT/capacity building of PLWHA, producing a booklet for PLWHA. .

Attempt to provide AIDs spending disaggregated in to specific programme areas as requested was not successful for many reasons. The allocations of WB funds were not on the basis of specific programme areas and the account system maintained for the WB funds was under different areas ie: civil works, training, consultancies (5 consultancies surveillance, IEC , M& E and large contracts for interventions to high risk groups and MIS) procurement of equipments and drugs and operative cost.

Overlapping of expenditure on prevention and care was another drawback. ie Expenditure to purchase HIV test kits could not be assigned in to a single category as they were utilised for VCT /surveillance & care. Provision of antiretroviral drugs was one of the category with a high expenditure in 2007 however it could not be disaggregated as expenditure for PEP and for care as there were no separate records maintained in the pharmacy /or NHAPP. Money allocated for sectors and provincial programmes were spent for purchase of equipments, training, communication, logistics, etc but data were not available in the format for analysis as funds were released in instalments as lump sum and returns on expenditure were recorded under the five categories mentioned above, and found to be misclassified in to the wrong category in many occasions (i.e. awareness programmes , advocacy and consultative Meetings were coded as training). Staff salaries could be partly accounted in STD/HIV care & prevention, as well as programme management (prevention and treatment are integrated in the STI clinic as doctors, PHI /PHN are engaged in both) except the administrative office staff. Therefore majority of funds will be assigned as unaccounted in to “other category” as instructed, which may give a wrong picture.

However the exercise was useful in creating awareness among the implementers, programme managers , donors and the accounting staff on the importance of keeping the relevant records and coding the expenditure categories in the future and when the operational plan and the budget for the new NSP is developed .
At all levels procedural delays in disbursement and utilisation of funds within the health services hampers the timely implementation of activities and reduces expected outcomes and impacts. Strategies to improve the financial flow are among the critical health reforms identified and are being incorporated in the new Health Sector Strategy.

AIDS Expenditure in 2007 on funds received by NSACP is presented below. The attempt to collect information on actual expenditure by donors and implementers had been a nightmare and was not successful due to reluctance of organisations and time constrains.

AIDS spending by NSACP 2007 - Total Rs 186,390,795.50 US$ 1,705,911.17

	government allocation	**donors funded /international**	Development partners WB	Others
Recurrent	545731945			
fuel	284 377			
Salaries	36,62452212.			
Others	1694891.68			
government counterpart CF for WB project	* 31190105.68			
(CSW project)		142243.50 UNFPA		
(VCT)		1068505.00 WHO		
Prevention /care	75,251,215.93	1,210,748.50	109908831.16	

2 GOVERNMENT HIV/AIDS POLICIES

National Composite Policy Index
The background to and the constraints faced in construction of each policy indicator are listed accordingly.

Total score = 17/20 Score % = 80 .5% Mean score = 16/4 4.5

The overall score of 80 .5% (17/20) could be regarded as satisfactory but the interpretation may be queried on effectiveness of the policies. The separate scores of the broad policy areas indicate that performance has been better in the areas of Strategic plan (85%) and Prevention (100%) than Care and Support (66%) and Human Rights (50%).

Annexure 1

3. NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE - PART A

Strategic plan

1. Has your country developed a national multisectoral strategy/action framework to combat HIV/AIDS?

(Multi- sectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

Yes X	**Period covered:** Since 1995 with MTP1 NSP for 2002-2006 NSP for 2007-2011	**N/A**	**No**

If NO or N/A briefly explain

Not applicable

***IF YES* ,complete questions 1.1 through 1.10: otherwise go to question 2**

1.1 How long has the country had a multisectoral strategy /action framework?
Over 12 years

1.2 Which sectors are included in the multisectoral stratergy/action framework with a specific HIV budget for their activities?

Sectors included	**Strategy /Action framework**	**Earmarked budget**
Health	Yes **X** No	Yes **X** No
Education	Yes **X** No	Yes No X
Labour	Yes **X** No	Yes No X
Transportation	Yes **X** No	Yes No X
Military/Police	Yes **X** No	Yes No X
Women	Yes **X** No	Yes No X
Young people	Yes **X** No	Yes No X
Others specify		
Ministry of fisheries and ocean resources	Yes **X** No	Yes No X
National child protection authority	Yes **X** No	Yes No X
National dangerous drug control board	Yes X No	Yes No X
Sri Lanka bureau of foreign employment	Yes **X** No	Yes No X
National Youth services council	Yes **X** No	Yes No X
Vocational Training Authority	Yes **X** No	Yes No X

If No earmarked budget, how is the money allocated?

Only the Health sector has a specific government budget allocation to National STD/AIDS control programme for HIV/AIDS .Generally the strategic areas are donor funded. Other sectors may get support from donors directly through grants but do not have ear marked budget for HIV /AIDS in the strategic plan though identified in the multi sectroral strategy. The NSACP recommends funds to support sectors.

The WB grant for the last five years has allocated a separate budget for sectoral activities. On request from the NHAPP/ NSACP the sectors submit bi -annual plans to the NHAPP with objectives & targets and the estimated budget for planned activities. Sectoral Coordinator at the NHAPP facilitates the development of sectoral plans in line with the National strategic plan with technical support from the NSACP with the participation of focal point/s in each sector , accountants ,procurement specialist , project director of the NHAPP& director NSACP.

The funds are allocated prioritising the sectors that have already have programmes in place , or committed to start , identified HIV/AIDS as an important issue in the sector targeting vulnerable populations (education, prisons, uniformed staff , external & internal migrants, marginalised populations including IDPs, vulnerable children ,youth) and the capacity of the sectors to reach the goals & targets on their own /with technical support and sustainability of the activities within the sectors using own funds in the long term. Funds are released on approval of the plans by the donors after signing a MOU with the Secretary of health and secretary or higher official of the Sector. A sectoral review committee evaluates the work& recommends continuing funds on reviewing the progress. Sectoral coordinator oversees the sectoral activities and monitors implementation of the projects. Progress reports are submitted regularly on physical & financial progress to the M&E focal point in the NHAPP

Prisons, foreign employment bureau and work place have already earmarked budget in the new NSP for 2007-2011

UN agencies give technical support or provide grants for small projects in the following manner. UNAIDS for M&E and programme planning (to NSACP), WHO for surveillance &VCT (to NSACP), UNICEF for life skill based education & general awareness for adolescents, (NIE /education sector) and PMTCT, including paediatric AIDS (NSACP) , UNFPA for reproductive Health ,(FHB,NSACP) World food programme for nutritional support to HIV affected (NSACP). USAIDS was the only bilateral donors to offer grants to CBOs. ,UNODC for prevention of substance abuse supports the NDDCB, ILO for HIV prevention in the world of work with special emphasis on estate sector .Development partners take a fair share of the burden , the WB with a huge grant for prevention & care for a multi sectoral response including supporting NGOS and civil society since 2003.GFATM will support sexual health education in schools and estate sector & for provision of ARV 2008 onwards. Few INGOs Plan Lanka, Save the Children support by small grants. (prisons)

Some sectors receive funds directly through donors such as UNODC to prisons and NDDCB UNICEF & UNFPA to education & youth , However the basis for allocations is not clear and overlapping of funding occurs due to lack of coordination among donors..

Internalisation of the HIV/AIDS work is encouraged incorporating HIV AIDS prevention activities in to the general plans in the future such as incorporating HIV/AIDS in the training curricular, and in the training programmes, HIV counselling included in general counselling(in military), prevention of drug abuse and HIV in prisons, negotiating skills empowering women against sexual abuse & HIV/AIDS for migrants in the existing orientation training (foreign employment bureau) Modules & IEC material developed could be reproduced so that only technical support is provided from the NSACP

1.3 Does the multisectoral strategy /action frame work address the following target populations ,Settings and cross cutting issues?

Target populations	
a Women and girls	a yes
b Youth	b yes
c. most at risk populations	c yes
d. orphans and other vulnerable children	d yes
Settings	
e Work place	e yes
f Schools	f yes
g Prisons	g yes
Cross- cutting issues	
h. HIV/AIDS and Poverty	h yes
j. Human rights protection?	I yes
k. PLHIV involvement	J yes
h Addressing stigma & discrimination	k yes
I Gender empowerment and /or gender equality	l yes

1.4 Were target populations identified through a process of need assessment or need analysis?

Yes **X**	No

If yes when was this need assessment / analysis conducted ?Year : 2001*,2006*

Comments:

Internal & external reviews of the national programme conducted prior to development of strategic plans identified high risk groups through rapid assessments surveys (interviews of key informants, observations & anecdotal information). The first Medium Term Plan (MTPI) in 1988 was followed by the MTP II in 1994, the formation of the UN Theme Group in 1996 and the National Integrated Work Plan in 1998. The external review in 2001 prior to the NSP for 2002-2006 conducted by WHO identified many vulnerable groups. (Sex workers, MSM, drug users, beach boys, internal & external migrants, MSM, transport workers, youth in and out of schools, military including police and internally displaced persons as to be targeted for prevention interventions. The External review in 2006 recommended to mainly focus the target on MARP (sex workers, IVDU, MSM including beach boys and prisoners) while continuing BCC to other groups.

The recently conducted BSS confirmed that beach boys , sex workers, MSM and drug users were having high risk behaviours .Contrary to the belief that factory workers and transport workers are practising high risk behaviours the data revealed that they were at low risk**.**

Experts consensus*:*

Several consensus meetings were held with experts and NGOS ,using Delphi technique to identify the risk populations and to asses the size of the populations for estimating number of PLWHA since 2002 based on assumptions, evidence on risk behaviours among populations and clients of sex workers from surveys, & information through NGOs working with the risk populations , legal authorities(police) , media , hotel & tourist industry etc .and the reports on increasing numbers of hidden/ marginalised populations ,sex worker networks close to military camps , MSM & drug user networks were also considered.

Surveys:*–DHS survey 2004 ,UNICEF survey on adolescents 2004 identified vulnerability of estate youth and supported by recently conducted ILO survey Findings from pre surveillance qualitative survey assessment conducted in 2004-2005 for identifying high risk populations for behavioural surveillance has shown that majority of construction workers and migrant workers were at low risk , sex workers were more hidden and so many categories exist (direct & indirect , street and brothel based, home based ,karaoke bar and casino girls) with different levels of risk and the estimated 30,000 sex workers were far too high . Fisherman & transport workers were at moderate risk while three wheeler drivers were the key informants for sex workers*

Ad-hoc surveys assessed risk behaviours (Qualitative & behavioural surveys) and HIV prevalence among key populations.

Analysis of reported data on PLWHA*: this exercise identified source of infection as MSM & commercial sex and external migration.*

Information from the region *on internationally recognised populations driving the epidemic in the region ,(Sex workers, IVDU, MSM) & occupational vulnerable groups (military, factory workers , transport workers, migrants) and youth (out of school) were taken in to account when selecting populations for interventions.*
In 2003 a large group of NGO/CBOS /sectors with expert assistance prioritized target groups for interventions and this exercise was repeated recently during the development of NSP.

1.5 What are the target populations in the country?

Most at risk populations (MARP) are

- .Sex workers
- .MSM ,
- .Beach boys
- .Drug users *
- . Prisoners

** Injecting Drug use is low at present (less than 4% - source BSS) however a continuous check on transition from inhalation to injecting is vital.*

Other groups / Vulnerable / Bridge populations

- External & internal migrants
- Military including police
- Transport workers
- Youth in & out of schools
- Military
- Estate population
- Internally displaced persons
- Fisherman

1.6 Does the multisecoral strategy /action framework includes an operational plan

Yes **X**	No

1.7 Does the multi-sectoral strategy/action framework or operational plan include:

a. Formal programme goals?	*Yes X*	*No*
b. Clear targets and/or milestones?	*Yes X*	*No*
c. Detailed budget of costs per programmatic area?	*Yes X*	*No*
d. Indications of funding sources?	*Yes X*	*No*
e. Monitoring and Evaluation framework?	*Yes X*	*No*

1.8 Has the country ensured "full involvement and participation" of civil society in the Development of multi sectoral strategy /action frame work ?

Active involvement X	Moderate involvement	No involvement

Comments

During 2006 an external review of the national response for prevention & control of HIV was carried out with the participation of UN agencies, external international experts, universities, National programme officials, representatives from the ministries of health & education, other sectoral agencies & civil society including NGOS, private sector & PLHIV.

During the planning of behavioural surveillance survey the relevant sectors, private sector and NGOs working with the vulnerable populations participated in developing survey instruments, mapping of populations and conducting the survey. The BSS findings were shared with the civil society and the at several stake holder meetings when developing the National strategy. Members of civil society were involved in preparing the universal access report setting targets and prioritising areas for action.(in setting the targets ,identifying the obstacles & recommendations for ensuring universal access to HIV prevention & care) which was submitted in 2006 .

Several workshops were organised by the NSACP to develop *the strategic plan* with participation of all stake holders including, civil society members (NGOS, community based organisations, PLHA, Business community, care groups, youth groups, legal and human right organizations. Though nearly 75 NGOs & CBOs were invited only about 20 participated. The documents were translated in to local languages to overcome language barriers & promote active participation.

Ratification of the Strategic plan and the ***National AIDS policy*** to support implementation of the plan was done with the participation of the civil society.

The National AIDS policy was revised in 2006 to ensure policy framework in place for formulating strategic directions protecting rights of PLHA, MARP & marginalised groups in access to care & treatment, etc with participation of civil society.

However it should be noted that this document is still in the draft form for over more than a year, and will be ineffective for any action unless made in to a legal / policy document.

Several workshops were held to develop *National M&E frame work***,** The National indicator framework for M&E with collaboration of civil society, relevant sectors and NGOs The draft National M&E Plan was developed in consultation with the civil society in 2006-2007.Active participation of NGOs ,CBOs were ensured in developing a *communication strategy* during 2006-2007 The national strategic plan is submitted to the National AIDS Council and key stake holders are represented in the NAC (donors, UN agencies, NGOs, civil society, ethical and legal experts, sectors and provincial health authorities).

1.9 Has the multi sectoral strategy / action frame work been endorsed by most external development partners (bi-laterals ; multi-laterals)?

Yes X	No

1.10 Have development partners (bi-laterals;multi-laterals) aligned and harmonised their HIV/AIDs programmes to the national multisectoral strategy or action framework?

Yes, all partners X	Yes ,some partners	No

Several WB projects had supported prevention activities over the years in line with the NSP NHAPP supported by WB grant from 2003 -2008 was planned inline with the NSP 2002- 2006 with an operational plan for multi sectoral involvement (13 sectors , civil society and covered all strategic areas in prevention including blood safety and strengthening TB programme. The global fund (GFATM) round 6 grants supports IEC counselling in estate & education sectors 2007 onwards, and provision of ART from 2008 in line with the NSP 2007-2011. WFP involved in nutrition support and ILO in HIV in work place .More partners will be encouraged to support the NSP over the next 5 years..

2 Has the country integrated HIV/AIDS into its general development plans such as:

a) National Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers d) Sector wide approach?

Yes X	**No**	**N/A**

2.1 *IF YES* in which development plan is policy support for HIV and AIDS integrated?

a) Yes b) yes c) yes d) yes

2.2 If yes which areas below are included in these development plans?

Policy area	**Development plans**				
	a)	**b)**	**c)**	d)	e)
HIV prevention		√		√	
Treatment for opportunistic infections					
ARV therapy					
Care and support(including social security or other schemes)		√			
AIDS impact alleviation					
Reduction of **gender** inequalities as relates to HIV/AIDS prevention /treatment: care&/or support	√				
Reduction of **income** inequalities as relates to HIV/AIDS prevention /treatment: care&/or support	√				
Reduction of stigma &discrimination		√		√	
Women 's economic empowerment Access to credit ,land, training			√		
Others -					

3 **Has your country evaluated the impact of HIV/AIDS on its socio economic development for planning purposes ?**

Yes	No **X**	N/A

If yes how much has it informed resource allocations decisions ? (Low to High) NA

Low					**High**
0	1	2	3	4	5

4. **Does the country have a strategy / action frame work for addressing HIV/AIDS Issues among its national uniformed services, military, police ,peace keepers .prison Staff etc ?**

Yes X	No

IF YES which of the following have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	*Yes X No*
Condom provision	*Yes X No*
HIV testing and counselling*	*Yes X No*

STI services	*Yes* X *No*
*Treatment	*Yes* *No*
*Care and support	*Yes* *No*
Others: [write in]	

**HIV positive persons are eligible for ARV and comprehensive care through government health institutions irrespective of their status. However no necessasity currently.*
Increasing number of young recruits enrolled to the services may pose a challenge on HIV prevention. The commercial sex networks were active around the transit camps, and training centres with influx of sex workers, the establishment of many houses &. Lodges to cater to the need of large number of uniformed services personnel in transit& training camps with recent escalation of war .The armed force have taken measures such as the time spent in transit camps crediting salary to the bank which has resulted in reducing risk activities.
A recent survey has shown that only 16% of soldiers who had indulged in risky behaviours had done so while being in the transit camps.
Sectoral programme of the NHAPP continued in 2006-7 with technical assistance of NSACP for uniformed services Army, Navy and Air force and police. The Army Medical Corps with technical guidance from the NSACP conducted programmes on HIV/AIDS - IEC activities, for behaviour change for adoption of safe sex practices, provision of condoms and screening for STIs and promoting voluntary counselling and testing for HIV among armed personnel even in the conflict areas covering North & East.

VCT centres were established in all the tri- forces with onsite testing however some still attend private sector .During 2005-2006 % increase of referrals to STI clinics for STI screening was seen., and increasing number have come forward for testing but no HIV positives were found. Over 2000 condom dispensers were installed in the camps and millions of condoms were distributed among the uniformed personnel as mentioned earlier..
The armed service personnel were a sentinel group surveyed in the annual sentinel surveillance since 2006& 2007 but none were positive A sexual behaviour survey among army personnel has been completed in the year 2007.

Similar Programmes for Air force and Navy personnel were carried out in collaboration with the medical core of the respective sectors funded by the WB project with technical support from the NSACP .from 2005-2007.

As mentioned earlier programmes are in place for prison officials.
No peace keeping force exist in Sri Lanka .However there are special pre departure training programme for Haiti bound peace keeping force .Condom promotion is one of the key areas however once in the foreign soil they are barred from engaging in sex, and condoms are not provided which is a major concern. .

**** What is the approach taken to HIV testing and counselling?*** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain

VCT for HIV is available in the Army ,Navy & Air Force integrated in to general counselling to avoid stigmatisation & improve access & promote testing & referral to care Voluntary Counselling is promoted with informed consent .Pre & post test counselling are provided .Steps are taken to maintain confidentiality of information and the test results will be only divulged to the person who takes up testing .

Group counselling is done during training sessions.

Pre departure Compulsory testing

Uniformed personnel are sent abroad on peace keeping missions and it's a fact that, pre departure HIV testing is requested to obtain VISA which is imposed by (requirement by) the country of visit. (ie Haiti bound peace keeping force)

5. Has the country followed up on commitments towards Universal Access made during the High-Level AIDS Review in June 2006?

Yes X	No

5.1 Has the National Strategic Plan/operational plan and national HIV/AIDS budget been

Revised accordingly?

Yes X	No

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes	No X

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimations and projection needs X		**Estimates only**	No

5.4 Is HIV and AIDS programme coverage being monitored?

Yes X	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes X	No

b) ***IF YES***, is coverage monitored by population sub-groups?

Yes X	No

IF YES, which population sub-groups?

Internally displaced persons
MSM,
Youth & In -school children,
Uniformed services ,
FSWs
Drug users,
Prison population,
Factory workers& transport workers

c**) Is coverage monitored by geographical area?**

Yes X	No

IF YES, *at which levels (provincial, district, other)?*
At Central level the M& E consultant at the NHAPP , monitor the physical and financial progress of the sectoral, NGO and provincial programmes through web based project monitoring system , via progress reports (Quarterly/ monthly)
Regional facilitators from the NHAPP monitor the activities at the provincial and district level by field visits and with provincial authorities at the monthly conferences chaired by the PDHS.
District and provincial AIDs committees which are active in some districts review the progress independently.

Provincial AIDS Committee is, **chaired** *by the provincial minister of health and members are Provincial health secretary, Provincial director of health services (PDHS)Representatives from: Police, Army, Education, Social Service, Department of Labour and NGOs. There is no MO/STD from the district.*
District AIDS Committee is Chaired *by the Government Agent – GA (Most senior government Official in the district), and other members are Deputy provincial director of health service (DPDHS), MO/STD, Representatives from: Police, Army, Education, Social Service, Department of Labour and NGOs. The membership of provincial and district committees Overlap and the functions of the committees need to be revised align to NSP,*

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes X	No

Overall, how would you rate <u>strategy planning efforts</u> in the HIV and AIDS programmes in 2007 and in 2005?

2007	Poor									Good		
	0	1	2	3	4	5	6	7	8	**9**	10	
2005	Poor									Good		
	0	1	2	3	4	5	6	7	**8**	9	10	

mments on progress made since 2005: 2003 score 7

The 2002-2006 strategic plan has been revised in the year 2007 with the recommendation of the external review carried out in 2006.The Findings of the first ever Behavioral surveillance survey (BSS) has been used as a guide to plan interventions for risk groups and .in the formulation of the new strategic plan .

1.Greater emphasis is given to focus prevention interventions addressing MARP ,mapping and estimating the size of the subpopulations, local research evaluating behavioral interventions and coverage while continuing to increase awareness / BCC for low risk and general population, policy development to ensure an enabling environment to reduce stigma & discrimination towards PLWHA.

An important policy statement made by His Excellency the President that adequate and early interventions be addressed towards relevant behavior development in the Youth of this country

2. Involved all stakeholders in the National strategic planning process. The ICAPP held in 2007 brought HIV/AIDS into focus , and to build partnerships with all implementers of the national response, and to share information on best practices and issues concerning PLWHA..

3. Recognising the need to devolve the response from National & central to peripheral levels, more involvement and coordination of provincial & district health staff , NGOS &Community based organizations at local level for planning & implementing prevention activities was decided. The Centre / National programme would continued to provide technical support and trained MO /STDs are responsible for manning the STI clinics and providing care & treatment and to engage in the prevention activities supported by the public health staff at the local level. Provincial/Deputy provincial director would be the focal point responsible for prevention efforts at the district level. District plans of operation will indicate how and where highly vulnerable populations will be targeted, involvement of NGOs and the private sector. Capacity building of NGOs , and health staff at district level is considered as a priority to meet these challenges.

Emphasis was given for active involvement of civil society and private sector, business community in planning and implementing programmes .The role of business community playing an active role with technical support in areas such as programme planning and management, good governance, Information technology, social marketing, monitoring and evaluation & providing funds for prevention activities.

4. Strategic information for guiding the response has been recognised as a priority and a plan for establishing a strategic information unit including, research, surveillance and M&E has been developed and is expected to be in place at the National centre by January 2008. National indicator framework has been developed with involvement of all stake holders according to 3 by one principles.

5.A training centre for VCT has been established.

Task analysis of the functions of the staff at the NSACP in the programme areas of prevention, care support , programme planning and strategic information is in progress .

11. Political support

Strong political support includes governments and political leaders who speak out often about AIDS and regylarly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. **Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?**

President/Head of government	**Yes X**	No
Other high officials	**Yes X**	No
Other officials in regions and/or districts	**Yes X**	No

2. **Does the country have an officially recognized national multi-sectoral HIV/AIDS management / coordination body? (National AIDS Council or equivalent)?**

Yes X	No

***IF NO**, briefly explain: Not applicable*

2.1 ***IF YES,*** when was it created? *Year:* **1988**

2.2 ***IF YES,*** who is the Chair? Dr Athula Kahandaliyanage
Secretary Of Health

]

2.3 ***IF YES,*** does it:

have terms of reference?	Yes X No
have active Government leadership and participation?	Yes X No
have a defined membership?	Yes X No
include civil society representatives?	Yes X No
IF YES, what percentage? 30% [	
include people living with HIV?	Yes X No
include the private sector?	Yes X No

have an action plan?	Yes No X
have a functional Secretariat?	Yes No X
meet at least quarterly? review actions on policy decisions regularly? actively promote policy decisions? provide opportunity for civil society to influence decision-making? *strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	*Yes* *No X* *Yes X* *No* *Yes X* *No* *Yes X* *No* *Yes* *No X*

3. **Does the country have a *<u>National HIV/AIDS body</u> or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?**

National AIDs Committee (NAC) through its subcommittee
And NSACP

Yes X	No

3.1 ***IF YES,*** does it include?

Terms of reference	Yes X	No
Defined membership	Yes X	No
Action plan	Yes	No X
Functional Secretariat	Yes	No x
Regular meetings	Yes	No x
	Frequency of meetings: At least twice a year ,as and when it is needed for decision making , review progress or burning issues	

The NAC is the functional national multisectoral co-ordination body mandated to define policy and co-ordinate activities implemented by the health sector (state and private), other sectors and civil society ,private sector and PLWA. Policy interventions are directed towards overcoming social and cultural barriers that foster discrimination and stigmatisation, in order to create an enabling environment that provides for the integration of HIV/AIDS affected persons into society and the widespread adoption of responsible sexual behaviours including safer sex practices and use of condoms. Over the past decade policy decisions were mostly on health issues (ART ,PMTCT, Patient care and PEP) but not on human right issues, or on creating favourable environment for PLWHA /reaching MARP.(barriers to promote condoms, brothel raids and sex worker harassments / arrests)

The sectoral policies need to be adopted in line with NSP for better implementation of prevention activities , especially education (sexual health education in schools) prison sector (promoting condoms),labour (right to work, mandatory testing for visa), media (responsible reporting)
The Terms of Reference of the NAC are: To advise the GOSL on policy regarding prevention and control of HIV/AIDS; To facilitate inter-sectoral co-ordination; Monitor the implementation of activities related to the NSACP and bring to the notice of the National Health Council (NHC) difficulties in implementation of any activities with respect to changes in the prevailing situation.
During the period 2006 -2007 NAC met twice and in 2007 only once to ratify NSP. The subcommittees of NAC were sadly defunct except the Legal and Ethical Issues subcomittee; has 5 sub-committees viz. Clinical care and counselling; Non Governmental Organisations; Laboratory and Surveillance and Information, Education and Communication who are responsible for implementation of activities.

IF YES *What are the main achievements?*
1. A National AIDS Council was formed in 2006 chaired by the Head of the state /His Excellency the President which is the highest governance body to enhance political support towards the National response through the involvement of the political hierarchy and the responsible Ministers of Line agencies. 2.Recomended NSACP proposal for conducting an external review of the National response to HIV/AIDS control in October 2006 by a team including members from national programme, sectors other than health , overseas HIV initiatives , international organisations ,universities ,NGOs and private sector, to identify the achievements of the national response to HIV by NSACP, other government and non government organizations in areas of STI/HIV prevention ,care & treatment for the past five years (2002-2006) ,and to provide recommendations for revision of the strategies & interventions for development of the new National Strategic Plan (NSP) for next 5 years 2007-2011 . 3. Guided and supported development of the new NSP (for 2007-2011) by active involvement of all stake holders. At the last meeting of NAC held in October 2007 strategic plan was ratified and has been published. 4.Held the ICAPP in August 2007 , with the initiative of the Honourable Minister of Health and civil society with the participation of NGOs, business community , PLHIV, government sectors ,political leaders ,donors and development partners and was a great success .This is the first time an international AIDS conference was held in a low prevalence country, with participation of over 2000 persons ,including over 500 sex workers 1000 MSMs ,human right groups &scientific community. Two HIV positives from Sri Lanka (male & female) for the first time came public and addressed the conference, voicing concerns and issues of PLHIV which is a way forward in fight against stigma & discrimination & active participation of PLHIV in the national effort. 5. Finalised the revised National AIDs Policy, which is now open for public comments prior to forwarding for cabinet approval soon. The Legal & ethical subcommittee of the NAC.has been very active in this process despite the long delay.

6. Coordinated World AIDS Day activities giving the leadership to involve all stake holders, and vulnerable populations. (Prisoners, drug users)
7.Launching of a web site -for public access to information on the NSACP (ie programme goals functions & service delivery points, current situation of HIV/AIDs-quarterly reports , review reports, strategic plan , epidemiological & behavioral data from sentinel surveillance , behavioral surveillance)
8. Universal access report was submitted in 2006. Developed a draft national communication strategy with the support of UNFPA.
9 securing GFATM funds (round 6) for HIV/AIDS education in estate sector , in school & out of school youth and to procure ART.
10. Facilitated purchase of low cost ARV drugs through discussions with Clinton foundation

Initially NAC met quarterly, but has not been the practice since 2005. Now the NAC meets as frequently when the need arises ,at least twice a year. It met several times in 2006, for planning the ICAAP and twice during the year 2007 A task analysis of the NAC is planned after more than 10 years of its inception to meet the new challenges

IF YES, What are the main challenges for the work of this body?

Several new ministries have been formed by the GOSL over the past few years and these are not represented in the NAC at present. Which affects smooth function of some sectors in combating HIV/AIDS? The new development plans, & policies demands new functions and responsibilities to the NAC. Absences of a functional secretariat to NAC since its inception is a draw back to efficient functioning of the NAC and heavy burden on the NSACP in follow up action and arrange regular meetings. Similarly an action plan has not been in place to focus areas that need attention and to monitor the activities. The highest level of officials represent the line ministries in the NAC ,however planning NAC meetings to bring all the sectors together with their busy schedules in their respective ministries had been a dilemma in the past and will be in the future too The subcommittees of the NAC (Legal & Ethical ,NGO, IEC, Laboratory & Surveillance ,Research ,HIV Care support & programmed planning) had been inactive , and have not met regularly. One reason was that the chairpersons of subcommittees were not included in the NAC in the past. Representation of civil society is inadequate for active participation and religious leaders of all faith should be represented in the NAC. The proposed task analysis of the NAC is to identify barriers and make recommendations for reorganizing the NAC to meet these demands.

4. **What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**

Percentage: could not estimate but low [write in]

5. **What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?**

a. Information on priority needs and services	Yes x No
b. Technical guidance/materials	Yes x No
c. Drugs/supplies procurement and distribution	Yes x No
d. Coordination with other implementing partners	Yes x No
e. Capacity-building	Yes x No
Other: [write in] Provide donor funds on performance , through NSACP	

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No X

6.1 ***IF YES,*** were policies and legislation amended to be consistent with the National AIDS Control policies?
Not applicable

6.2 ***IF YES,*** which policies and legislation were amended and when?

Policy/Law: *NA* *Year:* [write in]

Policy/Law: *NA* *Year:* [write in]

[List as many as relevant]

Overall, how would you rate the political support for the HIV/AIDS programme in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	**9**	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	**9**	10

His Excellency the President chairs the National AIDS Council the highest governing body. Issues statements on the World AIDS Day and during health sector progress reviews held annualy (Mahinda Chinthnaya) evaluates work done on HIV/AIDS .He was the chief guest at the 8th ICAPP.
High level minister's forum /meetings (health and Labour minister's co-ordinating) were organised by the Minister of Health at the 8th ICAPP.
Sri Lanka actively participates in parliamentarians for global action. Committed for scaling up of Universal access.
Minister of Labour is actively involved in and evaluates activities in the AIDS in the work place .
Minister of foreign employment /affairs is actively involved in planning HIV prevention programmes of the foreign employment bureau.

Several provincial council ministers have re activated District and Provincial AIDS comittees and initiated prevention activities through religeous and community leaders.

III. Prevention

1. **Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?**

Yes	x	No	NA

1.1 ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	√
Use condoms consistently	√
Engage in safe(r) sex	√
Avoid commercial sex	√
Abstain from injecting drugs	√
Use clean needles and syringes	*NA*
Fight against violence against women	√
Greater acceptance and involvement of people living with HIV	√
Greater involvement of men in reproductive health programmes	√
Other: [write in]	

Messages on Using cleaning syringes & needles and abstain from injecting drugs are not explicitly given in mass media campaigns , as injecting practices are low and the policy in preventing drug abuse is aimed at drug reduction than harm reduction . However the information is given when addressing specific populations at risk of such as out of school youth & especially living in shanty areas & prisoners.

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV and AIDS by the media?

Yes	X	No	

Several programmes addressed media on promoting accurate reporting during media forums for journalists, and world AIDs day activities. During health promotion talks over the electronic media a leading journalist who is an ambassador of HIV/AIDs addressed the issue on importance of responsible reporting to prevent stigmatising people. Several Tele- dramas produced by sectors and health education bureau highlighted the negative impact on inaccurate reporting

2. Does the country have a policy or strategy promoting HIV/AIDS-related reproductive and sexual health education for young people?

Yes X	No

2.1 Is HIV education part of the curriculum in

primary schools?	**Yes**	No X
secondary schools?	**Yes** X	No
teacher training?	**Yes** X	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes X	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes X	No

3. **Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions <u>for vulnerable sub-populations</u>?**

Yes	X	No	

***IF NO**, briefly explain: NA*
NA

***3.1 IF YES**, <u>which sub-populations</u> and <u>what elements of HIV prevention</u> do the policy /strategy address?*

- ✓ *Check for policy/strategy included*

	*IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Othersub-populations* BB/external migrantse
Targeted information on risk reduction and HIV education	√	√	√	√	√	√
Stigma & discrimination reduction	√	√	√	√	√	√
Condom promotion	√	√	√	√		√
HIV testing & counselling	√	√	√	√	√	√
Reproductive health, including STI prevention & treatment	√	√	√	√	√	√
Vulnerability reduction (e.g., income generation)	N/A	N/A	√	N/A	N/A√	NA
Drug substitution therapy	NA	N/A	N/A	N/A	N/A	NA
Needle & syringe exchange	NA	N/A	N/A	N/A	N/A	NA

Overall, how would you rate <u>policy</u> efforts in support of HIV prevention in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	**9**	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	**9**	10

Comments on progress made since 2005:
The revised National AIDs Policy emphasizes respect for the rights of people at risk or for living with HIV. Improved the policy statements such as non discrimination for MSM & sex work .and protecting human rights of PLWHA - right to marry, disclosing HIV status to partners, access to treatment & information.
On positive prevention -legal implication for purposely transmitting HIV to partners protecting rights of partners.
To target high risk groups in HIV prevention primarily in the low prevalence state, while continue addressing general population prevention strategies.
The National Policy was ratified by all partners in the response including PLWHA.
Policy on private health sector - implemented, regarding standards for safe delivery of health care, infection control etc.
A review of National policy and Laws is proposed to support the implementation of National AIDS Policy in HIV prevention .MARP coverage is still low for targeted interventions .of the 26 NGOs engaged in 2006 to carry out small projects only 3 reached sex workers none reached MSM .drug users, IDPs migrant factory workers, transport workers were the groups addressed with BCC and condom promotion .NGO lack capacity and commitment to carry out TI for MARP.
Advocacy need to minimise obstacles to reduce raids on brothels, arrest of sex workers, were carried out. Capacity building of NGOs were done on BCC, VCT. Focus on Policy change/legislations is the next step.
.

***other high risk groups the NSP address*

<u>Beach Boys</u> -

*Refers to young men who work near or on the beaches, typically tourist beaches, and who offer sexual services in exchange for some form of payment. These young men may also work as tourist guides and may not all identify as 'beach boys'. Beach boys may also be working in restaurants, hotels, guest houses and boat-related tourism (Buddhakorala, 1996). Over the years formative research and behavioral studies have shown beach boys as a high risk group as they are a mix of MSM, Bisexuals, male sex workers who associate tourists especially from high prevalence countries. They were included in the NSP as a target group for interventions and were included in the recently conducted behavioral surveillance which confirmed their high risk behaviours (low condom use , multiple partners , commercial sex and bi-sex and recently conducted survey on sex tourism (Sri Lanka Tourist Board) has shown that they are the key informants for paedophiles & tourists for promotion of child sex tourism in Sri Lanka*Drug users*

IDUs are very low in Sri Lanka, NDDCB estimates 1% injects among a population of 20-40,000 heroin addicts. Inhalation is the popular method of drug use . However the increasing number of drug users over the years pose a threat to HIV control if they switch to injecting which can fuel an epidemic. Recently conducted BSS indicates that 4% of all the drug users surveyed had injected over the past one year .Even though the numbers are low nearly 50% of those injected had sharing practices. 30% had Drug users specially the heroin addicts estimated to be 25-40,000 had been targeted by the NDDCB for risk reduction aims at reduction of drug intake than substitution harm reduction..Detoxification is the method used in the 4 drug treatment centres free of charge. HIV prevention through BCC, referrals for screening of STIs Syphilis, Hepatitis

B and encouraging to test for HIV & and, condom promotion is carried out for the target groups. The NDDCB has a strong system of disaggregated data collection which can form the basis for an early warning on shifts in drug use patterns, transition from inhalation to injecting

External migrants

HIV testing data indicate that more than 40% of women who tested positive are international migrants .They are exposed to higher levels of HIV risks at their destinations due to sexual harassment, poor negotiation powers for condom use , casual relationships with men from high prevalent countries etc. However many of these require pre departure HIV screening and therefore highly overrepresented in testing data. A recent analysis of HIV positives attending the STI clinics has shown that infected men had casual relationships with returnee migrant women. Its not clear how many of these women have acquired infection abroad and in Sri Lanka.

Foreign employment Bureau conducts 12 days pre departure training programmes for women and additional one day was included for HIV/ AIDS prevention with skill building programmes for negotiating skills for sexual harassment, condom promotion, family & community integration for returnees and encouraging routine offer of screening for STIs & HIV. Programmes are underway to officers of Airlines, immigration officials at Airports to be involved in facilitating the e dissemination of information's in-flight and in transit.

Prisoners –as mentioned earlier IEC &BCC programmes are conducted in prisons through peer leaders and welfare officers trained in HIV Several programmes addressed media on promoting accurate reporting during media forums for journalists, and world AIDs day activities. During health promotion talks over the electronic media a leading journalist who is an ambassador of HIV/AIDs addressed the issue on importance of responsible reporting to prevent stigmatising people.. Several Tele dramas produced by sectors and health education bureau highlighted the negative impact on control measures by inaccurate reporting on AIDS STI services (syndromic management) are available through well trained staff in the STI clinic in the prisons in Colombo & through the prison hospital or referred to the STi clinic. Elsewhere .VCT is promoted with informed consent. Onsite testing for HIV is available .Condom promotion is done however condoms are provided only to those going on home leave every 6 months .Condoms are placed in the wards and STI clinic. IEC material ars available in the cell, and income generation programmes are in place.

4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes X	No

IF NO, how are HIV prevention programmes being scaled-up? NA

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	***The activity is available in***		
	<u>all</u> districts* in need	***<u>most</u> districts* in need***	***<u>some</u> districts* in need***
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV			√
IEC on risk reduction	√		
IEC on stigma and discrimination reduction	√		
Condom promotion	√		
HIV testing & counselling	√		
Harm reduction for injecting drug users			NA
Risk reduction for men who have sex with men			√
Risk reduction for sex workers		√	
Programmes for other vulnerable sub-populations	√		
Reproductive health services including STI prevention & treatment	√		
School-based AIDS education for young people		√	
Programmes for out-of-school young people	√		
HIV prevention in the workplace			√
Other [write in] IDP *Plantation workers* *External migrants* *Internal migrants*			√ √ √ √

Overall, how would you rate the efforts in the <u>implementation</u> of HIV prevention programmes in 2007 and in 2005?

2007	Poor										Good	
	0	1	2	3	4	5	6	7	8	**9**	10	
2005	Poor										Good	
	0	1	2	3	4	5	6	7	**8**	9	10	

Comments on progress made since 2005: 8 and 2003 6

The WB review mission in 2006 commented that the focus on interventions for high risk groups was inadequate and has recommended that a revised project implementation plan be executed during the balance period. The revised project implementation plan has been developed and more emphasis has been given for interventions addressing high risk groups such as the CSWs, Drug users, Internal migrants and Transport workers with more geographical coverage .The sectoral plans were revised to conduct BCC programs, continue advocacy for support from higher officials, conducting base line surveys to develop appropriate interventions, and training peer leaders to reach the target populations.

The external review reiterated the above findings in 2006-2007 and recommended evidence based planning of prevention programs, using BSS findings of identified high risk practices and risk populations, high stigmatised attitudes to PLWHA, myths on transmission still prevailing in spite of continued IEC campaigns covering many populations over the years.

MARP are targeted through sectors (as evident by programmes in prison, for fishermen and external migrants) and NGOs (sex workers , drug users , internal migrants) and some provincial programmes . Its expected to meet the targets by increasing coverage by & ,capacity building of the NGOs and sectors

The format of the prevention programmes moved away from IEC to behavior development for low risk groups and BCC for MARP. More peer lead interventions to reach target population were designed than mass education programmes. The provincial programmes were focusing reducing stigma in health care settings and promoting standard precautions/Universal precautions, VCT .and sensitisation on ART and by continued training of health staff.

The need for an advocacy policy & strategy creating an enabling environment to implement targeted interventions in the sectors, (especially for sex workers minimising arrests by police , condom promotion in prisons, and discriminating attitudes towards drug users and MSM) is recommended and is a priority in the NSP.

The communication strategy which is being developed will ensure development of standard, quality, target group specific, uniform messages .A need for a research strategy for collecting information on gaps and practising ethics especially regarding vulnerable & marginalised populations was recognised All of these will be addressed in the strategic plan for 2007-2011.

Prevention activities were conducted through NGOS, Sectors, provincial authorities, some UN agencies and private sector WB funded activities were given below.

<u>Subprojects</u> – small scale behaviour change interventions were carried out through 26 NGO/CBO who successfully completed the first round of subprojects. Target groups

were drug users, transport workers, sex workers, factory workers, estate population, youth etc .

Subcontracts -Large contracts

6 NGOs were selected to provide interventions to sex workers, drug users and factory workers. Some have completed baseline surveys and some have used the results of the BSS to plan interventions. The project is ongoing, and peer out reach, BCC, VCT, condom promotion and linking with STD services are the key activities identified.

Sectors

Although 13 sectors were involved in the beginning in 2004-2005 in the first round, Prison, military, foreign employment bureau, labour and fisheries sectors were continuing to work and funded at present. Condom promotion (condom dispensers were installed in canteens and in officers mess in military) condoms made available to prisoners on discharge and in the wards in the prisons hospital, and VCT, BCC, screening for STIs, HIV/ AIDS included in training curricular, are the activities internalised in to sect Several programmes addressed media on promoting accurate reporting during media forums for journalists , and world AIDs day activities. During health promotion talks over the electronic media a leading journalist who is an ambassador of HIV/AIDs addressed the issue on importance of responsible reporting to prevent stigmatising people.. Several Tele dramas produced by sectors and health education *bureau highlighted the negative impact on inaccurate reporting oral programmes. Some have started utilising own funds for these activities.*

The present curriculum revision by the education department will give attention to concentrate in school education than informal education by NGOs /Medical officers and several organisations in the past. Adequate material for the teachers to teach life skills (2 per each area) based education in reproductive health will be supported by the NSACP.

GFATM.

Most recently the NSACP has obtained additional support through the Global fund for AIDS/TB/Malaria (GFATM) This fund will further strengthen and fill in some gaps in prevention, care and support programs for HIV. The key areas covered here are a program which covers 1300 schools in 10 selected districts, Plantation workers in Tamil speaking plantations in 5 districts for increasing condom use and strengthening voluntary counselling and testing, support for ARV, reagents and a program that builds provincial level teams that will be responsible for local planning of HIV prevention & support programs and also aimed at dispelling stigma and discrimination in the general population including health care institutions.

IV CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV/AIDS treatment, care and support?** (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes X	No

1.1 ***IF YES,*** does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes X	No

2. **Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

Yes X	No

***IF YES*, to what extent have the following HIV and AIDS treatment, care and support**
Check the relevant implementation level for each activity√
or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	***The service is available in***		
	all districts* in need	***most districts* in need***	***some districts*in need***
a. Antiretroviral therapy			√
b. Nutritional care		√	
c. Paediatric AIDS treatment			√
d. Sexually transmitted infection management	√		
e. Psychosocial support for people living with HIV and their families		√	
f. Home-based care			√
g. Palliative care and treatment of common HIV-related infections	√		
h. HIV testing and counselling for TB patients			√
i. TB screening for HIV-infected people	√		
j. TB preventive therapy for HIV-infected people	NA		
k. TB infection control in HIV treatment and care facilities	?√		
l. Cotrimoxazole prophylaxis in HIV-infected people	√		

m. Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)	√		
n. HIV treatment services in the workplace or treatment referral systems through the workplace	*NA*		
o. HIV care and support in the workplace (including alternative working arrangements)	*NA*		
p. Other programmes: [write in]			

*Districts or equivalent de-centralized governmental level in urban and rural areas

Yes	X	No	

The progress on scaling up of HIV care & support since 2005 has been already mentioned and is summarised below.

ARV therapy .

Accessibility- *Provision of ARV was commenced at the central STI clinic in 2004 and at present expanded services to Colombo North, Colombo South, and Kandy STI clinics. Due to the prevailing conflict situation in the north & east the services could not be extended to Jaffna as planned in the first phase of scaling up. Attention is being paid to scale up services gradually to the other provinces as well. Patient on ART has been increasing over the last 2 years and a total of 112 eligible persons among a cumulative total of 326 registered at the central STI clinic were receiving combination ARV by end 2007 according to national guidelines. Coverage of ART for adults and children in 2006 was 9.9% and increased to 14% in 2007. 6 children are on ART at present a 50% increase from last year .Since 2004 WB provided necessary funds for ART and will be continued until June 2008 , thereafter through funds from the 6th round of GFATM . .Patients are monitored using 6 monthly CD4 counts and viral load when it is available. HIV drug resistance testing is not available in Sri Lanka*
The facilities for investigations for follow-up and monitoring the disease progress and response to therapy such as CD4 & Viral load tests are available at the central STD clinic In the immediate future these tests will be done only at the central STD laboratory because of small number of HIV/AIDs patients attending these clinics. It will not be cost effective to establish testing facilities in the peripheral clinics alternatively blood samples for CD4 are sent to the reference laboratory in the central STD clinic.

Infection control units are in place in all hospitals & health staff have been trained in clinical care & infection control and post exposure prophylaxis Standard precautions are practiced , however lapses occur as seen by increasing demand for PEP over the years.PEP is available in all districts, free of charge to the health care workers. Recently the guidelines for disposal of dead bodies were updated and a new circular issued by the Ministry of Health.

The policy decision of the Ministry of Health, to admit patients to general medical wards for treatment is being implemented. Paediatric care is provided at the leading children's hospital in Colombo and in all major hospitals .At present, the numbers of terminally ill patients requiring in-ward care is relatively low. However, reported data points to a rising trend in the number of HIV cases being detected annually and the number are expected to come forward for testing and seeking care with availability of ARV. NSACP has taken measures to improve the facilities at the Infectious disease hospital (IDH) for in-ward care. (Infrastructure development, improve diagnostic facilities –by providing laboratory/ human resource development) In-ward care provides for management of common opportunistic infections, counselling etc. At most of the peripheral STD clinics facilities are available to manage opportunistic infection including Cotrimoxazole prophylaxis..The facilities for, comprehensive management of STIs are available in all the STD clinics. MO STDs are trained in provision of ARV and following up of HIV patients.

Although the State has taken steps to provide ARV therapy to HIV/AIDS affected persons at present, the burden of care (home) rests mostly with the families. Among the many NGOs and CBOs, only four are known to provide care at community level including 2 PLWHA networks. Involvement of civil society, religious leaders and private sector in reducing stigma and discrimination and encouraging positive attitudes towards HIV Positive people will lessen the burden of the families.

The policy relevant to the provision of care and support for HIV/AIDS affected people such as non discriminative policy at work place and in health care setting creating enabling environment and protecting rights of HIV positive people have been included in the National AIDs policy. The ongoing sensitising programmes for health care workers aimed at providing facts on ART, adherence to treatment &, counselling, was an opportunity to dispel myths on HIV transmission and reducing stigma towards PLHA in the health care settings.

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV/AIDS?**

Yes **X** No

4. **Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

Yes X	No

IF YES, for which commodities?: [write in]

ARV/ condoms ,substitution drugs

5. **Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?**

Yes X	**NA**	NO

5.1 ***IF YES,*** is there an operational definition for OVC in the country?

Yes	No X

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes	No X

5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes	No X

IF YES, what percentage of OVC is being reached? Not applicable]

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?												
2007	Poor											Good
	0	1	**2**	3	4	5	6	7	8	9	10	
2005	Poor											Good
	0	**1**	2	3	4	5	6	7	8	9	10	

Comments on progress made since 2005: score 1 in 2003-2005

AIDs Orphans (due to one or both parents dying of HIV/AIDS) are an emerging concern in Sri Lanka.*9 children infected with HIV are being followed up at the HIV clinic and 5 are orphans.2 chldren are being looked after by a NGO and other 3 children are with their aunt or grand mother .

The revised National AIDs policy statement 5 indicates that Sri Lanka recognises the HIV issues in the vulnerable children and will be addressed through the National Child Protection authority, a special body which focuses on issues of child abuse and violation and neglect of child rights including the impact of HIV on children . A project was commenced in 2005-2006 for HIV prevention in 6 dropping centers , with the objective to reach street children & out of school youth to develop skills to protect them from STD / HIV and Child abuse .Staff at the dropping centers (6) were trained in life skill based HIV/AIDs education and children attending the dropping centers were educated on life skills and income generating activities and a day out for children was arranged by the NHAPP in 2005.Since it was found the attendees were more of those after school for day care & recreational facilities and not attended by the target population the project was discontinued in 2006.

The burden of AIDS orphans still falls on the family at present AIDs orphans are looked after by few NGOs and some instances by providing financial assistance to the family (NEST) looking after the AIDS orphans As mentioned earlier nutritional support is provided through WFP to affected families with financial problems.

In Sri Lanka Orphans are being taken care at state run children homes under the social services department and commissioner of social services is the custodian. However provision of care to AIDS orphans in these institutions has not been successful. NSACP conducted HIV/AIDS awareness programmes for the staff at orphanages to dispel myths and stigma.

The NSP 2007-2011 strategy on care, treatment states that NSACP support, the religious organisations and NGOs to engage in community based care for chronically ill and orphans. Engaging the private sector for generating financial assistance is another future option. A comprehensive action plan will be developed to address the above issues including relevant policy development.

NSACP in accordance to strategy on policy development will sensitise leaders in relevant sectors (education, social welfare, and police) on the need for sectoral policies in line with the National AIDs Policy to effect HIV/AIDs prevention activities through sectors which will facilitate addressing issues on OVC.

National AIDS Policy regarding children states, that Sri Lanka is concerned about the fact that children are victims of HIV throughout the world. A child could get HIV/AIDS from the mother, due to the commercial sexual exploitation of children and child sexual abuse. The National STD/AIDS Control Programme will work closely with the National Child Protection Authority. NCPA has been conducting a series of mass media programmes on prevention of child abuse and protecting rights of children, 24 hour hotline service is provided for advice & dedicated staff actively engaged in follows up action with the social services department. Legislations to protect children from violence, sexual abuse & child sex tourism are in place. A recently conducted research on child sex tourism funded by UNICEF has shown that SL is promoted as a paradise for child sex tourism, and awareness *among parents, children are low on prevalence, available legislature.*

Monitoring and evaluation

Does the country have one national Monitoring and Evaluation (M &E) plan

Yes	**No**	**In progress X**	Years covered 2007 -2011

1.1 *If yes*, was the M&E plan endorsed by key partners in M&E ? NA

1.2 IF Yes was the monitoring and evaluation plan developed in consultation with civil society, including people living with HIV?

Yes **X**	No

1.3 If yes have the key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan.

Yes, **all partners**	**Yes, most partners X**	**Yes, but only some partners**	No

2. Does the monitoring and evaluation plan include ?

A data collection and analysis strategy	**Yes * X**	**No**
Behavioural surveillance	**Yes X**	**No**
HIV surveillance	**Yes X**	**No**
A Well defined standardized set of indicators	**Yes * X**	**No**
Guidelines on tools for data collection	**Yes * X**	**No**
A strategy for assessing quality and accuracy of data	**Yes * X**	**No**
A data dissemination and use strategy	**Yes * X**	**No**

* The draft M&E plan is prepared including all above, and will be finalised and ratified with stake holder consultation.

3, Is there a budget for the monitoring and Evaluation plan

Yes	**No**	**In progress X**	Years covered 2007-2011

3.1 *If Yes*, has funding been secured?

Yes	No **X**

4. Is there a functional Monitoring and evaluation Unit or Department?

Yes	**No**	**In progress X**

If No what are the main obstacles to establishing a functional M&E unit or Department ? Not applicable

4.1 If yes is the M&E unit based

In NAC or equivalent?	Yes X	No
Based in Ministry of Health?	Yes X	No

Elsewhere? Not applicable

4.2 ***IF YES,*** how many and what type of permanent and temporary professional staff are working in the M&E Unit/ Department?

Number of permanent staff	1	
Position: Focal point / Head	Full time / part time ? **Full time**	Since When ? **December 2007**
Position: NA	Full time / part time ? NA	Since When ? NA
Position: NA	Full time / part time ? NA	Since When ? NA
Position: NA	Full time / part time ? NA	Since When ? NA
Number of temporary staff	1	

4.3. *If yes* , are there mechanism in place to ensure that all major implementing partners submit their M&E data reports to the M&E unit or department for review and consideration in the country's national response ?

Yes	No X

IF YES, does this mechanism work? What are the major challenges?
Not applicable

4.4 ***IF YES,*** to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low High

0	1	**2**	3	4	5

.

5. **Is there a committee or working group that meets regularly to coordinate M&E activities**?

NO	Yes but meets irregularly X	Yes meets regularly

If yes, Date of last meeting: November 2007

5.1 Does it include representation from civil society, people living with HIV?

Yes	**No X**

If yes, describe the role of civil society representatives and people living with HIV in the working group: Not applicable

6 Does the M&E unit manage a central national data base ?

Yes X	**No**	N/A

6.1 ***If Yes*** what type is it? NSACP managed a central database with limited data in the past 3 years at the NHAPP of activities funded through the WB.
NA
6.2 ***If Yes***, does it include information about the content, target population and geographical coverage of programme activities, as well as their implementing organisations

Yes x	**No**

6.3 Is there a functional * Health Information System?

National level	Yes **X**	No
Sub national level	Yes **X**	No

Comments

Routine data from the island wide 26 STI peripheral clinics on STD and HIV,at district level are collected ,aggregated and Quarterly reports are sent to the epidemiologist /Surveillance coordinator **at the National level** based in the NSACP using specific record forms and reporting formats. These include number and type of attendance at the STI clinics, number of episodes by types of STIs, mode of attendance (referrals, self. contact tracing), disaggregated by sex and age. In addition HIV sentinel surveillance data among high risk populations are reported annually to the centre. A report on sentinel survey is published annually. HIV data reported from health facilities (private and public Laboratories, private hospitals and general practitioners) are analysed and quarterly reports are issued.

. The STI data are aggregated and analyzed at the national level and published in the annual bulletin and sent to epidemiology unit where disease surveillance reports bulletins are published, monthly, quarterly and annually.

The district level data are reported at the monthly conference held at the office of the Provincial director of health ,with participation of the provincial health team including medical officer of health ,medical officer of maternity & child health /regional epidemiologist Planning officer and other public health officials. The provincial plans are implemented by the provincial health team collaborating with the MO/STD and the progress of the preventive activities are reviewed by the PDHS/DPDHS at the monthly conference and a quarterly progress report is sent to the centre (NHAPP) .Data is disseminated at the District and provincial AIDs committee meetings for advocacy.

Quarterly progress reports (physical & financial progress) are sent to the M&E focal point at NHAPP including (drugs, consumables, reagents and test kits, equipments and the status of the programme activities in the district funded by WB)

All the data are analysed at central level and used at the central level in programme evaluation and designing strategies in annual planning. Information on programme data is published in the Annual health bulletin of the Ministry Of Health.

.

The progress of the activities of WB funded activities through NHAPP is monitored at the highest level at the ministry of Health by the secretary and DGHS at regular progress review meetings & reported at the NAC and at many forums.

The surveillance data are reported at many forums regularly and especially at the communicable diseases committee of the ministry of health chaired by the Director General of health services /secretary of health where representatives of universities, academic associations, and ministry of health meet quarterly and at sentinel surveillance dissemination workshop annually with participation of the TB programme. And at the World AIDS day activities .

At present the use of data at district level is not satisfactory as the Administrative body for the peripheral STD clinics is the provincial health authorities and there is no system for regular reporting. Realising the importance of linking the STD clinics with the district and provincial health units , attention was given to these aspects in planning the programme MIS .

However gaps exist in collation of data at district level especially on preventive programmes conducted by other partners (NGOS) and other sectors which are not funded through health

(NSACP) .The collaboration & coordination with NGOs, CBOs at the district level need to be improved by giving a feed back and sharing data.

6.4. Does the Country Publish At Least Once A Year an M&E Report on HIV Including HIV Surveillance?

Yes	No **X**	N/A

Sentinel surveillance report is published annually by the NSACP. The quarterly reports on HIV /AIDS are sent to epidemiology unit of ministry of health and are included in the epidemiological bulletins disseminated by the epidemiology unit .The annual report of the NSACP is sent to the medical statistician to be published in the annual health bulletin of the ministry of health including STI and HIV surveillance data. However during the past few years the bulletin was not published annually although the data is collected every year due to logistics& financial constraints. The last report published was in 2004.
The NSACP has launched a website recently and in future this will include details of plans, important events & ongoing activities and results of surveillance, research and evaluations for public view. It's planned to hold a dissemination workshop once a year and to publish an annual M&E report from 2008 onwards.

.

7. To What Extent is M&E data Is Used In Planning And Implementation?

Low **high**

0	1	2	**3**	4	5

What are examples of data use?

***** For Strategic planning – the behavioral surveillance data were used to identify and redefine the MARP by their level of risk behaviours and trends in risk behaviors .The information such as gaps in knowledge on methods of HIV transmission and prevention , poor attitude to PLWA ,low uptake of HIV testing & condom use was used for evidence based planning of targeted interventions giving more emphasis to most at risk populations, re -designing the approaches (specific BCC methods to promote safe sexual behaviors and condom use, enhance utilization of services by out reach programs for MARP at district level in collaboration with NGOs and peer groups linking with STI services, developing specific IEC material for BCC)

The information from external review conducted in 2006 was made use of in evaluating program effectiveness and national response and to identify gaps. The recommendations were considered in strategic planning, in the areas of programme planning, developing a comprehensive monitoring and evaluation system, restructuring the functions of NSACP, increasing engagement of civil society in planning and implementing the strategies.

The findings of world bank review mission in 2006-2007 that the focus on interventions for high risk groups was inadequate lead to revision of the project implementation plan More emphasis has been given for interventions addressing high risk groups such as the CSWs, Drug users, Internal migrants and Transport workers, by engaging 5 NGOs to work in identified districts to deliver a specific service package including , BCC , VCT , STI services and condom promotion with more geographical coverage and monitored by provincial health authorities. External migrants and prisoners were reached through the respective sectors SLFEB of the labor ministry and prison department. Steps have been taken to develop a well structured advocacy program and political, administrative, opinion leaders, religious leaders, the media personnel and the judiciary and law enforcement authorities were already addressed.

For advocacy –
Information from surveys and programme reviews were disseminated to policy makers and higher officials for support and create a favourable environment to carry out preventive work .In the sectors , this lead to more commitment and support by higher officials including ministers recognizing HIV/AIDS as an important issue ,and paying attention for preventive work by internalization of HIV in to the existing programmes (incorporating in to training curriculum's , condom promotion, to provide STI services, peer training for BCC , counselling) , in defence , prisons and labour sector.
The need for updating the guidelines to suit the new challenges in the care & treatment of patients was realized and steps have been taken to develop new guidelines for PMTCT
Paediatric AIDs & HIV/TB and updating guidelines on PEP, STIs.
The data from research & surveys (operational research, audits on clinical management) were disseminated at the annual academic sessions of the college of venereologists highlighting areas that needs attention to improve quality of service delivery.

To obtain donor funds
Increasing demand for technical support and trained staff in the areas of care & treatment BCC, VCT , M&E ,infection control ,laboratory training , etc were highlighted in the external & internal reviews . As a result donor assisted capacity building programmes for several categories of staff were conducted. External expert's assistance were obtained through donors for developing a communication strategy, M&E strategy, strategic plan and costing of HIV response for the next 5 years.

For estimations and projections
Information from surveillance and research and routine data from monitoring systems were utilized for estimating number of PLWHA and make projections for ART needs (for PLWHA, PMTCT) AIDS deaths, and the state of the epidemic with /without interventions.

To guide planning surveillance (BSS , sentinel surveillance & research).
The Identified data gaps were taken in to consideration to improve existing surveillance systems such as including MARP in SS& BSS and STI surveillance ,to conduct BSS and SS every two years , plan a research strategy to identify future research needs to complement surveillance etc..

What are the main challenges for data use?

Reluctance or resistance by Policy makers and implementers accepting vulnerabilities based on scientific evidence (NGOS, provincial authorities to change focus), existing policies & laws that are not supportive for planning & implementing strategies for MARP and .Limited resources (human, funds, material) for dissemination of information to Different levels of policy makers, and implementers and the populations at risk are some of the obstacles for data use .The information on behaviours that are socially and culturally not approved lead to more discrimination and stigmatisation of the already marginalised groups such as MSM, sex workers Etc. and labelling of new groups as harmful. groups of populations (fisherman , three wheeler driver and factory workers .The disaggregated statistics locally may lead to more arrests or legal action (negative media reporting) and make the difficult to reach populations more hidden .

Quality of data, and timeliness of data

M&E is still considered as fault finding missions and reporting of poor performance leads to either poor reporting or providing data of low quality. The data is not sent regularly and on time for analysis and are not available for programme planning. Simple reporting mechanisms will improve the reporting of data.

Lack of understanding of the limitations in collecting data on behaviours lead to false interpretations and complacency..

The national communication strategy when finalized and implemented will address some of these issues while the proposed advocacy strategy to be completed in early 2008 with the objective of enhancing support from policy makers and implementing authorities leading to policy change will facilitate data collection .dissemination and implementing prevention interventions effectively

. A review of National policy and Laws is proposed to support the implementation of National AIDS Policy in HIV prevention.

(There was no formal unit responsible for collating all data, which is done in piecemeal by the surveillance coordinators and Epidemiologist .Analysis of data in dissemination of data.

No formal place & designated persons with identified roles & responsibilities, trained mainly on M&E and supportive staff, lack of equipments, logistic problems& Funds were the obstacles.

8, In the last year, was training in M &E conducted?

At national level If yes number trained	Yes **X** 130 all staff at NSACP	**No**
At sub national level If yes number trained	Y 1013 provincial staff	**No**
Including civil society If yes number trained	Yes X 3-4	**No**

Overall How Would You Rate the M&E Efforts of the HIV/AIDS Programme
2007 score **7**
2003 score **5**

Comments :
M&E is identified as a priority in the strategic plan 2007-2011.
External review recommendation for establishing a strategic information unit is being Implemented and a M&E unit will be operational in early 2008 with strengthened system of surveillance and research. A consultancy was engaged in 2007 to develop the M&E plan and is in place. National draft M& E frame work has been developed ,with set of National core indicators , incorporating relevant UNGASS& /.UNIVERSAL ACCESS indicators Dedicated staff identified to the M&E unit .Functions and roles of the key staff positions are being developed.
NSACP web site is in place linked to the ministry of health and the National strategic plan, with goals and objectives, surveillance reports; external review report, update on HIV situation, where STI services are available, and FAQ on HIV/AIDs are available for public view.
Comprehensive Patient management information system for STI & HIV with links to pharmacy, laboratory and administration is in place at the centre ,piloted and is expected to Function from January 2008. A manual to guide the data entry has been developed.
Web based Project & programme monitoring & tracking system is in operation for monitoring the prevention activities carried out by sectoral, NGO & provincial authorities.
Several work shops have been conducted for training of provincial staff , sectors and NGOS in M&E , including hands- on training on project monitoring system

First round of Behavioural surveillance has been completed and rich information on risk behaviours, gaps in knowledge on HIV prevention and transmission , taking up and availability of services ,exposure to intervention and source of information are available for programme & strategic planning .Annual sentinel surveillance conducted and impact indicators were collected

.
.
Research studies on community prevalence of STIs, operational research on quality of services in the STI clinics , drug resistance patterns for GC & Chlamydia were completed and research awards assessing stigma, PMTCT , epidemiological study MSM are being evaluated First round of Behavioural surveillance has been completed and rich information on risk behaviours, gaps in knowledge on HIV prevention and transmission , taking up and availability of services ,exposure to intervention and source of information are available for programme & strategic planning .
Research studies on community prevalence of STIs, operational research on quality of services in the STI clinics , drug resistance patterns for GC & Chlamydia were completed and research awards assessing stigma, PMTCT , epidemiological study MSM are being evaluated

Monitoring and evaluation is in-built in to the implementation strategies of the NSACP. The National AIDs Committee under the chairmanship of the Secretary Health reviews overall progress of activities. In addition, the select subcommittees: Care & support, Surveillance and research, IEC, legal Ethical and NGO, review activities relevant to each broad programme area. Both internal and external reviews of the programme are conducted and the recommendations are taken into consideration when formulating National Strategic plans.

Overall monitoring and evaluation will be strengthened with the construction of the (PMIS) data base that will facilitate extraction of data to determine whether programme goals and objectives are being met.

.

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE PART B

1. HUMAN RIGHTS

Many delays have been experienced in initiating action to draft legislation relevant to HIV/AIDS. Some of these issues have related to the constituting and functioning of the Legal and Ethical Issues Subcommittee. With the Ministry of Justice and Constitutional Affairs assuming chairmanship of the Committee, steps have been taken to initiate action with respect to many outstanding issues. Among these, the Ministry of Justice is awaiting concurrence of the Ministry of Health to proceed with consideration of the need for HIV /AIDS legislation related to all aspects of protecting the rights of the individual.

1. **Does the country have laws and regulations that protect people living with HIV against discrimination ?(such as general non-discrimination provisions or provisions that that specifically mention HIV. focus on schooling, housing, employment, health etc.)?**

Yes	No **X**
Comments: While agreeing that, all rights are as enshrined in the Constitution and applicable to all persons irrespective of their HIV status. (Education & health provided free in state run institutions) specific laws to protect persons living with HIV/AIDS from discriminatory events and occurrences and is not in effect. The revised National AIDS policy which has been ratified in 2006-2007, with the participation of all stake holders including civil society and PLWA has still not been formulated as a legal document. It has been opened for public comments and is awaiting ratification by the parliament to be gazetted as a law. The civil society has no access to the policy and therefore could not comment as its an effective National AIDs Policy. There has been a long delay over a year in the process. .	

2 Does your country have Non discrimination laws or regulations which specify Protections for vulnerable sub populations.

Yes **X**	No

2.1 ***IF YES*** for which sub populations?

Women	Yes X	No
Young people (adolescents and youth)	Yes X	No
*IDU	Yes	No X
*MSM	Yes	No X
*Sex workers	Yes	No X
Prison inmates	Yes X	No
Migrant /mobile populations	Yes X	No
Other *Children	Yes X	

Anti domestic violence bill

*Comments: Laws are currently lacking for prisoners, MSM & sex workers .No Mechanism in place to ensure these laws are practised. & having their desired effect

Laws for protecting international (external migrants) migrants especially to Middle Eastern countries for employments are enacted through the FEB of the labour ministry .Its compulsory to obtain pre departure registration in the FEB. The employer has to sign a bond to provide a minimum salary, and protection for employee. In case of Violence and sexual harassment legal AIDs /assistance is provided through SL high commission in the foreign country.

3. Does the country have laws and regulations or policies that present obstacles to effective prevention and care & support for vulnerable sub- populations?

Yes **X**	**No**	
If yes, for which sub populations : Women Young people IDU MSM Sex workers Prison inmates Migrants /mobile populations Others	yes **X** **X** **X** **X**	no

Sec 365 of Penal code which criminalises sodomy & same sex relationships is an obstacle to carrying out prevention and awareness efforts for MSM. It also is an obstacle in distribution of condoms to male prisoners. The vagrancy act /vagrancy ordinance also restricts the work with both male and FSW through vagrant act .The laws relation to drug use also hampers work with IDDU and drug users. However compulsory practice of contraceptive method (Depo-Provera) for a period of 3 months pre departure is reported.

4.**Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy /strategy**?

Yes X	No

Comments:
The revised national AIDs policy states that the Government of Sri Lanka recognizes that all People living with illness or disability, including people with HIV and AIDS are entitled to The Enjoyment of their fundamental human rights and freedom without any unjustified Restrictions.
These include the rights of everyone to life, liberty and security of person; freedom from inhuman or degrading treatment or punishment; equality before the law, absence of discrimination; freedom from arbitrary interference with privacy or family life, freedom of movement; the right to contract a marriage and have a family; right to work and to a standard of living adequate for health and well-being including housing, food and clothing; the right to the highest attainable standard of physical and mental health; the right to education, the right to information which includes right to know about HIV/STD related issues and the use of condoms, the right to participate in the cultural life of the community and to share in scientific Advancement and its benefit. However, steps shall also be taken to prevent persons from wilfully and knowing infecting HIV to other persons.
Civil society views that although NSP mentions about a NA policy & legislation it does not mention human rights specifically although it's mentioned under guiding principles for national response.
.

5 Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and /or most at risk populations.

Yes	No **X**

If Yes briefly describe the mechanism

Yes **X**	**No**

There is no formal mechanism currently, as any other person PLWHA also can go to courts and lodge a complaint for any HR violation. Or address the HR commission. However they are reluctant to come out and fight for claiming their rights. .

6.**Has the government ,through political and financial support ,involved vulnerable populations in government HIV-policy design and programme implementation**?

Situation is improving but not satisfactory. Only a symbolic presentation, not a meaningful involvement. The responsibility lie with PLWHA too as an individual or organisation they should be heavily and actively linked up with the authorities for understanding meaningful involvement by improving their skills.
Civil society were invited to NA Policy draft meetings initially, but do not know the out come and no access to a draft but participated in finalising NSP.

7. Does the country have a policy of free services for the following

HIV prevention services	Yes X	NO
ARV	Yes X	NO
HIV related care & support interventions	Yes X	NO

If Yes ,given resource constraints briefly describe what steps are in place to implement these policies.

Not familiar with related policies for these since not published yet. But all 3 areas are in operation and people are provided free of charge to any one require them through state sector via NSACP, Health education Bureau and Family health bureau.. People should be inducted on the related policies .ARV is provided free via NSACP. However supportive environment is not enough for PLWHA to come out.

8 **Does the country have a policy to ensure equal access, between men and women, to prevention ,treatment ,and care &support ,? In particular to ensure access for women outside the context of pregnancy and child birth?**

Yes X	**No**

9. Does the country have a policy to ensure equal access to prevention, treatment, care support, for most at risk populations?

Yes	**No X**

Comments:** refer above The draft policy states attention will be paid to encourage sex workers to be concerned about their own health and that of their clients. Steps will also be taken to prevent the harassment of sex workers. Resources will be allocated for interventions to protect male, female, trans-gender sex workers and their clients from HIV infections. All persons, irrespective of gender and their state of vulnerability to HIV/AIDS are entitled to equal access to preventive and curative care. At present policy is being framed as a basis to formulating laws relevant to vulnerable groups.

9.1 Are there differences in approaches for different most at risk population?

Yes	**No X**

If yes briefly explain

NSACP addresses treatment and general awareness campaigns but does not address specific human right concerns of MARP.

10. **Does the country have a policy prohibiting HIV screening for general employment purposes?**
(Recruitment,assignment,relocation,appointment,promotion,training, benefits)?

Yes	**No X**

***Are not aware of such*.**

11. **Does the country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national /local ethical review committe**e?

Yes	**No DNK**

If yes does the ethical committee include representatives of civil society and PLWHA

Yes	**No DNK**

Comments: Most of members were not aware. The university representative explained that ERC is functioning better than 2-3 years ago. ERC are present in most institutions, universities and private .Member of civil society is always included in the ERC. However no PLWA in any of those. No practicing policy as yet specifically.

12 Does your country have the following monitoring and enforcement mechanisms?

Existence of independent national institutions for the promotion and protection of human rights ,including human rights commissions ,law reform commissions, watch dogs and ombudspersons which consider HIV and AIDS related issues within their work.	**Yes X** *But HIV is not specifically mentioned*	**No**
focal points within governmental health and other departments to monitor HIV related discrimination in areas ,housing &employment	**Yes**	**No X**
performance indicators or benchmarks for a) compliance with human rights standards In the context of HIV and AIDS efforts	**Yes**	**No X**
b) Reduction of HIV related stigma & discrimination	**Yes**	**No X**

Comments if any:
The Human right commission, watch dogs are attending to general human right issues but not clear of their role related to HIV Issues.

13.Have members of the judiciary have been trained /sensitized to HIV/AIDS and human rights issues that may come up in the context of their work.?

Yes	**No X**

Civil society agreed that some sensitisation had been carried out but need to continue more.

14. **Are these following legal support services available in your country ?**

Legal aid systems for HIV and AIDS case work	**Yes**	**No X**
private sector laws firms or university based centres to provide free bono legal services to PLWHA IN areas such as discrimination .	**Yes**	**No X**
Programme to educate ,raise awareness among people PLWHA concerning their rights	***Yes X**	**No**

Legal aid provided not specific to HIV.
***** *Mainly through NGO/PLWHA*

15. Are there programmes designed to change societal attitude of discrimination and stigmatization associated with HIV /AIDS to understanding and acceptance?

	Yes X	**No**
If yes what type of programmes?		
Media	X	
School education		X
Personalities regularly speaking out	X	

Overall how would you rate the policies, laws, and regulation in place to promote and protect human right s in relation to HIV/AIDS?

2007 - score 0 1 2 **3** 4 5
2005 0 **1** 2 3 4 5

Overall how would you rate the efforts to enforce the existing policies, laws and regulations?

2007 score **2**
2005 score 2

11 **Civil society participation**

1. **To what extent has the civil society contributed to strengthen the political commitment of top leaders and national policy formulation?**

Score 0 1 2 **3** 4 5

2. To what extent has civil society representatives have been involved in the planning and budgeting process for the National strategic plan on HIV and AIDS or for the current activity plan. (Attending planning meetings and reviewing drafts?)

Score 0 1 2 **3** 4 5

3 To what extent are the services provided by civil society to areas prevention and care are included in

a) Both the national strategic plan and reports?

Score 0 1 2 **3** 4 5

b) in the national budget

Score 0 1 2 **3** 4 5

4 Has the country included civil society in a national review of the national strategic plan :

Yes X	**No**

If yes when was the review conducted? **2006**

5To what extent is the civil society sector representation in HIV related efforts inclusive of its diversity

Score - 1 2 **3** 4 5

List the types of civil society organisations representing civil society in HIV and AIDs

PLWA.MSM , Migrants, PLWHA, Policy development agencies ,drug prevention groups, micro economic development societies
There was a concern by PLWHA that these organisations represent their own agenda PLWA should be directly involved

6 T o what extent civil society able to access,

a) Adequate financial support to implement HIV action?

Low High
0 1 **2** 3 4 5

b) Adequate technical support to implement HIV action?

0 1 **2** 3 4 5

Overall how would you rate the efforts to increase civil society participation?

Poor											**good**
2007	0	1	2	3	4	5	**6**	7	8	9	10
2005	0	1	**2**	3	4	5	6	7	8	9	10

Comments on progress made.

NSACP efforts to include civil society on the World AIDs day, and planning, and has improved very much over the years .. It was requested to communicate planned actions to civil society more & regularly It was agreed that civil society also has a role to get involved by building their capacity and following up actions. It was commented that in the low prevalence, mass scale civil society involvement in all the activities is not warranted and few interested members always are present when invited.

However the civil society is finding difficulties in securing funds. This aspect has not improved, as the NHAPP mechanism of engaging NGOS is very complex.

111 Prevention

1. Has the country identified the districts (or equivalent geographical /decentralized level) in need of HIV prevention programmes?

Yes X NO

Districts where MARP concentrate (urban areas ,western province , tourist destinations , central province ,,Kandy Matale ,along beaches southern , northern belts.) Transport workers in Dambulle (long distance lorry drivers)
High prevalent districts identified from sero surveillance and geographic locations where large number of HIV positives are reported .

IF NO, how are HIV prevention programmes being scaled-up? NA
*Some interpreted this as **nationwide***

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	**The activity is available in**		
	all districts* in need	**most districts* in need**	**some districts* in need**
Blood safety	√ ,		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV			√
IEC on risk reduction		√	
IEC on stigma and discrimination reduction	**NA**	√	
Condom promotion		√	
HIV testing & counselling	√		
Harm reduction for injecting drug users			NA
Risk reduction for men who have sex with men	NA		√
Risk reduction for sex workers		√	
Programmes for other vulnerable sub-populations		NA	√
Reproductive health services including STI prevention &	√		

treatment			
School-based AIDS education for young people	NA	√	
Programs for out of school young			√
HIV prevention in work place		NA√	
Other [write in]			

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	**4**	5	6	7	8	9	10
Comments on progress made since 2005: No comments specifically. But addressing MARP has not been enough by the NSACP .However in the new NSP due attention is given. Suggested that targeting should be through specific messages; however it was acknowledged that during the NGO interventions, focus group discussions were held with the target groups for developing IEC material and they were not happy to have specific material for vulnerable populations, as they felt it discriminate them more.											

1V CARE & SUPPORT

1Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes X	No

Nation wide - was the response from some as they interpreted it as the health policy is to provide services to all who need care..

IF YES, to what extent have the following HIV and AIDS treatment, care and support

Check the relevant implementation level for each activity√or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	**The service is available in**		
	all districts* in need	**most districts*in need**	**Some districts*in need**
a. Antiretroviral therapy			√
b. Nutritional care		√	
c. Paediatric AIDS treatment		NA	√
d. Sexually transmitted infection management	√		
e. Psychosocial support for people living with HIV and their families			√
f. Home-based care		NA	√
g. Palliative care and treatment of common HIV-related infections	√		
h. HIV testing and counselling for TB patients			√
i. TB screening for HIV-infected people	√		
j. TB preventive therapy for HIV-infected people	NA		
k. TB infection control in HIV treatment and care facilities	**?**√		
l. Cotrimoxazole prophylaxis in HIV-infected people			√
m PEP for occupational exposure	√		
n HIV treatment in Workplace		NA	
• HIV care & support in work place • Including alternative working arrangement	**NA**		

*Districts or equivalent de-centralized governmental level in urban and rural areas

- *It was the consensus after discussion that as the number of PLWHA are still low and are distributed all over the country (some districts very few or no PLWHA) its fare to have few centres providing all the services while some services are provided through the district based STI clinics .The availability of some services such as for TB screening were not clear to the civil society. More communication as to the services available as mentioned above is needed.*
- *There was not much of a disagreement with the government comments on the same.*

Overall how would you rate the efforts in the implementation of HIV treatment ,care & support in 2007 and 2005

2007 **5**
2005 **2**

The requests from the civil society to go forward,

- *The National AIDS policy to be approved by the parliament and the policy is in place not later than July 2008.*
- *Archiving all activities on HIV/AIDS in the programme and communicated to civil society.*
- *Funding will be affected with out a policy*

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	***<25%**	**<25-50**	**50-75%**	**>75%**
Prevention for vulnerable population				
IDU	***<25%**	**25-50%**	**50-75%**	
MSM	**25%**	**25-50**	**50-75%**	***>75%**
Sex Workers	**<25%**	***25-50%**		**>75%**
Counselling & testing	**<25%**	****25-50%**	**50-75%**	**>75%**
Clinical services (OI/ ART	***25%**	**25-50%**	**50-75%**	**75%**
Home based care	**<25%**	**25-50%**	***50-75%**	**75%**
Programs for OVC	**<25%**	***25-50%**	**50-75%**	**75%**

*** Counselling services are provided by NGOs , however on -site testing not offered Refer to STI clinics for testing. Government comments were similar*

4. Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?

Majority did not know.

Yes	NO	**NA**

5.1 **IF YES,** is there an operational definition for OVC in the country?

Yes	No NA

5.2 **IF YES,** does the country have a national action plan specifically for OVC?

Yes	No NA

5.3 **IF YES,** does the country have an estimate of OVC being reached by existing interventions?

Yes	No NA

IF YES, what percentage of OVC is being reached? Not applicable]

Score	2007	2
Score	2005	2

Comments on the progress from 2005

AIDs Orphans are an emerging problem in Sri Lanka and only a single NGO - NEST looks after the AIDs orphans, the burden falls on other family members. Civil society takes note that in future the country needs to address the issue and make a plan of action.

Annexure 1

Consultation/ Preparation process for the national report on monitoring the follow – up to the Declaration of Commitment on HIV/AIDS.

1] Which institutions /entities were responsible for filling out the indicator forms?

a)	NAC or equivalent	Yes	No	
b)	NAP	Yes **X**	No	
c)	Others	Yes X		No

2) With inputs from

Ministries :	Education	X
	Health	X
	Labour	X
	Foreign affairs	
	Other	
Civil society organizations	X	
People living with HIV/AIDs	X	
Private sector	X	
UN organisations	X	
Bilaterals	X	
International NGOS	X	
Others NGOS	X	

3) was the report discussed at a large forum?	Yes
4) Are the survey results stored centrally?	Yes
5) Are data available for public consultation?	Yes

Name/Title

Dr N Edirisinghe

Director, National STD/AIDS Control Programme

Date 31st JANUARY 2008

Signature