COUNTRY PROGRESS REPORT
Sri Lanka
2010-2011

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SRI LANKA

Reporting period: January 2010-December 2011

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List of Acronyms

ANC	Antenatal clinics
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioural Surveillance Survey
CCC	Ceylon Chamber of Commerce
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHBC	Community Home-Based Care
CSDF	Community Development Services Foundation
CSO	Civil Society Organisation/Non-Governmental Organization
CSR	Corporative Social Response
DMH	De Soysa Maternity Hospital for Women
ECS	Elimination of Congenital Syphilis
EFC	Employment Federation of Ceylon
ELISA	Enzyme Linked Immunosorbent Assay
EQAS	External Quality Assessment
FHB	Family Health Bureau
FHI	Family Health International
FPA	Family Planning Association
FSW	Female Sex Worker
GAMCA	Gulf Approved Medical Centers Association
GDP	Gross Domestic Product
GFATM	Global Fund on AIDS, TB and Malaria
GOSL	Government of Sri Lanka
HEB	Health Education Bureau
HSV	Herpes Simplex Virus
HPV	Human Papilloma Virus
ICS	Immuno Chromatographic Strip test
ICAAP	International Conference in AIDS in Asia Pacific
IDH	Infectious Disease Hospital
IDP	Internally Displaced Persons
IDU	Injecting Drug User
IEC	Information, Education, Communication
ILO	International Labor Organization
IVDU	Intravenous Drug Users
ISA	In-Service Assistants
ITI	Industrial Technology Institute
JKSRF	John Keels Social Responsibility Foundation
LGBT	Lesbians, gay, bisexuals and trans-genders
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MCH	Maternal & Child Health
MDG	Millennium Development Goals
MLT	Medical Laboratory Technicians
MOH	Ministry of Healthcare & Nutrition
MO/STD	Medical officer of sexually transmission disease clinic
MSM	Men having Sex with Men
NAC	National AIDS Committee
NBC	National Blood Centre

NBTS	National Blood Transfusion Service
NCPI	National Composite Policy Index
NDDCB	National Dangerous Drugs Control Board
NGO	Non-Governmental Organization
NHAPP	National HIV/AIDS Prevention Project
NIE	National Institute of Education
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
NVP	Nevirapine
NTB	National Tuberculosis Programme
OSH/HR	Occupational Safety Health and Human Resources
PDHS	Provincial Director of Health Services
PEP	Post Exposure Prophylaxis
PHI	Public Health Inspector
PHM	Public Health Midwives
PHN	Public Health Nurse
PHNS	Public Health Nursing Sister
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RDS	Respondent Driven Sampling
SAARC	South Asian Association for Regional Corporation
SIM	Strategic Information Management Unit
SLBFE	Sri Lanka Bureau of Foreign Employment
SLSI	Sri Lanka Standards Institute
SR	Sub-Recipient
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TOT	Training of Trainers
TTI	Transfusion Transmitted Infections
UAE	United Arab Emirates
UNHCR	United Nations High Commission for Refugees
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
VCCT	Voluntary Counselling and Confidential Testing
VD	Venereal diseases
WB	World Bank
WHO	World Health Organization
YFHS	Youth Friendly Health Services
ZDV	Zidovudine

I. Status at a glance

Currently Sri Lanka is experiencing a low level HIV epidemic. The estimated number of people living with HIV as at end 2009 was 3000 and the estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Survey data observes that even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1%. As at end December 2011, a cumulative total of 1463 HIV persons were reported to the NSACP. The main mode of transmission is due to unprotected sex between men and women (82.8%). Men who have sex with men have accounted for 12.3% of the transmission while mother to child transmission was 4.4%. Transmission through blood and blood products was 0.4%. Injecting drug use in Sri Lanka is not a common phenomenon (0.5%). However, certain socioeconomic and behavioral factors which are present in the country may ignite an epidemic in the future. The presence of a large youth population, internal and external migration, clandestine but flourishing sex industry, low level of condom use, concurrent sexual relationships among most-at-risk-populations (MARP) are some such factors. Low level of sexually transmitted infections (STI), availability and accessibility to free of charge health services from the state sector, high literacy rate, low level of drug injectors, are factors considered to be protective.

The National AIDS Policy of Sri Lanka has been approved by the Cabinet of Ministers in 2011. The policy focus on prevention, treatment, care and support for all citizens in a non discriminating environment where the protection of fundamental rights are upheld to the highest standards as enshrined in the Constitution of the Democratic Socialist Republic of Sri Lanka.

Currently Sri Lanka is in the process of developing the National Strategic Plan for HIV for 2012-2016.

In 2010, a mapping exercise was conducted to map the female sex workers and men who have sex with men. Four districts were covered in this process and population sizes were extrapolated to the whole country. The estimated FSW and MSM were 41,000 (35,000 - 47,000) and 31,000 (24,000-37,000) respectively.

NSACP continued its collaborative efforts with the National Blood Transfusion Service in maintaining the spread of HIV through transfusion of contaminated blood at low levels. During 2010 and 2011 only one transfusion related HIV infections were reported in the country. Prevention of mother to child transmission of HIV is being addressed using the four prong strategy recommended by WHO/UNICEF and the main focus is on the first prong considering the low HIV prevalence in the country.

The annual sentinel sero surveillance which took place since 1993 will now be conducted once in two years from 2007 onwards. The routine survey which was carried out in 2011 including female sex workers, MSM, drug users continued to observe the low prevalence of HIV.

During the reporting period the GFATM funds were mobilized for interventions among Female sex workers, in school youth, plantation sector workers and provision of antiretroviral therapy (ART). Preparations have been made to intervene MSM, Beach boys and drug users commencing from 2012.

Successive governments in Sri Lanka adopted a policy of providing free health services to people from the state sector. In keeping with this policy ART is being offered in the government sector

since 2004. Due to close monitoring, counselling and services provided by the NSACP and other treatment centers the default rates were low.

The STD clinics continued to carry out primary prevention interventions together with other stakeholders and also provide comprehensive STI management to interrupt the transmission of STI and HIV. Voluntary counseling and testing services were strengthened in the STD clinics with refresher training courses for counselors. The medical and paramedical staff was trained in counseling, and STI data management during the years under review.

Since beginning of the epidemic, Sri Lanka has worked towards a comprehensive HIV/AIDS programme with political leadership, recognizing the importance and value added of effectively engaging all relevant sectors and planning evidence based interventions.

II. Overview of the AIDS epidemic

Sri Lanka is classified as a country with a low level epidemic of HIV in the South-East Asia region. According to UNAIDS estimates, around 3000 people were living with HIV as at end December 2009. The estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1%. The female sex workers and their clients, men who have sex with men, injecting drug users are identified as the most at risk populations in the country. Although classified as a middle- income country, with a population of almost 20 million, Sri Lanka, has achieved remarkable social and health indicators some of which are in par with those of developed nations.

In order to track the level of HIV infection in different sub populations and to provide strategic information for policy and programme development, the National STD/AIDS Control Programme (NSACP) has been conducting annual HIV sentinel unlinked sero-surveillance (SS) since 1993. Low HIV prevalence levels were observed over the years and this was maintained in 2008/09 even among the most at risk populations (Table 1).

Table 2. HIV Sero-prevalence among sentinel population groups in Sri Lanka during last 5 years

Population group	Year of sentinel surveillance survey					
	2005	**2006**	**2007**	**2008**	**2009**	**2011**
Female sex workers	(0%) 0/1136	(0.2%) 2/1,216	(0%) 0/1218	Not included	(0%) 0/1032	(0.2%) 2/1006
MSM	Not included	Not included	Not included	(0%) 0/242	(0.48%) 2/411	(0.9%) 3/349
Drug users	Not included	Not included	Not included	(0.19%) 1/539	(0%) 0/1004	(0.2%) 2/831
STD attendees	(0.04%) 1/2272	0.4% 8/2,215	(0.08%) 5/2456	Not included	(0.15%) 4/2746	(0.2%) 6/3276
TB patients	(0.1%) 2/1528	(0.1%) 1/1,332	(0.08%) 1/1233	Not included	(0%) 0/1547	0.1% 1/1416
Military	(0%) 0/3200	(0%) 0/1200	(0%) 0/1241	Not included	(0%) 0/1380	(0%) 0/1200

No significant changes in the HIV prevalence were noted over the years among the subpopulations included in the sero-surveillance.

The National AIDS Policy encourages HIV testing counseling and disallows mandatory testing. HCT services are available at STD clinics. STD clinic attendees are offered the HIV test routinely and testing is done with consent following counseling. Provider initiated counseling and testing is carried out in hospital settings when signs and symptoms or medical conditions are suggestive of HIV/AIDS. The private sector carry out HIV testing for pre-departure external migrants at the request of the destination country and the screening test positive samples are referred to the NSACP for confirmation of HIV infection but data on the numbers tested carried out in these settings is not supplied to the NSACP routinely. Donated blood is routinely screened for HIV in the respective blood centers. Data from such sources reveal the following important epidemiological information.

Almost three decades since the detection of the first HIV infection in Sri Lanka, as at December 2011, a cumulative total of 1463 HIV infections have been reported to the National STD/AIDS Control Programme. Of them, 374 have been reported as AIDS and 253 have succumbed to the illness. Over

the years a slow but a gradual increase in the number of reported cases is observed in part due to the increase in testing. Availability of ART free of charge in the country has encouraged more people to come forward for HIV testing.

The majority (80%) of those infected were in the 25-49 year age group. The current ratio of HIV positive men to women in Sri Lanka is 1.4:1. It is important to note that women are over represented in testing since a large number of migrant women undergo pre departure mandatory testing as a requirement of the destination country.

HIV infection due to blood and blood products has been extremely low (0.4%). Only 4 cases of transfusion related HIV infections have been reported. The blood safety policy adopted in Sri Lanka since 1988 has helped to maintain this low prevalence. Government sector blood banks carry out HIV tests as per standard operational procedures on all donated blood prior to transfusion.

The Harm Reduction Network estimates that there are almost 240,000 opiate users and the National Dangerous Drug Control Board(NDDCB) estimates that there are about 45,000 heroin users and 20,000 cannabis users in the country. According to NDDCB estimates, less than 2% of the heroin users are injectors. At present injecting drug use is practiced only by a very few.

Vertical transmission was accountable for 4.4% of the total reported cases. The sero-positivity among antenatal mothers has been low.

Certain socio-economic, cultural, behavioral and health related factors such as high literacy rate, accessibility and availability to free health services including STD services, high school enrolment rates, high levels of gender equality, the relatively high status of women, low levels of injecting drug use may be helping to keep HIV infection at low levels. On the other hand there is a sizeable number of MARP operating in the country. Although soliciting sex is illegal, the sex industry is flourishing and the mapping exercise has estimated that there are 35,000-47,000 sex workers in the country. The estimate for MSM is 24,000-37,000. In addition to the presence of most at risk groups such as female sex workers and their clients, MSM including beach boys and the practice of high risk behaviors such as low consistent condom use, multiple partnerships among them are potential risk factors for the spread of HIV. Consistent condom use among female sex workers during the last sexual act with a paying partner was in the range of 80-95% and 64% among men who had sex with another male partner. Since consistent condom use with all types of partners is low among sex workers and MSM exposes them to the risk of HIV infection. Although the injecting drug users are few in number, the ones who inhale and snort drugs do engage in sex with other men and patronize the sex trade. Although not sizeable but overlapping sexual behaviors among female sex workers, MSM and drug users would be a potential threat to the spread of HIV in the country. The proportion of men who visits female sex workers is estimated to be 3.5% of the total male population. However, the daily clients turn over in the sex trade is low. The BSS (06/07) observes that the number of clients per female sex worker is between 1.6-3.3 during the last working day. A study among MSM (2008) has shown that the average number of male partners for a year was 6.8. More data on concurrent sexual relationships among these groups will throw light on the future of the epidemic and planning targeted interventions.

Low STI rates have been observed among MARPs and in the general population. Similar to the global trends, the STI surveillance data shows that the bacterial STI are declining but viral STI (HSV and HPV) trends are increasing. Genital herpes is the leading STI in the country.
The BSS carried out in 2006/07 has shown that relatively low levels of risky behaviors take place among vulnerable groups such as three wheel drivers and factory workers in the free trade zone

Vulnerability factors such as separation of spouses due to overseas migration appear to be posing a threat to the HIV burden in Sri Lanka. Since the detection of the first HIV infection in Sri Lanka it was observed that a significant number of HIV infections are being diagnosed among external migrant workers. The available data reveals that 40% of HIV infected females have acquired the infection probably outside the country.

III. National response to the AIDS epidemic

The Government of Sri Lanka (GOSL) has responded to HIV/AIDS even before the detection of the first HIV infection in Sri Lanka. The Anti VD Campaign which was established in 1952, based on a British Model for control and prevention of venereal diseases was restructured in 1985 and was named National STD/AIDS Control Programme (NSACP). The GOSL is fully committed to the prevention and control of HIV/AIDS in the country and has recognized it as a developmental issue with social and health implications and responded by the formulation of policies and series of strategies with broad participation of all stakeholders. The NSACP which comes under the purview of the Ministry of Health is spearheading the national response with all other stakeholders of the health and non- health state sectors, non-governmental organizations, business community, people living with HIV in its multi-sectoral, decentralized approach. The three ones principle guides the national response, one multi sectoral strategy, one national comprehensive strategy and one HIV/AIDS monitoring and evaluation framework. The first Medium Term Plan launched in 1988, followed by the second in 1994, National Integrated Work Plan (1998) and the National HIV Prevention Project (2003-2008) under a grant from the World Bank/International Development Association have helped in maintaining a remarkably low level of spread of HIV among both the general population and individuals considered at higher risk on the basis of their sexual behaviors and practices. The award of the Global Fund for AIDS Tuberculosis and Malaria (GFATM) six round grants has helped in the implementation of interventions to curb the spread of HIV infection.

The National AIDS Committee (NAC) which was formed in 1988 as the policy formulating body of the Ministry of Health on HIV/AIDS continued its commitment by overseeing implementation of the response to HIV/AIDS during the years 2008/09. The NAC which is chaired by the Secretary for the Ministry of Health care & Nutrition (MOH), with representation from various government, non government, civil society and people living with HIV/AIDS was restructured in November 2009 to improve inter sectoral collaboration. Six subcommittees, namely prevention, treatment, care and support, advocacy & communication, multisectoral, policy, legal and ethical, strategic management & information, are set up to deal with operational issues and make recommendations to the NAC concerning the national response. The National AIDS Policy was ratified by the Parliamentary Cabinet of Ministers in 2011.

The goal of the National STD/ AIDS Control Programme (NSACP) is to maintain the current low prevalence of HIV infection with targeted prevention interventions to the most at risk populations (MARP) and also to other vulnerable groups and the general population and scaling up care, support and provision of treatment anti retroviral therapy (ART) and mitigating stigma and discrimination to improve the quality of life of people infected with or affected by HIV. The National Programme provides both preventive and curative services together with a network of 28 peripheral STD clinics distributed island wide Guiding principles for the national HIV/AIDS response are strategies based on evidence, respect for human rights, gender considerations and involvement of PLHIV. Two core strategic objectives namely 1) increased coverage and effectiveness of prevention interventions 2) increased coverage and effectiveness of care, support and treatment interventions and four supportive objectives 1) Improved generation and use of information for planning and policy development 2) increased involvement of relevant sectors and levels of government in the response 3)more supportive public policy and legal environment for HIV/AIDS control 4)improved management and coordination of the response have been identified. In 2011, the indicator frame work was updated with the objective of monitoring and evaluating the national response. The National M&E framework will help in tracking the epidemic with its indicators which are grouped into five key priority areas: prevention; care, support and treatment; policy development and legislation; strategic information management and strengthening national coordination and management capacity. These indicators reflect the national information needs.

The following programme areas continued to function in 2010/11 to achieve the above mentioned objectives;

- HIV Care, Support and treatment
- Comprehensive Management of STI
- Counseling
- IEC activities targeting the general public and specific risk groups.
- STD/HIV surveillance system.
- Condom promotion in prevention of transmission of STD/HIV infections.
- Laboratory facilities
- Screening blood and blood products
- Instituting Infection control measures including universal precautions in all medical institutions and in the field services.

The NSP has moved towards greater integration of HIV related activities with other health, development and sectoral activities. In such a backdrop towards achieving its goal, the national programme continued to direct the national response through planning, monitoring and coordination of all stakeholders such as health sector organizations e.g. Family Health Bureau, Health Education Bureau, National Blood Transfusion Services, National Respiratory Disease Control Programme and other Government non-health, Ministries such as Ministry of Labor, Education, Dept of Prisons, Sri Lanka Bureau of Foreign Employment and the Tri-Forces, and several CSOs distributed island wide and organizations of PLHIV. With the devolution of administrative powers under the 13th amendment of the Constitution of Sri Lanka, the provincial health services including HIV/AIDS comes under the purview of the Provincial Director of Health Services (PDHS). The majority of STD clinics come under the provincial administration. The peripheral STD clinics which are manned by a trained medical officer together with its public health team carry out community based field services and curative care with technical guidance from the NSACP. The primary health care personnel, civil society organizations work in partnership with the STD team.

During the reporting period, the main strategy was to scale up the coverage of comprehensive prevention interventions among those most at risk with priority given to sex workers and clients, men who have sex with men (MSM) and partners, drug users and prisoners. Since sex work, drug use and sex between men are barely tolerated and is illegal and is frequently looked down upon by society there are limitations in mounting and supporting effective prevention efforts focusing on people at the highest risk of HIV in the country. Over the last four to five decades, government health services are provided free of charge to all citizens and in this background in 2004, a policy decision was taken by the Government to provide ART free of charge to PLHIV in the Government sector. Both first and second line drugs, adult fixed dose combinations are available. Availability and accessibility to treatment, support and care services for PLHIV and their families were enhanced during the reporting period.

IV. Best practices

Tracking the epidemic

Unlinked sentinel surveillance was first introduced in 1993 to track the level of HIV infection in different sub populations and provide information for policy and programmes development. Several stakeholders from the health, and CSO assist the NSACP to conduct this annual event. The data collected from sentinel surveillance was used to track the epidemic, make estimates of MARP in the country.

The Strategic Management Unit (SIM) was established in 2009 and is expected to improve collection of strategic information, analysis and generation of evidence based information for dissemination to programme planners for the development of district level plans in accordance with national policies and strategies.

National STD/AIDS Control programme launched it is official website in 2011. This enabled information dissemination to all stakeholders.

Another significant achievement is the implementation of the online Patient Information Management System (PIMS). All STD clinics can log into the PIMS and enter STI patient related data using this system. Since January 2011, 5 STI clinics started using this new online system.

Supply of HIV free safe blood

Sri Lanka is one country in the South Asia region which has been able to keep the spread of HIV by transfusion of contaminated blood at an extremely low level. The success is due to the blood safety policy adopted in 1988. A policy decision was made by the Government of Sri Lanka to screen all donated blood collected in the government blood banks for HIV and other transfusion related infections. The National Blood Policy of Sri Lanka was presented to the Parliament and the Transfusion act has been enacted. A private Medical Institutions Bill that incorporates legislative powers to the Ministry of Health in respect of private health care facilities to regulate private sector blood banks has also been approved by Parliament.

Provision of STI services

The STI services in Sri Lanka was established in 1952 and since then control and prevention interventions have been taking place in a systematic manner. The NSACP consists of an administrative wing and treatment and care service which is supported by the National Reference Laboratory and it networks with 30 island wide STD clinics. All STD clinics are manned by a trained medical officer. The other medical staff is also trained in various aspects including delivery of clinical care without stigma and discrimination, counseling, laboratory services. Primary prevention activities are carried out by a public health care team and are assisted by primary health care staff in the respective areas, CSOs and PLHIV. The roles and responsibilities of the primary health care providers such as MOH, PHMW, PHNS, PHI were revisited and confirmed by the Deputy Director General of Public Health Services in 2009. The public health team carries out awareness, behavior change communication programmes for MARP and the general public. Comprehensive management of STI is done on an etiological or syndromic basis depending on the availability of laboratory facilities. Treatment protocols for etiological and syndromic management of STD in Sri Lanka are available in all centers. Drugs for STI treatment including ceftriaxone, cefuroxime, doxycycline, metronidazole, acyclovir are available in all STD clinics. STD services are available to all and are free of charge in the government sector. Counseling, partner notification, condom promotion and

provision are included in the package of services. All STD attendees are offered HIV testing and counseled before testing. Confidentiality is maintained during pre and post test counseling and examination for STI. STD clinics serve as VCT centers. The STD services play an integral part in screening antenatal mothers for syphilis. All mothers diagnosed with syphilis are treated and followed up at STD clinics and the management of infants is carried out in coordination with the pediatrician. The antenatal screening programme is monitored at the monthly MOH conference. With the launch of the ECS programme the RDHS is responsible in the smooth delivery of this service at district level.

Data from STD Clinic are collected using standard formats and is entered into various registered by trained staff. Quarterly returns are submitted to the center where data are analyzed and used for policy and programme planning. The STI data over the years shows a declining trend of bacterial infections with an increase in viral STI.

Mapping and size estimation of key populations at risk (FSW and MSM) in Sri Lanka

As yet, evidence suggests that the HIV epidemic in Sri Lanka remains at a relatively low level. However, experience from other countries in South Asia have shown that concentrated HIV epidemics involving vulnerable key populations can expand quickly within those sub-populations and affect the wider population through “bridge populations” (usually men who have sexual partnerships with both members of higher risk key populations and lower risk partners).

Therefore, to prevent the establishment and potential expansion of an HIV epidemic in Sri Lanka a key strategy will be to reduce the potential for transmission in important networks of vulnerable key populations, particularly where such networks are large and dense and therefore prone to rapid HIV transmission within and from these networks. The first key step in developing targeted interventions for vulnerable key populations is assessing their location, size and basic operational characteristics. Experience in diverse settings of South Asia has shown that structured mapping can provide accurate estimates of the size and location of key populations and thereby provide guidance for the scoping and targeting of HIV prevention programs and services.

The National STD/ AIDS Control Programme established a steering group to guide this initiative with membership drawn from the NSACP, senior ranking law enforcement agents, the two implementing community based organizations (Companions on a Journey and Community Strength Development Foundation) and the UN system. Technical assistance was provided by the World Bank through the University of Manitoba, who provided experienced staff from both India and Pakistan. The two key community based organizations received a comprehensive training, where a pilot methodology was field tested.

Hot spots for Men who have sex with men and female sex workers have now been mapped in 4 of the 25 districts across the island. Initial results from the mapping exercise will provide clearer estimates of numbers and locations making at-risk populations easier to reach with prevention services. The methodology has been adopted by the NSACP for scale-up to further 10-13 districts under the Global Fund round 9 interventions with implementation starting in late 2010.

V. Major challenges and remedial actions

To convince some leaders and policy makers of the importance of addressing issues on HIV/AIDS is a challenge due to current low HIV prevalence in the country.

The national drug policy has not adequately considered the risk of HIV transmission through IDU and with the next revise this issues should be given due consideration. Harm reduction practices need to be introduced and if the policy environment is conducive this intervention could be introduced overcoming stigma and discrimination.

Sri Lanka is a high labor exporting country. Evidence shows that external migrant workers are importing the infection to Sri Lanka and steps should be taken to minimize their vulnerabilities in destination countries and also adopt a mechanism to promote VCT for the returnees. Currently migrants are not considered as MARPs. Less prominence is given to this group as they are not considered as a group which would ignite a chain of infections.

Currently routine data are collected only from public STD clinics on a quarterly basis. However this data is collected and submitted manually. STD clinics have no IT facilities. Capacity should be built to collect and analyze data in a less cumbersome manner and facilitate timely dissemination of data smoothly to all stakeholders. There is a scarcity of data at the national level particularly from the CSO and other stakeholders and steps should be taken to establish a system of flow data to the National programme from all stakeholders.

Most of the data from surveys cannot be used for national planning and implementation as they are conducted on selected populations and using sampling methods which cannot be generalized to the specific populations.

Need to build the capacity of M&E unit to overcome some of the constraints described above. Need have uninterrupted and sufficient funds and personnel with IT experience to carry out M&E activities. However amid these constraints HIV and STI surveillance data are disseminated by annual reports and through the web site of the national programme whenever possible.

Although the NSACP is able to carry out the baseline basic tests some tests are not available in the central laboratory. Since the numbers of samples are also small purchasing equipments for such tests is not feasible. As an alternative the private sector hospital laboratories should support the NSACP in carrying out some of these tests. Although it is necessary to scale up treatment, care and support and establish ART centers at Provincial Hospitals it may not be effective if facilities are not available.

Reducing stigma and discrimination is a challenge especially because the problem of HIV/AIDS is invisible in the low prevalence situation. Media communication strategy should be planned with the relevant stakeholders.

Although sentinel surveillance has been an ongoing activity STD staff fails to enroll the identified sample size of most of the sentinel groups especially female sex workers and MSM. The CSO should support the government sector as the link between MARP and the STD clinics in some areas is not strong. Capacity building opportunities for the STD clinic staff should be explored as it is mandatory to work with the MARPs. Special training on novel methodologies on MSM/FSW/DU networking and strategies which can be adopted in winning the confidence of MARPs should be considered.

Improve the funding for the sentinel surveillance. CSOs working with the MSM and FSW provide monitory or materialistic incentives for the MARPs members. As such it is very difficult for the government STD clinic staff to work with those groups as they expect similar incentives from the government sector for their participation. Due to insufficient funding incentives were not provided to date. Further, some payment should be allocated for STD clinic staffs who work after normal working hours.

CSOs have limited technical capacity in programme planning and implementation. Capacity building is vital. Need to strengthen networking and linkages of the few CSOs working on HIV. Need to create and strengthen additional civil society groups led by MARPS. Establishment of an effective coordinating mechanism between government and civil society is necessary to enrich further the national response. Lack of in-country financial commitment to continue the prevention progammes will jeopardize the existing prevention interventions.

The scaling up of treatment, care and support activities is addressed through the proposal to complement those that are being implemented currently with Global Fund Round 6 grant resources component with the first two key care strategies of the National HIV/AIDS Strategic Plan 2007 – 2011: Increased quality and use of voluntary confidential counselling and testing services and increased quality and coverage of HIV and AIDS treatment services.

Prevention

Prevention efforts will be the responsibility of the Nongovernmental PR a leading CSO, named Sarvodya, through 3 sub Recipient(SR) CSOs with experience in working with MARP (MSM, CSW, DU) with technical support and procurement of commodities and pharmaceuticals by NSACP.

Targeted Interventions

A comprehensive package of services to deliver targeted interventions for MARP were agreed upon based on strategic evidence (BSS, research and programme records) and experience of organisations working with MARP during several stakeholder consultations (CSOs working with MARP, members of key populations, NSACP, academics & professional bodies). Peer led education on safe sex/drug using practices, condom promotion, STI services and VCT will be an effective intervention. Action will be taken to monitor drug using behaviour and setting environment for harm reduction interventions for IVDU if the need arise.

Advocacy at two levels to create enabling environment to implement these activities are planned. At the central level for hierarchy, political leaders, policy makers etc and local advocacy for the law enforcement officers, authorities, local administrators ,community leaders and gate keepers etc.

Capacity building of civil society

Strengthening of the capacity of CSOs currently working with MARP ,and development of civil society groups composed of key populations at higher risk to lead the response to HIV in their own communities is given attention .This includes establishing networks for organizations and agencies who work, or want to work, with key populations at higher risk. Technical assistance in institutional development of small CSOs also been proposed.

Mapping and size estimations

A major gap in strategic information, social mapping and reliable population size estimates that can be agreed upon by consensus in order to determine coverage of prevention services were listed as a priority activity covering 13 districts. The mapping exercise commenced in 2009 in 5 districts will provide methodology and implementing issues.

Strategic information, monitoring and evaluation

Due attention is given for strengthening second generation surveillance (conducting IBBS) national size estimation of key populations, estimating PLHIV and formative and operational research.

Strengthening of M&E system is identified as a key area to meet the gaps identified. A a comprehensive M&E plan including time bound targets, set of indicators and data collection strategy and tools agreed upon by the implementing partners is developed. A specific budget for M&E activities is identified for strengthening of the SIM unit, human resource development, program and project monitoring system and a joint monitoring mechanism is proposed for better coordination of the implementing partners and the PR and sub recipients.

Care and support to PLHIV

Participation of PLHIVs in provision of care and support to target population is encouraged in this proposal through engaging them in developing and delivering a package of services including counseling and advice on treatment preparedness, nutrition, spiritual matters, and sexuality.

Provision of supportive environment to PLHIVs and MARPs seeking care at STD clinics will be addressed through training of health care workers on informed consent, confidentiality and non discriminating attitudes towards the target populations.

Key strength of the proposal is that a participatory approach was used involving key stakeholders (government, CSOs ,private sector, professional associations, PLHIV and their organizations, members of high risk populations, bilateral donors and UN agencies) in every step of developing the proposal including prioritizing of strategic areas, preparation of work plans, developing the monitoring and evaluation plan and costing in a transparent manner giving ownership to all for better coordinated action.

VI. Support from the country's development partners

During the reporting period the key support has come from the Global Fund on AIDS, Tuberculosis and Malaria through a Round 6 grant and round 9 grant.

Sri Lanka was also included in a successful Global Fund regional proposal on HIV and men who have sex with men covering South Asia.

During 2011, UNAIDS and TSF (SA) provided financial and technical support to conduct NASA in Sri Lanka.

Individual UN agencies brought strategic support throughout this period in terms of awareness and programmatic support largely in the form of technical assistance. The UN Joint Team on AIDS in Sri Lanka supported the government through a Joint Programme on AIDS. The major focus of the programme was for the development of a mapping methodology for most-at-risk groups (SW, MSM) with technical assistance provided by the World Bank and UNFPA; undertaking a survey of stigma and discrimination with people living with HIV through UNDP; a HIV risk assessment of conflict affected populations through UNHCR; a risk assessment of fishing communities through ILO; development of a national policy on HIV prevention in the World of Work through ILO; HIV prevention interventions for both internal and external migrants through ILO and IOM and strengthening of surveillance and estimates through WHO and UNAIDS.

VII. Monitoring and evaluation environment

During the year 2009 a separate unit for Strategic information & Management (SIM Unit) was established for the first time in the National STD/AIDS Control programme to coordinate monitoring and evaluation activities of the national response. Six full-time staff were recruited to this unit from the permanent staff of NSACP. This was a major achievement during the reporting period in monitoring and evaluation area. The objectives of Strategic Information Management in NSACP are to provide an overall picture of HIV and AIDS scenario in the country and national response to HIV and AIDS, to provide accurate, timely and stakeholder-friendly information, to enable planning, learning and effective decision making at various levels using evidence, to address accountability in the program, to meet various national and international reporting needs and to provide an effective system for bringing together information from multi-sectoral agencies to address information needs at various levels.

However there is no routine budget allocation identified for monitoring and evaluation activities from the government. Funding depend mainly on donor funds. Only limited funds were available to some of the activities such as software and web updates, professional IT and statistician's services. However amid these constraints some HIV and STI data are collected, analysed and disseminated as reports and quarterly reports through the web site of NSACP and used for programme planning and resource allocation.

National STD/AIDS Control programme launched it is official website in 2011. This enabled information dissemination to all stakeholders.

Another significant achievement is the implementation of the online Patient Information Management System (PIMS). All STD clinics can log into the PIMS and enter STI patient related data using this system. Since January 2011, 5 STI clinics started using this new online system.

ANNEX I

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

Which institutions /entities were responsible for filling out the indicator forms?		
a) NAC or equivalent	Yes	No X
b) NAP	Yes X	No
C) Others	Yes	No X
2) with the inputs from		
Ministries:		
Education	Yes X	No
Health	Yes X	No
Labor	Yes X	No
Foreign affairs	Yes	No X
Others	Yes X	No
Civil society organizations	Yes X	No
People living with HIV	Yes X	No
Private sector	Yes X	No
United Nation Organizations	Yes X	No
Bi-lateral	Yes X	No
International NGOs	Yes X	No
Others	Yes X	No
3) Was the report discussed in a large forum?	Yes X	No
4) Are the survey results stored centrally?	Yes X	No
5) Are data available for public consultation?	Yes X	No
6) Who is responsible for submission of the report and for follow-up if there are questions on the country progress report?		
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ANNEX 2

National Commitments and Policy Instrument (NCPI)

This is available at the URL: http://aidsreportingtool.unaids.org/116/sri-lanka-report-ncpi