Democratic Socialist Republic of
Sri Lanka

NATIONAL HIV/AIDS STRATEGIC PLAN 2007-2011

National STD and AIDS Control Programme
Ministry of Healthcare and Nutrition
Colombo, Sri Lanka

PREFACE

HIV infection was first detected in Sri Lanka in 1987 and it will continue to be with us for many decades to come. The estimated number of people living with HIV as at the end of 2007 is around 3500-4000. Hence, Sri Lanka is considered a country with a low prevalence of HIV infection. However, a gradual increase in new cases is being observed and the feminization of the epidemic is emerging. The presence of certain socio-demographic and behavioural factors may change the present HIV landscape.

Over the last two and a half decades various interventions were targeted to the highly vulnerable groups and also the general population and youth without stigmatizing those who are engaging in high-risk behaviours. In addition, programmes were carried out to sustain political and societal commitment to HIV/AIDS prevention, to reduce stigma and discrimination against people living with HIV /AIDS. A multi sectoral, multi disciplinary approach was adopted for its sustainability. In addition, antiretroviral therapy was made available for eligible persons.

Based on the above factors and the recommendations of the external review carried out to assess the national response against HIV during the five year period ended in 2006, a new strategic plan for 2007 – 2011 was formulated. This was completed with a wider participation of stakeholders from government, non-governmental organizations, business community, religious leaders and people living with HIV. This plan has identified main strategies based on a set of principles and has identified programme priorities, and areas in which various sectors need to focus future actions. Monitoring and evaluation will be based on the indicator frame work.

The National Strategic Plan (2007-2011) will be implemented by all sectors of government and civil society, under the technical guidance of the National STD/ AIDS Programme (NSACP) with high level leadership from the National AIDS Committee to accelerate the scale up of HIV testing, prevention, care and treatment services and ensure collecting robust strategic information to monitor and guide the national response to HIV epidemic.

HIV/AIDS is going to be with us for a very long time, as it shows no signs of weakening its grip but how far it spreads and how much damage it does is entirely depend on us. If we failed to act now we will be paying later

Sri Lanka has made significant progress in our fight against HIV/AIDS. The successful implementation of the National Strategic Plan (2007-2011) can provide us with a chance to successfully reduce the impact of HIV/AIDS in our country.

Finally I express our profound gratitude to all those who have worked on this document. I urge everyone that only a robust effort to provide universal access to all the prevention, treatment, care and support program quickly to people will suffice.

Thank you.

Director,
National STD/AIDS Control Programme

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EXECUTIVE SUMMARY

The HIV/AIDS pandemic is increasing throughout South Asia, but Sri Lanka remains a low prevalence epidemic: less than 0.1 percent of the population carries HIV. It is unlikely that Sri Lanka will develop a generalized HIV epidemic, but concentrated HIV epidemics among female sex workers (FSW), men who have sex with men (MSM), and their sex partners cannot be ruled out. Similarly, if drug users (DU) switch to injecting, rapid transmission of HIV will set in; as experienced in many Asian countries. This scenario is highly probable due to the existence of high transmission settings for HIV in the country, such as prisons and correctional facilities, where there is high occurrence of drug use and unsafe sex. Finally, an estimated 3000-5000 Sri Lankans already have HIV and there is a need for better medical care and a supportive environment, as they often face stigma and discrimination.

In terms of the national response, the major gaps in the response as identified in the 2006 external review are: 1) insufficient focus on FSW and clients, MSM and partners, and DU; 2) insufficient involvement of NGOs and private sector to increase coverage; 3) insufficient collection and use of strategic information: M&E and research; 4) inadequate programme management at the centre (NSACP) and insufficient decentralisation of the response to provincial and local governments.

The Government of Sri Lanka's (GoSL) National HIV/AIDS Strategic Plan for the years 2007-2011 (NSP) was developed, with broad stakeholder participation, as a coordinated response to HIV/AIDS. The guiding principles for the national response include recognition of 1) the need for evidence to formulate responses; 2) respect for human rights; 3) recognition of gender inequalities in HIV control; and 4) the need for community participation and involvement of people with HIV.

The overall goal of the NSP is to reduce the impact of HIV/AIDS on the social development of the country. The national goals are 1) to maintain the low HIV prevalence among most-at-risk-populations (MARP) and the general population; and 2) to increase the quality of life of those already infected. The NSP has 6 strategies to achieve these goals. The two core strategies are:

1. Increased coverage and quality of prevention interventions;
2. Increased coverage and quality of care, support and treatment intervention.

To support the above, the four additional strategies are:

3. Improved generation and use of information for planning and policy development;
4. Increased involvement of relevant sectors and levels of government in the response;
5. More supportive public policy and legal environment for HIV/AIDS control;
6. Improved management and coordination of the response.

A national strategic information management plan (SIM) has been developed to complement and enhance the national programme's existing HIV/AIDS monitoring and evaluation framework. The SIM will provide the NSACP with a sustainable system to generate and share strategic information to service providers, programme planners and policy makers. The NSACP has also developed a set of core impact, outcome and output indicators that they will regularly report on.

The Implementation of the NSP depends on the efforts of many government departments, non-government organisations, the private sector and Sri Lanka's development partners. The NSACP coordinates the response, through development of technical strategies and guidelines, development of annual operational plans and budgets, resource mobilisation, and capacity building of all implementing partners.

ABBREVIATIONS

ANC	Antenatal Clinic
ART	Anti-Retro Viral Treatment
ARV	Anti-Retro Viral (Medication)
BCI	Behaviour Change Intervention
BSS	Behavioural Sentinel Surveillance
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CSM	Condom Social Marketing
DGHS	Director General Health Services
DHS	Demographic Health Survey
DU	Drug Users
FHB	Family Health Bureau
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, TB & Malaria
GOSL	Government of Sri Lanka
HEB	Health Education Bureau
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	HIV Sentinel Surveillance
IBBS	Integrated Behavioural and Biological Surveillance
IDH	Infectious Disease Hospital
IDU	Injecting Drug Users
IEC	Information, Education & Communication
ILO	International Labour Organisation
M&E	Monitoring & Evaluation
MARP	Most-at-risk-Population(s)
MDG	Millennium Development Goals
MO	Medical Officer
MoD	Ministry of Defence
MoE	Ministry of Education
MoF	Ministry of Fisheries
MoFE	Ministry of Foreign Employment

MoH	Ministry of Healthcare & Nutrition
MoL	Ministry of Labour
MSM	Men who have Sex with Men
MTCT	Mother-to-child Transmission
NAC	National AIDS Committee
NBTC	National Blood Transfusion Center
NBTS	National Blood Transfusion Service
NDDCB	National Dangerous Drug Control Board
NGO	Non Governmental Organisation
NHAPP	National HIV/AIDS Prevention Project
NIE	National Institute of Education
NSACP	National STD/AIDS Control Programme
NSP	National HIV/AIDS Strategic Plan
NTP	National TB and Respiratory Diseases Control Program
PAC	Provincial AIDS Committee
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
SIT	Strategic Information Team
SLFEB	Sri Lanka Foreign Employment Bureau
STD	Sexual Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Workers
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNDP	The United Nations Development Programme
UNFPA	The United Nations Population Fund
UNGASS	The United Nations General Assembly Special Session on HIV/AIDS
UNICEF	The United Nations Children's Fund
UNODC	The United Nations Office for Drugs & Crime
UNSW	University of New South Wales (National Centre in HIV Social Research)
USAID	The United States Agency for International Development
VCCT	Voluntary Confidential Counselling & Testing
WB	The World Bank
WFP	The World Food Programme
WHO	The World Health Organisation

SECTION

1 INTRODUCTION

HIV/AIDS prevalence in Sri Lanka is very low compared to the South Asian region. However, the epidemic is on the rise in the country and there is an impending need to provide proper care and support for thousands of Sri Lankans already living with HIV; while creating strategies to modify high risk behaviour.

The Government of Sri Lanka (GoSL), through the National HIV/AIDS Strategic Plan (NSP), will provide direction and leadership to the national HIV/AIDS response for the next five years (2007-2011). The long term strategies and broad activities contained in the NSP will be translated annually into short- term detailed operational plans to guide implementation. The NSP is developed with broad participation from relevant stakeholders including people living with HIV (PLHIV), with guidance from a multisectoral steering committee and coordinated by the National STD/AIDS Control Programme (NSACP).

Sri Lanka is committed to internationally agreed Millennium Development Goals (MDG), including MDG 6: To halt and reverse the spread of HIV/AIDS. The latter as well as the principles and targets of the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment on AIDS; guide the objectives of the NSP. The NSP also supports the goals of Sri Lanka's national poverty reduction strategy.

This document is prepared for the government, including all government sectors that can contribute to the HIV/AIDS response, for civil society partners as well as for development partners.

SECTION

2 THE HIV/AIDS SITUATION AND RESPONSE

2.1 Situational analysis[1]

The UN estimates that, as of December 2006, there are 3000-5000 people living with HIV in Sri Lanka; reported number of cases by the National STD/AIDS Control Programme (NSACP) as of the third quarter for 2007 was 923. The HIV prevalence among the general population is less than 0.1%.; even among most-at-risk-populations (MARP), such as female sex workers (FSW), men who have sex with men (MSM) and their sex partners, HIV prevalence has remained less then 1%.

Several factors protect Sri Lanka, compared to other south Asian countries, from HIV transmission despite repeat introduction of HIV into the population since 1986. These include 1) good access to health services including STD services; 2) low prevalence of STI, even among populations practicing unprotected sex with multiple sex partners; 3) high level of education; 4) relative high gender equality; 5) low level of injecting among drug users, and relative isolation as an island state.

However, groups with higher risk to HIV exposure exist, such as 1) FSW and their clients; 2) MSM, including 'beach boys' who sell sex to tourists. Although injecting drug use (IDU) is uncommon in Sri Lanka, some 4% of DU do inject, and experience in other countries shows that injecting behaviour can suddenly increase and thus spark off very effective HIV transmission.

High-risk environments also exist, including prisons and correctional settings, where sexual risk behaviour and drugs are common, but condoms absent. In other settings, such as urban slums, plantations, conflict zones and camps for internally displaced people, access to health and social welfare services is limited, including sexual health services and information.

2.2 Response analysis

The Government of Sri Lanka (GoSL) has responded to HIV/AIDS since the 1980s. The Three ones principle guides the national response: one multisectoral authority; one national comprehensive strategy; and one HIV/AIDS monitoring and evaluation (M&E) framework. In addition, NSACP recently drafted a national AIDS policy, which emphasizes respect for the rights of people at risk for or living with HIV, and which sets out priorities for the national response.

The National AIDS Council is the highest governance body chaired by the President and with relevant ministers as members. The National AIDS Committee (NAC) oversees implementation of the response, is chaired by the Secretary for the Ministry

1 More details on situation and response are in the report of the 2006 External Review of the National Response

of Healthcare and Nutrition (MoH), with other Ministerial Secretaries, NGOs and donors as members.

The NSACP is responsible for coordination of the national HIV/AIDS response, through planning, monitoring and coordination of all stakeholders. The NSACP is co-located with the central STI clinic and the national reference laboratory for STI/HIV. NSACP oversees STI treatment services at 26 districts, scaled up VCT and HIV clinical management services; piloted prevention of parent to child transmission (PPTCT), and developed HIV/STI clinical management guidelines.

Within the health sector, several departments provide HIV/AIDS related services: family health bureau (PPTCT), health education bureau, NBTS[2], NTP[3] and obviously the health services department (clinical care). Other government sectors also respond to HIV, including the Ministry of Education (school-based life skills education) and Ministry of Labour, as well as the NDDCB[4] (DU and prisons) and the foreign employment bureau (pre-departure education). NSACP supports several ministries and departments to build their AIDS competence, such as defence (prevention and VCT), youth affairs, fisheries, and the police department. In line with ongoing efforts of decentralisation and devolution, provincial, district and municipal AIDS committees coordinate local responses with support of the NSACP.

The potential of NGOs for the response remains largely untapped. Some NGOs raise awareness among certain communities or the general population, others provide community care. However, in view of the need to scale up coverage of prevention services among the MARP, very few NGOs are willing and have the capacity to undertake targeted interventions.

Few development partners support the national HIV/AIDS response. The World Bank provides a 12.5 m US$ grant for management strengthening, surveillance and prevention and care services, ending mid 2008. The Global Fund (GFATM) committed 1.8 m US$ for prevention services in schools and plantations, and for purchase of ARV. Among bilateral donors, only USAID supports HIV prevention through grants and technical assistance to CBOs, and this project will end in January 2008. The UN system provides technical assistance, including some funding for pilot projects in the areas of national programme management (UNAIDS); surveillance (WHO); PPTCT and sexual health education for adolescents (UNICEF and UNFPA); world of work responses (ILO), and food support to AIDS affected families (WFP).

According to the 2006 external review, the quality of the public sector health services seems good, but coverage is less. This is evident in prevention interventions, especially among the MARP, for whom Sri Lanka agreed a universal access (UA) coverage target of 80% by 2010. As of 2007, coverage of behaviour change interventions (BCI) for FSW, MSM and DU is less than 10%, given current estimates of population sizes.

2 National Blood Transfusion Service.
3 National TB and Respiratory Disease Control Programme.
4 National Dangerous Drugs Control Board

However, access to HIV care services is better. Until June 2007, 355 HIV patients were registered for medical care, and 111 patients started on ART, out of an estimated 500 with advanced HIV infection.

The major gaps in the response as identified in the 2006 external review are: 1) insufficient focus on FSW and clients, MSM and partners, and DU; 2) insufficient involvement of NGOs and private sector to increase coverage; 3) insufficient collection and use of strategic information: M&E and research; 4) inadequate programme management at the centre (NSACP) and insufficient decentralisation of the response to provincial and local governments.

2.3 Priorities for the next 5 years

On the basis of the above situation and response analysis, NSACP and partners have identified the following priorities for the period 2007-2011:

- Prevention remains the focus of the response: coverage of comprehensive prevention interventions among those most-at-risk will be drastically increased: with priority for FSW and clients, MSM and partners, DU, especially those who are incarcerated.
- Support, care and treatment services for PLHIV and their families, based on a national comprehensive care strategy, action plan and technical guidelines.
- Civil society organisations, including NGOs, CBOs, religious groups and private sector will be engaged to complement the public sector prevention and care services.
- Relevant non-health ministries will mainstream HIV responses into their policies, services, as part of their core budgets.
- Strategic information will be collected, analysed and disseminated to policy makers and programme planners, through development of a national M&E framework; establishment of a strategic information unit in the NSACP and technical capacity building.
- The NSACP will strengthen its own institutional and human capacity, in order to support provinces and districts with planning and implementation, and undertake resource mobilisation for sustainability of the national response.
- After ratification of the national AIDS policy, NSACP will work with relevant ministries to develop sectoral policies and laws, including sensitisation, capacity building, monitoring and enforcement of such laws and decrees.

SECTION

3 GUIDING PRINCIPLES FOR THE NATIONAL HIV/AIDS RESPONSE

Several guiding principles underlie the national strategic plan. They apply to each strategic area, and affect national planning and service delivery equally, as crosscutting concerns.

3.1 Strategies based on evidence

Evidence is needed to ensure that all activities are effective, i.e. contribute to the national goals of preventing new infections and improving the lives of those affected. Given the limited resources, there is also a need to establish cost-effectiveness of interventions to ensure rational allocation of resources. Formative research is a national priority; to understand and quantify risk behaviours and vulnerabilities, including population size estimates, and to provide baseline data for future evaluation. Evaluative research will be emphasized to demonstrate effectiveness and cost-effectiveness of all prevention and care interventions.

3.2 Respect for human rights

The national AIDS policy recognises the intimate link between HIV/AIDS and human rights. People who have a higher risk of HIV exposure are often the most difficult to reach, because homosexuality, soliciting and drug use and trafficking are illegal, and drives them underground. The NSP and the National AIDS Policy mirror the Sri Lankan constitution in taking as guiding principles universal human rights and dignity of all Sri Lankans, including their sexual and reproductive rights. There should be no discrimination of on the basis of gender, HIV status, sexual behaviour or sexual orientation. HIV testing without prior informed consent is never acceptable (unless anonymous unlinked for screening purposes), and each HIV test result has to be confidential.

3.3 Gender considerations

Women are biologically more susceptible than men to sexual HIV transmission; women generally have less control over their sexual behaviour; less access to services, and they are more likely to suffer stigma due to HIV infection. Research also indicates relatively high levels of sexual violence against women (and boys). For these reasons, all planning, service delivery, and research must be done with gender equality in mind.

3.4 Involvement of communities and people with HIV

Behaviour change interventions (BCI) are most effective if based on real needs, and delivered by peers. The NSP recognises the imperative of participation of communities in the design, implementation and evaluation of service. PLHIV have an important role in prevention and care, and their experiences and involvement makes interventions more effective and relevant. The NSP promotes meaningful involvement of PLHIV.

SECTION

4 NATIONAL GOALS AND STRATEGIC OBJECTIVES

The NSP supports the Poverty Reduction Strategy Paper (PRSP) and the Millennium Development Goals, especially MDG #6: To halt and reverse the HIV epidemic by 2015. The overall goal of the national response is to reduce the impact of the HIV/AIDS epidemic on social development of Sri Lanka.

4.1 National Goals

The dual goals of the NSP 2007-11 are:

1. Current low prevalence of HIV among most-at-risk-populations (MARP) and the general population maintained.
2. Quality of life of people infected with, or affected by HIV, improved.

4.2 Strategic Objectives

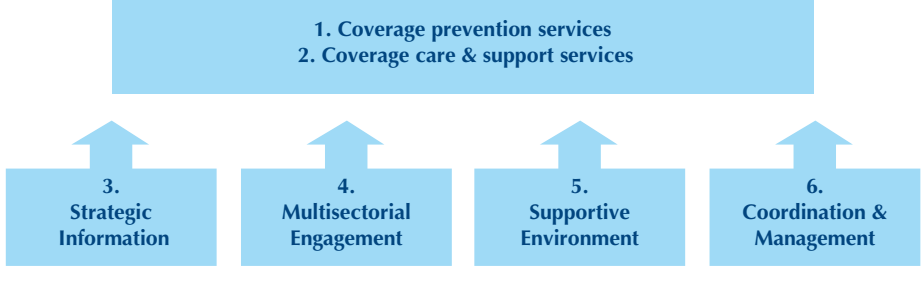
The strategic objectives of the NSP, to achieve the national goals are:

1. Increased coverage and effectiveness of prevention interventions.
2. Increase coverage and effectiveness of care, support and treatment interventions.

Other objectives to support the above core strategies are:

3. Improved generation and use of information for planning and policy development.
4. Increase involvement of relevant sectors and levels of government in the response.
5. More supportive public policy and legal environment for HIV/AIDS control.
6. Improved management and coordination of the response.

Figure 1:



SECTION

5 SPECIFIC STRATEGIES AND MAJOR ACTIVITIES

Each strategic objective of the national response contains several specific strategies. This chapter identifies the main actors and actions to achieve these specific objectives.

5.1 Strategy 1: Prevention

1. Increased scale and quality of comprehensive interventions for MARP: FSW & clients, MSM, (injecting) DU and prisoners.
    - NGOs to expand and start BCI for FSW, MSM and DU.
    - Prison department to expand services to inmates, including FSW, DU and MSM.
    - MoH to increase accessibility of STD services for FSW and MSM.

2. Increased scale and coverage of HIV communication interventions for general population and lesser risk populations (youth, migrant workers, etc.)
    - NSACP to finalise communication strategy for general population, addressing stigma, discrimination, general awareness and knowledge[5].
    - NSACP to contract communication firm for multi media campaign.
    - NSACP to organise awareness campaigns for world AIDS day, memorials etc.
    - MoE to mainstream skills based RH education, including HIV in teacher training and student curriculum.
    - MoFE to mainstream AIDS prevention among migrants and their families.
    - MoL, Employers organisations and trade unions to develop HIV strategies.
    - NGOs to support expansion of workplace interventions.

3. Increased quality and coverage of STI services.
    - NSACP to maintain and upgrade STI clinical services in 26 sites.
    - NSACP to train government and private providers[6] on delivering syndromic. Management.
    - Provincial health departments to provide STI services.
    - NSACP to monitor and update national management algorithms on the basis of research.

5 See also 5.6: the general awareness campaign may be combined with the advocacy strategy

6 Formative research is needed to identify from who people seek STD treatment

4. Increased quality and coverage of PPTCT services.
    - NSACP and FHB to finalise national PPTCT strategy and guidelines in collaboration with professional colleges.
    - FHB to organise training programme on PPTCT for relevant health workers, e.g. in antenatal clinics and referral hospitals.
    - FHB to include PPTCT in all MCH communication packages.
    - FHB in coordination and collaboration with NSACP to expand comprehensive[7] and appropriate[8] PPTCT services to all districts.

5. Increased quality of blood transfusion services.
    - NBTC[9] to monitor and update the national blood transfusion policy and guidelines.
    - NBTC to train NGOs, lab, blood bank and hospital staff on blood safety.
    - NGOs to expand promotion and collection of voluntary blood donations.

6. Reduced transmission in the health services.
    - NSACP in coordination with professional bodies to monitor and update standard precautions and post-exposure prophylaxis (PEP) policies and guidelines.
    - NSACP to train public and private health care providers on standard precautions and PEP.
    - Provincial health departments to train and equip all health care providers.
    - NSACP to ensure availability of ART for PEP in all hospitals.

5.2 Strategy 2: Care, treatment and support

1. Increased quality and use of VCCT services.
    - NSACP to monitor and update testing policies and guidelines for VCCT.
    - NSACP to increase human resources and infrastructure to allow quality counselling by trained counsellors[10] and rapid testing in government and non-government settings
    - NGOs to create demand for VCCT among the MARP.
    - NSACP to support private sector and NGOs to provide quality VCCT to MARP.

7 PPTCT has four components: HIV prevention for women; unwanted pregnancy prevention for positive women; transmission reduction through ART prophylaxis; and treatment for positive mothers and infants

8 The draft national strategy recommends 'opt-in' approach for testing, and couple counselling

9 National Blood Transfusion Center

10 Including nurses, public health inspectors

2. Increased quality and coverage of HIV and AIDS treatment services.
    - NSACP to develop a comprehensive care and support strategy, protocols and guidelines.
    - NSACP to support Government hospitals, TB services and private hospitals to scale up HIV/AIDS clinical care (including ART) sites guided by patient load, through training.
    - MoH to provide infrastructure support to scale up clinical care.
    - MoH (MSD) to procure and supply of ARV medication and reagents to all treatment sites.
    - NSACP to monitor HIV/AIDS treatment outcomes and adjust national regimens and training accordingly.

3. Increased quality and coverage of home and community based care for PLHIV
    - NSACP to develop, monitor and update national home and community based care guidelines.
    - NSACP to support NGOs and religious organisations to engage in community based care for the chronically ill and orphans.

5.3 Strategy 3: Generating and using strategic information

1. National integrated behavioural and biological surveillance (IBBS) implemented, documented and disseminated.
    - NSACP to review and revise the national surveillance protocols, combining behavioural and HIV/STI surveillance.
    - NSACP to commission urgent formative research on size estimates and mapping of MARP, especially FSW, MSM and DU.
    - NSACP to contract national research institute(s) and international technical assistance for IBBS.
    - NSACP to document the IBBS and organise dissemination workshops for stakeholders.

2. Formative and operational research implemented, documented and disseminated.
    - NSACP to support NAC Subcommittee on research, and collaborate with the ethical review committees.
    - NSACP to develop annual research priorities and research agenda.
    - NSACP to annually disseminate all AIDS-related research[11], through an annual research conference and/or annual research update.
    - NSACP and ethical review committee (UoC) to jointly develop and review committee to apply guidelines for high-quality and ethical research.

11 Broad research: socio-behavioural as well as biomedical, by NGOs as well as researchers.

3. HIV/AIDS related services monitored, documented and disseminated through national progress reports.
    - NSACP to finalise a health management information system to monitor and report on HIV/AIDS service coverage, use and outcomes.
    - NSACP to train public and private sector health service providers in HMIS.
    - Service providers in the public, private and NGO sectors to report on service coverage, use and outcomes to NSACP. (NTP (MoH) on HIV/TB services; NBTS (MoH) on blood transfusion services; FHB (MOH) on PPTCT services; MoEd on life skills education in schools; MoD on STI/HIV prevention and care services; NGOs on prevention care & support services, etc.
    - NSACP to develop and disseminate regular[12] updates & annual reports on national service coverage and use.

5.4 Strategy 4: Multisectoral involvement and decentralization

1. Increased engagement and capacity of NGOs in prevention, care and policy development.
    - NSACP will strengthen existing partnerships and establish new mechanisms on the basis of equality and mutual respect at all levels.
    - NSACP will develop mechanisms to subcontract (or have others contract) and provide technical assistance to civil society organisations to undertake HIV/AIDS services, research, communication activities, etc.

2. Increased engagement and capacity of key ministries/departments.
    - Ministries/departments of Prisons, Police, Defence, Education, Youth Affairs, etc. will scale up HIV/AIDS programmes as part of their own work plans and budgets.
    - NSACP will continue to provide technical inputs to the HIV/AIDS programmes of the ministries/departments of Prisons, Police, Defence, Education, etc.
    - NSACP will, based on evidence of need, liaise with additional ministries/sectors to mainstream HIV/AIDS in sectoral policies, work plans, and budget.
    - NSACP will provide (or request from UN agencies) technical support for sectoral HIV/AIDS assessments to inform advocacy or strategic planning.
    - NSACP will provide (or request from UN agencies) strategic planning support to relevant ministries and sectors.

12 Frequency to be determined by information needs assessment among service providers

3. Increased engagement and capacity of local governments (municipal, provincial and district).
    - NSACP will continue to provide technical and strategic planning support to existing 8 provincial AIDS committees, 26 district AIDS committees and the Colombo municipal AIDS committee.
    - NSACP will, based on established needs, sensitise additional local government leaders in high transmission areas on the need for local responses.
    - NSACP will support (technically and through seed funding) local formative research and strategic planning, and training for HIV/AIDS responses.

4. Increased engagement and capacity of the "world of work".
    - MoL, employers' and workers' organisations will sign and implement a tripartite agreement in HIV in the workplace.
    - NSACP will technically support (and request ILO support for) MoL, SLFEB and MoF to design and implement workplace policies and programmes.
    - NSACP will undertake 2-yearly workplace surveys[13] with support from ILO.

5.5 Strategy 5: Policy development and legislation

1. Supportive National HIV/AIDS policy passed.
    - NSACP will work towards ratification of the National AIDS Policy.

2. Sectoral HIV/AIDS policies developed in accordance with the NAP.
    - NSACP will sensitise departmental leaders in relevant sectors (Health, Prisons, Police, Defence, Social Welfare etc) to the need to address provisions from the constitution and AIDS policy in sectoral policies.
    - NSACP will provide support to relevant sectors to develop policies, and plans to train service providers and sensitise law enforcers.
    - NSACP will commission a mid term national AIDS policy review on HIV/AIDS to assess sectoral policy priorities.

3. Compassionate and supportive attitudes improved among lawmakers, advocates, law enforcers etc.[14]
    - NSACP will finalise a national advocacy strategy[15].

13 Needed for UNGASS 2008 progress report.

14 See also 5.1: there may be some overlap between the multi media campaign, which targets general population groups.

15 Development process of 1) advocacy strategy and 2) general awareness strategy may be combined.

- NSACP will commission a segmented, multi media campaign to reduce stigma and discrimination around HIV in families, schools, health sector and community at large
- NSACP will (as part of the advocacy strategy) sensitise members of the judiciary, law enforces and human rights activists on the National AIDS Policy and sectoral decrees.

5.6 Strategy 6: Strengthening national coordination and management capacity

1. Increased institutional and human capacity at the NSACP.
    - NSACP will undertake functional task analysis, on the basis of the NSP Operational Plan.
    - NSACP will establish functional units (e.g. strategic information; programmes; strategic planning and reporting; finance and procurement) with terms of reference.
    - NSACP will undertake human resource development of all staff members according to their roles and functions.

2. Effective functioning of NSACP coordination mechanisms.
    - MoH will revitalise and host quarterly meetings of the NAC and subcommittees.
    - NSACP will create multi-sectoral partnership mechanisms to increase government –civil society coordination for the national response.

    .

3. Increased financial management and procurement capacity NSACP.
    - NSACP will establish a "finance and procurement" unit, with terms of reference.
    - NSACP will develop annual procurement plans and reports to GoSL and donors.

4. Resource needs monitored and resources mobilised.
    - NSACP will undertake annual work-planning and costing exercises, including resource gap analysis.
    - NSACP will develop and implement a resource mobilization strategy for mobilisation strategy for the national response.
    - NSACP will host quarterly meetings with the Ministry of Planning and Finance, and funders of the national response, including but not limited to the World Bank (WB) and the Global Fund (GFATM).

SECTION

6 IMPLEMENTATION OF THE NATIONAL RESPONSE

The Implementation arrangements for the NSP include several management functions: 1) overall governance and strategic oversight; 2) day-to-day management, operational planning and coordination; 3) implementation of activities, including service delivery; 4) capacity building at all levels; 5) financial management.

6.1 Governance of the national response: NAC

Governance of the national response involves strategic oversight and leadership. The National AIDS Council, chaired by the President and with the ministers as members, is the highest governance body in the national response. The National AIDS Committee (NAC) is responsible for national strategy and policy development. The NAC is chaired by the Secretary Health and has secretaries of relevant ministries as members, plus representatives from NGOs and donors. The NAC will be revitalised and meet twice per year, and NAC subcommittees will also be re-established to provide technical advice for specific areas, e.g. prevention; care & support; research; surveillance[16]; and legal & ethical issues.

The Country Coordinating Mechanism (CCM) is the governance body for those AIDS (and Tuberculosis & Malaria) activities that are funded through the GFATM. The CCM meets as and when needed.

6.2. Coordination and Management: National STD/AIDS Control Programme

NSACP is responsible to ensure effective implementation of the NSP and resulting annual operational plans, and for resource mobilisation. Each year, NSACP will develop a detailed 2-year operational plan and budget, on the basis of the 5-year plan, taking into account funding commitments for that period.

6.3 Service delivery & implementation: implementing partners

Many implementing partners are responsible for service delivery and other supportive activities such as research and advocacy.

NSACP will create an enabling environment, where service providers and implementers can coordinate with the NSACP on implementation issues.

16 The existing subcommittee "surveillance and laboratory" will be split into two: 1) "strategic information" and 2) "laboratory services".

Implementing partners include government organisations as well as civil society organisations. Implementing partners include but are not limited to 1) public and private health services, to provide clinical care, STI management, health education, etc.; 2) NGOs/CBOs, to implement interventions for MARP, peer support for PLHIV, etc.; 3) private sector firms, for example to implement a national multi-media campaign; 4) public and private education and social service providers, to mainstream HIV into existing services; and 5) research groups, to undertake studies.

6.4 Capacity building

Capacity building is crucial to all aspects of the national response. The NSACP will develop a capacity building strategy, identifying 1) technical assistance needs in all areas of the national response and for all implementing partners, and 2) technical assistance opportunities from UN and other specialist organisations to fulfil these TA needs. NSACP will update capacity building work plans annually.

The key capacity building organisations are 1) NSACP, through development of technical guidelines and training for STI, VCCT, clinical management, standard precautions etc.; 2) technical UN agencies (WHO, UNFPA, UNICEF, etc.), through sharing international standards; 3) national and regional specialist organisations, for example in the areas of targeted interventions design for MARP, workplace interventions, IBBS, etc.

6.5 Financial management

The NSACP finance and administration team will undertake financial management of the national response, including financial reporting to all donors on funds received by the GoSL, and resource mobilisation for the NSP operational plans. NSACP will develop annual procurement plans, as per government and donor regulations, to support procurement and contract management. NSACP accounts are audited internally and externally, according to GoSL and donor requirements. HIV/AIDS services in other sectors will be budgeted and managed by the relevant health departments (e.g. NTB, HEB) and other ministries (e.g. education, Defence). NSACP will only fund and budget for technical assistance and seed funding for pilot programming.

SECTION

7 THE NATIONAL STRATEGIC INFORMATION MANAGEMENT SYSTEM 2007-2011

One of the four overarching lines of actions suggested by the 2006 external review is availability and usage of strategic information; including bridging the information gaps in identified areas. To monitor the HIV/AIDS situation in Sri Lanka and progress towards the objectives of the NSP, a national HIV/AIDS strategic information management Plan (SIM) has been developed. The SIM incorporates monitoring and evaluation into a larger information management system to guide and ensure that the effectiveness of the NSP is adequately monitored. The SIM system will also help in bringing together key stakeholders and institutions involved within one umbrella, thereby improving co-ordination in generation and management of information across the national programme. A set of core indicators for the national HIV/AIDS programme will be the backbone of this system and will form the basis of monitoring the national response to HIV/AIDS in Sri Lanka.

Guiding Principles of the SIM

Guiding principles are like cornerstone of design and implementation of a SIM system. These are:

- **3 ones:** At the international conference on AIDS and STI held in Nairobi, Kenya there was strong consensus on three principles applicable to all stakeholders in the country level HIV/AIDS response.

One country-level monitoring and evaluation system is an important and agreed principle of the "Three Ones".

- **Building on existing systems:** NSACP has existing M&E mechanisms that provide a good base for building the new SIM system. This system will not create additional layers or means of information collection and processing, but improve the existing layers and means.
- **"Evidence and Results based":** The system is oriented towards generating and using information based on programme results. This will create opportunities for results and evidence based learning and planning at various levels. The system will focus on monitoring programme outputs at regular intervals with timely and accurate analysis; enabling corrective action and for maintaining strategic direction.
- **Key Information Needs:** System meeting needs and demands of information of various stakeholders at different levels.
- **Mechanisms:** Includes both Independent, impartial assessments along with internal self assessments.
- **Harmonisation of tools and formats:** Standard set of tools to collect and analyse information.

- **Feedback loops operate:** System works in circular fashion of action-analysis-reporting-feedback-action. Not just one way.
- **Balance between collection and analysis:** Striking a balance between providing a meaningful overview of every program area and a national overview.

Objectives of Strategic Information Management Plan

The objectives of the SIM are:

- To provide an overall picture of HIV and AIDS situation in the country and national response to HIV and AIDS;
- Provide accurate, timely and stakeholder-friendly information;
- To provide an effective system for bringing together information from a variety of stakeholders to address information needs at various levels.

The strategic information generation will be a cyclic process throughout the programme processes in the next five years (2007-11).

National Core Indicators

The national programme core indicators are a limited set of indicators that NSACP will report on each year. The guiding principle for developing core indicators has been the focus on "measurement of progress" towards strategic objectives, results and programme component of the national response. The indicators so developed and finalised also reflect the national information needs as enunciated by UNGASS declaration of commitment (targets per 2008); Universal Access and the AIDS-related MDG (2015). The core indicators are summarized below in tabular form by program area. Consistent with the NSP, the indicators have been 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.

Table 1:

NO.	RESULT AREA	TYPE	INDICATOR
Prevention			
1	Increased scale and quality of comprehensive interventions for MARP	Output	Percentage of most at risk (SW, MSM, DU) are reached with HIV prevention program in the past 12 months
2	Increased scale and quality of comprehensive interventions for MARP	Outcome	- Percentage of female sex workers reporting the use of a condom with their most recent client - Percentage of men reporting the use of a condom the last time they had anal sex with a male partner - Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
3	Increased scale and quality of comprehensive interventions for MARP	Impact	Percentage of most-at-risk population who are HIV positive
4	Increased scale and quality of comprehensive interventions for MARP	Outcome	Percentage of Most at risk groups who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
5	Increased scale and coverage of HIV communication for general population	Outcome	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
6	Increased quality and coverage of STI services	Outcome	Percentage of most-at-risk population, as well as, general population who are tested positive for syphilis
7	Increased quality and coverage of STI services	Output	Percentage of STI treatment facilities with no STI drug stock outs > 1 week within last 12 months
8	Increased quality and coverage of PPTCT services	Output	Percentage of HIV positive pregnant women who receive antiretroviral (ARV) to reduce the risk of mother to child transmission
9	Increased quality and coverage of PPTCT services	Output	Proportion of women accessing antenatal care (ANC) services who are tested for syphilis
10	Increased quality and coverage of blood transfusion services	Output	Percentage of donated blood units screened for HIV in a quality assured manner
11	Reduced transmission in health services	Outcome	Percentage of TB patients screened for HIV
12	Reduced transmission in health services	Outcome	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

NO.	RESULT AREA	TYPE	INDICATOR
Care, Support and Treatment			
13	Increased quality and use of VCT services	Output	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results
14	Increased Quality and coverage of HIV/AIDS treatment services	Output	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy
15	Increased Quality and coverage of HIV/AIDS treatment services	Impact	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy
16	Increased Quality and coverage of HIV/AIDS treatment services	Output	Percentage of adults and children with HIV having access to high quality affordable drugs for Opportunistic Infections
Policy development and legislation			
17	Supportive National HIV/AIDS policy passed	Output	National Composite Policy Index
Strategic Information Management			
18	Increased institutional and human capacity at NSACP	Output	A functioning, accessible research inventory database, updated yearly
Strengthening national co-ordination and management capacity			
19	Resource needs monitored and resources mobilised	Outcome	AIDS spending by categories and financing source

SECTION

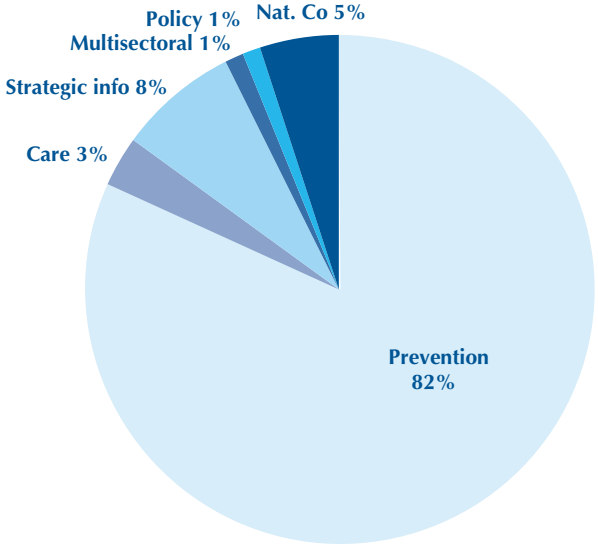
8 ESTIMATION OF COSTS FOR IMPLEMENTING THE NATIONAL STRATEGY 2007-2011

In 2007 a costing process was carried out to estimate the cost of implementing the National HIV/AIDS Strategic Plan 2007-11 in Sri Lanka. The main results from this process show total resource requirements for HIV interventions in the range of USD 44.8 (scenario I)-48.4 million (Scenario II) over the period 2007-11. The costing of the HIV strategy used two scenarios to estimate the costs of individual HIV interventions. Scenario I include a relatively modest scale-up of MSM and HAART and Scenario II estimate the costs of reaching out to more MSM groups and uses the coverage rates of provision of anti-retroviral treatment used in the application to GFATM/Round 7. The resource allocation and breakdown of costs for scenario I is provided below.

Total Resource Allocation

The resource allocation components follow the national HIV strategy: prevention, care & support, strategic information, multi-sectoral & decentralisation, policy & legislation, and national coordination (Figure 2).

Figure 2:
Total resource allocation



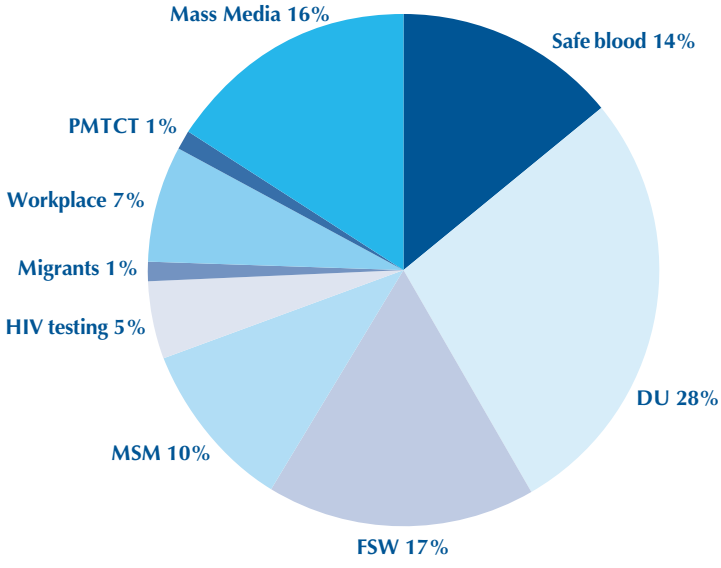
The allocation of resources in scenario I over 2008-11 shows that prevention interventions will dominate resource requirements by consuming 82% of total resources, strategic information will consume 8%, and national coordination will consume 5%. Care and support will consume 3%. The resource allocation assumes that the interventions covering MARP, in the case of Sri Lanka: FSWs, and their clients

and MSM, are scaled up over the years. Injecting drug use is not common at Sri Lanka (approx. 2% of drug users are IDU).

Total Resource Allocation for Prevention

In term of the total resources for prevention the MARP at 55% and mass media and awareness campaigns at 16% will consume the largest share of the allocation of resources (Figure 3).

Figure 3:
Resource allocation, prevention



Total cost of HIV interventions 2007-11 (Scenario I)[17]

Table 2 shows details of cost scenario I with a total cost of USD 44.8 million assuming going to scale for "visible" MSM groups and a moderate number of "hidden" MSM groups and a conservative estimate of PLHIV needing HAART in the planning period. There are some HIV interventions without funding after 2008, for example home-based care, HBC, multi-sectoral and decentralisation, policy and legislation (based on reduced resource need), and national coordination including capacity building & physical infrastructure. The resource allocation for 2009-11 are thus for some HIV activities underestimated.

17 Table 2 is based on costs for October 2007.

Table 2:

HIV intervention	2007	2008	2009	2010	2011	2007-11
Prevention						
Safe blood	1,206,190	1,206,190	1,039,210	1,039,210	1,039,210	**5,530,010**
DU, DU-FEM (NGOs and GOV)	1,353,956	1,740,594	2,129,173	2,584,443	3,027,099	**10,835,266**
FSW	196,236	784,946	1,373,655	1,962,364	2,354,837	**6,672,037**
MSM	119,614	159,485	239,227	318,970	398,712	**1,236,008**
Jail interventions	14,166	22,089	29,801	37,514	47,892	**151,461**
HIV testing	384,915	384,915	384,915	384,915	384,915	**1,924,576**
Ext. Migrant workers	96,000	96,000	96,000	96,000	96,000	**480,000**
Workplace	453,425	519,952	586,478	653,005	653,005	**2,865,866**
STI scale-up	1,087	2,174	3,262	4,349	5,436	**16,308**
PMTCT	30,715	30,882	31,048	31,215	31,381	**155,241**
VCT	8,000	9,600	11,900	13,600	24,073	**67,173**
Mass Media	1,289,990	1,289,990	1,289,990	1,289,990	1,289,990	**6,449,950**
Sub-total (Prevention)	***5,154,295***	***6,246,816***	***7,214,660***	***8,415,575***	***9,352,550***	***36,383,896***
Care and support						
HAART	119,243	165,497	215,270	268,563	325,376	**1,093,950**
OI	16,957	20,248	24,246	29,096	34,965	**125,513**
TB-HIV	183	5,226	5,269	5,312	10,373	**26,362**
HBC	105,810	105,810	8,600	8,600	8,600	**237,420**
Sub-total (Care and support)	***242,193***	***296,780***	***253,386***	***311,571***	***379,315***	***1,483,245***
Strategic information						
MIS for HIV and AIDS	73,350	73,350				**146,700**
MER incl Operational Research	129,750	129,750	137,284	137,284	137,284	**671,352**
Surveillance incl. IBBS	890,000	25,000	890,000	25,000	890,000	**2,720,000**
Sub-total (Strategic information)	***1,093,100***	***228,100***	***1,027,284***	***162,284***	***1,027,284***	***3,538,052***
Multisectoral & decentralisation	***150,253***	***218,931***	***81,750***			***450,933***
Policy and Legislation	***302,000***	***327,000***				***629,000***
National coordination						
Physical infrastructure	389,877	200,438				**590,315**
Capacity building, HR	1,224,500	512,500				**1,737,000**
Sub-total (National coordination)	***1,614,377***	***712,938***				***2,327,315***
TOTAL	**8,556,217**	**8,030,566**	**8,577,080**	**8,889,430**	**10,759,148**	**44,812,441**

SECTION

9 NEXT STEPS - THE WAY FORWARD

To make this plan a reality and move the process forward detailed work plans with attendant budgets need to be developed in partnership with the representatives from the various ministries, the donors and other stakeholders. These documents are crucial since the National Strategic Plan will be of limited use until existing funds can be utilized and donors can align their financial resources with the strategic priorities. Once this occurs, then implementation can begin and the beneficiaries will receive the support needed for their programmes and intervention activities. For Sri Lanka to achieve its goal and to achieve the optimum use of resources in support of the programme, harmonization has to occur at the national level with respect to the coordination and alignment of activities. Co-ordination among partners is also essential to ensure the smooth implementation of the Strategic Plan