A Report

In-depth review of the current HIV Prevention and STIs Strategies and Implementation Models for Key Affected Populations (KAPs) in Sri Lanka

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Date: **18th July 2016**

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ACKNOWLEDGEMENT

The Alliance Regional Technical Support Hub (South Asia) on behalf of the review team, would like to express its sincere gratitude to the Director and Senior management Team and GFATM project staff at the NSACP, Executive Director FPASL and the programme team of GFATM (peer led Intervention) project at the PR, SR and SSR who participated in the review and the LFA of the GFATM for the guidance, support and cooperation.

The team would like to specially thank the peer educators and community members who participated in the review for their commitment and cooperation.

NGO, Community Based Organisations who assisted in preparation of field work and participated in the review, are especially acknowledged for their contribution and sharing their experiences to enrich the findings of the review.

ACRONYMS

AIDS	Acquired Immune Deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BB	Beach Boys
BCC	Behavioural Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CBT	Community Based Testing
CCM	Country Coordinating Mechanism
CSS	Community System Strengthening
DIC	Drop-in Centre
DU	Drug User
ED	Executive Director
FGD	Focus Group Discussions
FSW	Female Sex Workers
FS	Field Supervisors
FPASL	Family Planning Association of Sri Lanka
GFATM	Global Fund for AIDS, TB and Malaria
GFPR	Global Fund for AIDS, TB and Malaria Principle Recipient
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IBBS	Integrated Biological and Behavioural Survey
IEC	Information, Education and Communication
IDI	In Depth Interview
IR	In -depth Review
KAP	Key Affected Population
KI	Key Informant
KP	Key Population
LGBT	Lesbian, Gay, Bisexual, and Transgender
LFA	Local Funding Agent
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MESS	Monitoring and Evaluation System Strengthening
MO	Medical Officer
MSM	Men who have sex with men

MTR	Mid-Term Review
NAC	National AIDS Committee,
NAP	National AIDS Programme, generic term for the NSACP
NGO	Non-Governmental Organization
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
OSDV	On Site Data Verification
PE	Peer Educator
PHI	Public Health Inspector
PHNS	Public Health Nursing Sister
PLHIV	People Living with HIV
PLHA	People Living with HIV and AIDS
PLI	Peer Led Interventions
PR	Principal Recipient
PUDR	Progress Update Disbursement Request
PWID	People who inject drugs
PWUD	People who use drugs
SIM	Strategic Information Management
SOP	Standard Operating Procedure
STD	Sexually Transmitted Disease
STI	Sexually Transmitting Infections
SR	Sub Recipient
SSR	Sub- Sub Recipient
SW	Sex Worker
TG	Transgendered people
UNAIDS	Joint United Nations Programme on HIV/AIDS

EXECUTIVE SUMMARY

Sri Lanka has maintained low adult HIV prevalence of less than 0.01% for the past decade with 3,000 (range 2,000 to 5,000) estimated adults of living with HIV in 2014[1] . The 2014 NSACP Annual Report further mentions a cumulative total of 2,073 people were diagnosed with HIV. The proportion of male cases increased from 46% of cases in 2003 to 73% of cases in 2014 with majority in the age groups of 25-49 years. Heterosexual non-commercial sex was reported with the highest share among the modes of transmission in the period 2009-2014. Sri Lanka is one of four countries in the Asia Pacific region that has shown up to a 25% increase in new HIV infections in the period 2001-2011. The increasing number of new cases diagnosed each year is likely to be the result of increased case detection through intensified HIV testing rather than an actual increase in HIV incidence.

In the beginning of 2015, a Mid-Term Review (MTR) of the 2013-2017 National Strategic Plan (NSP) was conducted to assess the overall course of the national response to HIV/AIDS and sexually transmitted diseases (STIs) and the progress towards NSP objectives and targets as well as documents achievements, lessons learned and challenges ahead. The MTR examined the five thematic areas of the NSP (Theme 1 - Prevention; Theme 2 – Diagnosis, Treatment and Care; Theme 3 – Strategic Information; Theme 4 – Supportive Environment; Theme 5 – Health Systems Strengthening and Supply Chain Management)

To complement the findings and recommendations of the 2015 MTR, an in-depth review of the current HIV and STIs prevention strategies and implementation models sex workers (SWs), men who have sex with men (MSM), beach boys (BB) and people who use and/or inject drugs (PWUD/PWID) in Sri Lanka was conducted jointly by NSACP of Sri Lanka (as GF PR 1) and FPA Sri Lanka (as GF PR2).). The Alliance Regional Technical Support Hub (The Hub) was selected to carry out the review. A team of three well-experienced experts was formed to carry out the said review between February and March of 2016. Based on the findings of the review the report was prepared which was disseminated at the national level on 5 April 2016. The report also includes some of the suggestions made in the national dissemination meeting.

The report is divided into 3 chapters which includes,(1) introduction of the study, (2)findings of the study and (3) the recommendations. The objective of the review study mainly focussed on quantitative and qualitative assessment of the service delivery, level of integration and coordination of the interventions and different service delivery modalities for KAPs; and concrete recommendations to inform the development of a National HIV and STIs Prevention Strategy for key populations as well as reprogramming. The review methodology included the review of the available documents, data and reports; data collection at various levels of the project implementation through FGDs and in-depth interviews.

At the policy and strategy level the national strategic plan and leadership identified peer education as a critical strategy for reaching out to KAPs and also to provide effective care, support and access to treatment. A unique strength is that similar understanding of the programme was shared across all levels of programme beginning at the leadership and running down to the front line peer educators. The gap however in terms of programme implementation plan and connectivity of the national M&E plan with that of the MIS for the peer led intervention indicated the requirement for improved coordination and development of programme implementation plan, national MIS and guidelines.

[1] NSACP Annual Report 2014

With the grant support from the GFATM, the peer led intervention for KAPs is implemented through CBOs and NGOs in 13 districts (10 districts – FSWs; 6 districts – MSM; 8 districts – drug users, and 7 districts – beach boys). The selection of the districts is based on BSS and Size Estimation carried out prior to 2013-14 in the country. The service delivery package for all KAPs is same which includes, IEC and BCC, condom promotion and escorting to the STD clinics. There is no single document which explains the programme and its component and various processes including the service delivery. The peer educators modify messages and services according to the situation and sub-category of the peer based on their own perception and understanding of the facts to deliver it to different categories of peers. The female drug users are reached by sex worker peer educator while transgender community is reached by the MSM peer educators. Such an approach has compromised the effectiveness of the services, especially for these two groups.

The peer educators are selected by the field supervisors and SSR programme coordinators which is reviewed by the SR and PR before their selection is confirmed. For skill development, the peer educators were initially trained in 5 day residential workshop which later on took place for 2 days. Since the trainings are not regular, new peer educators receive hands-on training from other peer educators and field supervisors. The programme has only one training module to train all categories of workers. Since the beginning of the programme only two training have been organised. The retention of peer educators by the programme is a significant challenge as most are engaging in other activities for their regular income. The programmatic pressure to meet the activity targets, increased burden of reporting, delayed payments, random calling for meetings and data verifications, are quoted as major hindrances to continue working as peer educator, as it affected their regular job.

The M&E plan and system at the PR2 has efficiently combined both, manual and web based tools to record progress of the programme. Adhering to the performance based remuneration model, reporting mechanisms is focussed on and linked to the payment of salaries and incentives. Due to separate reporting mechanisms and different technologies used by PR1 (NSACP) and PR2 (FPASL), only during Joint Project Implementation Review Meeting data are compared, issues discussed and resolved.

The field team while appreciates the requirement of data, are concerned of several reporting formats for various reasons. Additionally the data verification approaches and methods were mentioned as factors that also negatively influence the work of the peer educators. The data shared with the review team indicates that the project has been able to cover 33% FSW, 48% of MSM populations, 19% Drug users and 33% Beach Boys against the National Size Estimation, NSACP 2013. The coverage of KAPs while increased substantially in 2015 as compared to previous two years, the escorting to STI clinics has remained a challenge and stands at 33% of the reached populations on an average for the entire project period. Additionally the peer dropout rate stands at average of 15%.

Significant level of stigma and discrimination against KAPs remains challenge for the programme as it impedes the outreach as well as access to the services. Although different programmes in the country are working with the public systems to help establish a supportive environment for KAPs and to enable their access to care, support and treatment services, these are sporadic and lack adequate follow-up.

As informed, all 33 provincial STD clinics are located in the hospital setting. It also has laboratories to conduct the required tests, including for HIV and syphilis. Pre and post-test counselling is done by the doctors who are trained in counselling, but lack a suitable space to offer counselling in some

STD clinics. Counselling however is not an essential feature in the STD clinics, and mostly depends on the patient load on the day of visit. All services, including condom education and distribution on demand, test and treatment at the STD clinics are offered free of cost to the clients. The discussion, specifically with the MSM community indicated that they faced stigma and discrimination at the STD clinics, especially when interacted with the support staff. Several of the KAPs avoided visiting the STD clinics as they were discriminated and harassed besides placing their sexual identity at risk of exposure.

To provide IEC and BCC to the peers PEs were given only one set of small booklet and a supply of leaflets. Additionally they had a plastic model of a penis (dildo) and some condoms to carry out condom use demonstration. The booklet and leaflet given to the peer educators across all KAPs are same in their design and content and do not address specific issues of different groups and sub-groups of the KAPs. Since the booklet and leaflets given for IEC and BCC had too much of text the PEs and FS found it less interesting and difficult to use in the field. The condom supplies were reported as adequate and except once no stock out was reported during past 3 years.

The concept of Drop-in-centres (DICs) was well received among the functionaries who also understood its utility for enhancing the outcomes of KAP interventions. However, they lacked clear understanding of its operational aspects. However, there were several concerns, especially regarding the confidentiality and the provider of the services at such DICs. It was also felt that the DIC for different population groups should not be operated together. It was interesting to note that the PEs could relate the effective use of DICs for community based testing.

The review team explored the possibility of the community based testing at all levels of its data collection efforts. At the decision making and management level officials are quite supportive to the idea of community based testing and feel that it can be done effectively through public-private-partnership approach where the involvement of the KAPs is essential. The requirement of building the capacity of the CBOs and NGOs was strongly felt by the decision makers and managers at the national level as this can only ensure the success of the community based testing initiative.

A detailed matrix of findings and recommendation has been provided as annexure 5 of this report. However some recommendations from the study categorised at (1) National level (2) KAP focused and NGO/CBO level is provided here under:

At National Level:

1. In the larger interest of the national programme it is important to have a national level programme guideline for peer led targeted intervention which follows the national strategic directions.

2. There should be a small pictorial booklet summarising the national programme guideline and service package, responsibilities of a peer educator, separately done for each group and sub group of KAPs, based on field experiences.

3. The policy and strategy to facilitate and ensure interaction and coordination between different national level programmes should be established for optimum utilisation of available resources and increased effectiveness of different programmes.

4. The programme should have a component of community system strengthening with funding support for active involvement of the KAPs in the service delivery.

5. The operationalization of the service package needs a different treatment with each of the KAP groups.

6. The country should be revising its National Counselling and Testing Guideline to include the community based testing and relevant protocols for its various aspects.

7. As the mandate of the testing lies with the NSACP, it should be taking the responsibility of coordination and monitoring of the roll out of the community based testing at the national, provincial and district levels.

8. The PR for the peer led intervention programme should make sustained advocacy efforts to mobilise the government to update and strengthen the STD clinics.

9. The programme requires an effective communication strategy addressing the specific needs of IEC and BCC for different segments of target population

KAP focused Service Integration:

1. There is a need to re-visit and undertake a fresh size estimation and mapping of KAPs, particularly in the districts where the programme is being implemented.

2. There is an urgent need of well-planned and integrated effort towards creating enabling environment for all KAPs by improving the interaction and coordination with various advocacy and capacity building programmes.

3. It is recommended that small steps for advocacy are essentially planned and embedded in the current intervention design, such as legal literacy, building communication skills and developing negotiation skills of vocal community members and leaders for different groups of KAPs.

4. The facilitation of community interaction programmes and involvement of key community leaders to talk about the situation and rights of the KAPs at the local levels will help build supportive environment for the KAPs.

5. It is recommended that a study should be undertaken to assess the gap between the demand and supply of condom, lubes and needles-syringes preferably at the SSR level.

6. Reflecting the general acceptance to the concept of Drop in Centre and given the Sri Lankan context of low prevalence and size of KAP, the review team suggests the implementation of DIC approach, separately for MSM, FSW and DU communities.

7. It is suggested that a certain amount for a fixed number of target should be determined and essentially be paid to all PEs and for all additional number of peers, extra incentive to be paid.

8. A policy and strategy should be developed to support and build the capacity of the community based organisations of KAPs as they are the only link between the national programmes and the KAPs.

9. The programme should address the needs of female drug users and transgender community by recruiting enough number of peer educators from among these sub-groups.

At Health care service provider/NGO/CBO levels:

1. In order to increase the retention of the peer educators it is important that they are strengthened through regular efforts of training and capacity building.
2. In order to help peer educators reach their targets it is important they are supported in their work, mentored on regular interval and encouraged through facilitation by providing them supportive supervision.
3. The peer education programme should recruit and train adequate number of counsellors to enrich the quality of outcome of the programme
4. The staff members especially those at lower ranks at the STD clinic required to be sensitised regarding the privacy and confidentiality of every client that visits them.
5. Pocket meetings should be considered to be converted into group sessions which should be conducted at the hotspot or at the DIC as they are developed.
6. It would be in the interest of the programme to maintain a buffer stock of condoms at each level of the management. Also there has to be an alert system in place which raises flag as soon as the stock goes below a certain limit.
7. It is recommended that the communication materials used by the peer educators in the field should be more pictorial and interesting rather than being heavy with text. The peer educators should also be given some communication aids such as edutainment games and flip cards to be used for IEC and BCC sessions with the peers.
8. In addition to community mobilisation and IEC campaigns the community based testing programme must be supported with strong system of counselling, report delivery and strong linkage, referral and follow-up system with the STD and ART clinics.
9. It is recommended that there is a wider consultation with the peer educators and field supervisors to design the mechanism for performance based incentive.

INTRODUCTION:

Sri Lanka has maintained low adult HIV prevalence of less than 0.01% for the past decade with 3,000 (range 2,000 to 5,000) estimated adults of living with HIV in 2014 (NSACP Annual Report 2014-2015). Based on the 2014-2015 NSACP Annual Report, a cumulative total of 2,073 people were diagnosed with HIV. The proportion of male cases increased from 46% of cases in 2003 to 73% of cases in 2014 with majority in the age groups of 25-49 years. Heterosexual non-commercial sex was reported with the highest share among the modes of transmission in the period 2009-2014. Sri Lanka is one of four countries in the Asia Pacific region that has shown up to a 25% increase in new HIV infections in the period 2001-2011.

In a low-prevalence context like Sri Lanka, programs must focus a large share of their efforts on prevention activities for the most at-risk populations, if an epidemic is to be averted. Prevalence data on MARPs is also limited. While coverage of key populations (female sex workers, men who have sex with men) with targeted prevention programs have been introduced the coverage still need to be increased[2].

Identifying key populations driving the epidemic in Sri Lanka is challenging, as no particular population group has higher rates of infection than any other, and HIV prevalence has remained below 1% in the last ten years. However, key populations engage in behaviours that would increase their exposure to HIV if the virus were to enter their sexual networks. These include female sex workers (FSWs) and men who have sex with men (MSM), both of which exist in fairly large numbers in Colombo, and to a lesser degree in other larger cities. Beach boys (BB) are also a population with risky behaviour, but they are a relatively small group. There are a large number of people who use drugs (PWUD) in Sri Lanka, but the vast majority of them does not inject drugs or share needles, which is the main risk behaviour for HIV transmission in this population. If this population shifts to injecting, the potential for HIV to spread would be more of a threat; therefore the situation must continue to be monitored.

In the beginning of 2015, a Mid-Term Review (MTR) of the 2013-2017 National Strategic Plan (NSP) was conducted to assess the overall course of the national response to HIV/AIDS and sexually transmitted infections (STIs) and the progress towards NSP objectives and targets as well as documents achievements, lessons learned and challenges ahead. The MTR examined the five thematic areas of the NSP (Theme 1 - Prevention; Theme 2 – Diagnosis, Treatment and Care; Theme 3 – Strategic Information; Theme 4 – Supportive Environment; Theme 5 – Health Systems Strengthening and Supply Chain Management)

To complement the findings and recommendations of the 2015 MTR, an in-depth review of the current peer-led HIV and STIs prevention strategies and implementation models among sex workers (SWs), men who have sex with men (MSM), beach boys (BB) and people who use and/or inject drugs (PWUD/PWID) in Sri Lanka was conducted jointly by NSACP of Sri Lanka (as GF PR 1) and FPA Sri Lanka (as GF PR2)

The term of reference (TOR) was prepared and EOI from technical experts/agencies were invited to conduct the review. The TOR for the review is appended as annexure -1 to this report. Based on the quality of the proposal and the proposed budget Alliance Regional Technical Support Hub (The Hub) was selected to carry out the in-depth review.

The Hub formed a team of three well-experienced experts to provide technical support/assistance to carry out the in-depth review of the current HIV Prevention and STIs Strategies and

[2] http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-sri-lanka accessed on 7 March 2016

Implementation Models for KPs in Sri Lanka. The team of experts consisted of two international and one national consultant. The field work was carried out between 25 February and 2 March 2016. The timeline of the fieldwork is appended as annexure -3.

Structure of the Report

The report is presented in following sections:

1. The study, where the objective, methodology and limitations of the study are discussed.

2. Findings of the study section discusses the data gathered by the team from the documents, in-depth interviews, focus group discussions and programme reports, regarding the functioning of the programme, its strengths and challenges.

3. Recommendation section of the report discusses possible actions to improve the programme output and outcomes that are based on the suggestions of the participants of the study and other published documents on similar subjects.

CHAPTER-1: THE STUDY

Objectives of the Review

1) To assess strengths and identify specific operational aspects for improvement in the current peer model implemented by NGOs as the Principal Recipient (PR), Sub- Recipients (SRs) and Sub-Sub-Recipients (SSRs), including recruitment, training and retaining peer educators; organizational development of NGOs and CBOs; target setting at the national and sub-national level to ensure geographical and population coverage, service quality improvement strategies, etc.,

2) To assess specific programmatic achievements and areas requiring improvements in the above interventions for KPs as well as prioritize those most likely to lead to impact.

3) To assess the scope, scale, comprehensiveness of, quality of service delivery, level of integration and coordination of the interventions and different service delivery modalities for KAPs

4) To identify opportunities for sustainability and continuation of interventions and programs that reach key populations in the community beyond Global Fund grant span to maintain the low prevalence of HIV in the country

5) Provide concrete recommendations that will inform the development of a National HIV and STIs Prevention Strategy for Key Populations as well as reprogramming implementation modalities for KPs interventions to be supported through the Global Fund Funding Model grant in contribution to the national HIV and STIs response.

Methodology

The team of 3 professionals from Alliance Regional Technical Support Hub conducted the review between the period January to March 2016. The review consisted of a desk review which took place from end of January 2016 to 3rd week of February 2016. The desk review was followed by field visit from 25th February to 3rd March 2015.

Desk Review:
The review team did a thorough study of the relevant documents that was made available by FPA SL and NSACP. The list of the documents is attached as annexure 4 of this document. The team also analysed programme related documents, data, reports, narrative reports; and some documents that help understand the support available and provided to the programme. Additionally the team also reviewed the process information, and other studies such as Integrated Bio-Behavioural Survey report, mapping reports, Behaviour Surveillance Survey report, size estimation report etc.

Based on the inferences drawn from the desk review of the documents, tool for data collection were developed which focused on substantiating the preliminary findings and explore additional information to understand the outcome of various aspects of the programme.

Field Visit:
The desk review was followed by the field visit which done from 25th February to 3rd March 2016. The visits were done in three districts of Sri Lanka where the peer led targeted interventions are being implemented namely Colombo, Gampaha and Galle.

The review team actively solicited input from as many members of the programme as was feasible within one-week in-country field visit. Assisted by FPASL central office and NSACP the review team used primarily in-depth interview and focus group discussion methods to review activities related to the peer led targeted intervention among MARPs supplemented by observations. The in-depth interviews and FGDs were guided by a set of key questions which are appended as annexure-2.

The visit of the review team coincided with the transition period when the project activities from the Round-9 grant had concluded and the subsequent grant implementation was yet to be started. The availability of the project clients, members of the project team as well as the SRs and SSRs thus depended exclusively on their willingness to participate in the review. Another factor that affected the selection of the sites was the distance from the Colombo, since the team could not visit far away sites due to time and resource constraints. Nevertheless, the team chose to visit at least one project each for MSM, DU, FSW and BB. While selecting from among the SR and SSRs willing to participate in the study their performance was also taken into account. At least one better and one not-so-good performing SR and SSRs were selected for the data collection from among those consented to the PR's request to participate in the study.

The selection of the respondents from among the peers, peer educators and other team members depended on their availability and willingness to participate in the FGDs. The key informants from the programme management and decision making levels were selected depending on their position and influence in the project related decision making.

Coverage of the Review

Informant	Numbers	Tool
NSACP Team	6	In-depth interview
PR Team	16	3 In-depth interview and Focus Group Discussion
SR Team	6	Focus Group Discussion
Programme Coordinators	7	Focus Group Discussion
Field Supervisors	32	Focus Group Discussion
Peer Educators – Drug User	22	Focus Group Discussion
Peer Educators – FSW	23	Focus Group Discussion
Peer Educators – Beach boys	7	Focus Group Discussion
Peer Educators – MSM	24	Focus Group Discussion
Peer – Drug User	7	Focus Group Discussion
Peer – FSW	4	Focus Group Discussion
Peer – Beach boys	4	Focus Group Discussion
Peer – MSM	7	Focus Group Discussion
STD Clinics	3	In-depth interview and observation

Limitations of the Study

1. **Sampling:**

The review study does not claim to represent views of all the stakeholders involved in the implementation of the project as it did not reach out to a perfect representative sample of the stakeholders. Within the time available for the field work, the three members' team visited only 3 districts of the 13 intervention districts and none of the sites. All FGDs except one each with the BB and FSW peers were done in the field. Rest all were conducted in safe official settings to avoid any possible implication of exposure.

The sampling strategy that was developed in consultation with the FPASL included following:

- The documents, data and reports that are provided primarily by the FPASL and the NASCP are to be reviewed
- In-depth interview with at least 3 and maximum of 5 officials in key position who influence the decision making
- In-depth interview with at least 2 and maximum of 4 managers of the PE programme and at least 1 member from PE intervention team at the SR and SSR
- At least 5 randomly selected PEs from each KP group x at least 2 FGDs
- At least 5 randomly selected members of each KP group x at least 2 FGDs
- Doctors at STD Clinics x at least 2 clinics

Other limitations of the study are mentioned below.

2. **Timing and geographical coverage**

At the time of the review the implementation of the intervention was halted due to completion of the 2nd phase of the first GFATM grant for the programme. It is awaiting the start of the new grant under new funding model of the GFATM. In spite of the fact that none of the project team member was employed or receiving any incentive from the work or from the review study, their participation in the study in significant numbers was very encouraging.

Although the team feels that their responses and discussion were close to the reality, their being motivated by the perception that the results of the review can affect the continuity of the project is hard to rule out completely. The possibility of the PEs being motivated or influenced for their response was thought for two reasons. One, that in a case where the turn-over of the PEs has been quite high during past years and also there has been several complaints during the project period regarding the treatment meted out to the team members, PEs and field workers didn't mention any challenges. Other reason is that the FS and PEs were gathered by the SR and SSRs in their offices and were explained the purpose of the discussion. The review team in no way suspects the SR and SSR for any wrong-doing but wish to caution the reader of the report of this possible effect.

Although the project is being implemented in hot-spots of 13 districts, the team could visit only Colombo, Gampaha and Galle districts. The findings of the review thus be applied carefully as the availability of services in other districts may vary besides the variation in socio-cultural contexts.

Even in the districts the team's visit was restricted to the project offices and only in one case it could talk to the peers in their work area. The visit in the field was restricted by the fact that the project had stopped and most peers and PEs had gone to their regular jobs. The team also had to complete the field work within 5 days, covering long distances to reach to the districts.

3. Presence of PR team member representative

The review team was guided in the field by a senior team member of the PR team for most of the FGDs and in-depth interviews. Although the team feels that most participants at the in-depth interviews and FGDs weren't affected by the presence of the PR team member, the stress on some faces were quite visible while sharing the information or responding to the questions, especially at the levels of managers and supervisors.

4. Linguistic barrier

Except one, the members of the review team spoke and understood only English whereas most participants in the field communicated only in Sinhala, the national language of Sri Lanka. The international team members depended on the interpretation of information provided to them by the national consultant and one of the local team members who were not trained in translation. There is thus a possibility of loss of information due to linguistic barrier which should be kept in mind while reading the information provided in the report.

CHAPTER-2: FINDINGS OF THE STUDY

The findings of the study are based on the following –

- Desk review of the documents pertaining to the policy, strategy, programme planning, systems, processes, trainings, legal environment, monitoring and evaluation, reports, programme reviews, research, evaluations and other surveys and studies conducted in the country relating to the situation among key affected population groups, and several other studies available in this regard on internet and in other domains. The documents for review were provided mainly by the FPASL and NSACP, Sri Lanka.
- Field work for data collection which primarily depended on observations, focus group discussions, and in-depth interviews with the key stakeholders of the programme in the country.

The findings of the study are grouped under different stages and sections of the programme planning and implementation for better reading as below:

1. Policy and Strategy

The National Strategic Plan 2013-2017 mentions the peer education in the context of prevention strategy. It has identified 5 strategic directions. Under first strategic direction of Prevention one of the sub-strategies is *Behaviour change modification through outreach and peer education*.

Further under the strategic direction 4, the NSP states that "*Community, home and peer support is one of the important areas of support for people living with HIV whose medical needs are being met. While the STD/HIV public health programme can do outreach and follow up patients, home and community support by peers is important to reinforce long term compliance to care and treatment.*"

However, in absence of a programme implementation plan it is difficult to assess how much of the two mentioned sub-strategies were planned to be translated into action. The monitoring and evaluation framework of the NSACP also lacks any such indicator that reflects the efforts related to peer education. It was noted in the in-depth interviews that the annual reports by the NSACP is a recent phenomenon, which only has reflected the data available with the NSACP, and none of the data from other agencies working in the country have been included in this reports. Although the programme documents and data available with the other principal recipient of the GFATM grant in the country FPASL, indicates that PE led targeted intervention among KAPs has been implemented.

The in-depth interviews indicated that the NSACP believes KAPs can be reached effectively only through peer led intervention that are implemented by NGOs in the country. However the country doesn't have any existing mechanism to support such efforts through its own resources. There is also a lack of trust between government and NGOs in the country. Considering the PE led intervention is an only effective tool to reach out to KAPs in the country for the prevention and control of HIV and AIDS, the NSACP is determined to help sustain NGOs effort in future. The NSACP, as stated by a senior official will soon be approaching the Government of Sri Lanka to allocate funds to support NGOs involved in such interventions. However no detail plan was shared.

Although the PE led intervention is being implemented in hot-spots of 13 relatively highly vulnerable districts of the country, the policy and strategic level exploration reflect several gaps in

its connection with the mainstream programming and government's ownership of the programme. Indeed, the programmatic understanding and involvement of the NSACP officials and thoughtfulness to scale-up and sustain the efforts in the country is encouraging. It is also important to note that without the policy and strategy level support of the NSACP in particular and government in general implementing such a programme for KAPs could not have been possible. The approval mechanism of the CCM and the GFATM require a well-placed programmatic approach and strategy within the national framework and since the programme under review is well within the National Strategic Framework, the Round 9 of the GFATM has been granted to NSACP and the FPASL.

Indeed, in order to continue to maintain the understanding and supportive environment for such an important programme it is important that the policy and strategy documents and the role of the leadership are well established through proper documentation and improved coordination.

2. Programming and Service Package: Peer Model

Structure:

The FPASL implements the PE led targeted interventions for KAPs through CBOs and NGOs for FSWs in 10 districts, for MSM in 6 districts, in 8 districts for drug users, and in 7 districts for beach boys. The selection of the districts made by the NSACP is based on the high numbers of each key population as estimated by the Behaviour Surveillance Survey and Size Estimation carried out in the country. District wise targets for each KAP have been set, taking into account the estimated size of the concerned populations in each district. The number of peer educators recruited to deliver the service package is based on the targeted numbers of key populations to be reached in each district. The number of peers to be reached by each peer educator is between 10 and 20 depending on the type of the key population. There is also target number of the peers for each PE which has to be escorted to the clinics (30 to 40% of the reached peers) and has limitation on the number of condoms to be distributed per peer, per month.

The SRs and SSRs for the programme implementation were selected through a transparent process and system. A committee comprising of members from PR1 and PR2 and UNAIDS was formed that invited EOI from NGOs and CBOs through an open advertisement in national newspapers. The applications thus received within the deadline were reviewed and assessed by the committee. Based on clearly defined criteria the SRs and SSRs were selected to implement the programme. A fresh process was started to select a new SR or SSR when there was a need due to geographical expansion or in order to replace a poor performing organisation.

Service Package:

The details of the PE led intervention programme and the services package for KAPs is available across several documents, the grant document, periodical reports, training modules, procedure manual for implementation of GFATM (Round 9-phase II HIV programme), mid-term- review report 2015, report of the IBBS 2014 and monitoring and evaluation plan for the programme. There is also a set procedure and format to facilitate the selection of the peer educators. The PR team also has drafted the service definition which helps understand the programme.

According to the information available across the documents mentioned above the PE intervention model is delivering basic/minimum service package for sexual health and HIV prevention via a trained peer educator. The package has three principal components:

- IEC and BCC - education on sexual health/HIV prevention, understanding of risk behaviour, distribution of leaflet and other IEC materials etc.
- Condom promotion – condom use demonstration, explaining the steps in condom use, and condom distribution
- Escorting to a state STD clinic for voluntary and confidential counselling and testing services

All the key population groups, FSW, MSM, DU and BBs receive a common service package. Few features such as the number of peers to be reached by a given peer educator and the number of condoms to be provided are the only differences among these packages.

The peer educators are also required to fill out the reporting formats based on their work in the field, which includes, work calendar, field diary, records for leaflets and condoms distributed, referral slips and records of escorting of peer to the STD clinics.

However, there is a lack of a specific programme implementation plan and programme implementation guideline to maintain uniformity across the districts and SSRs in terms of programme implementation. Indeed, it is important to note there is a sharing of same understanding of the programme and service package form the top officials at the FPASL and NSACP to the peer educator in the field. This is a unique strength of the programme.

It is also important to note that there is a same set of programmatic activity and service package for all categories and sub-categories of KAPs in all places. The peer educators though modify messages and services according to the situation and sub-category of the peer. This is good as well as carries a significant risk, as the variation in messages and services are based on their own perception and understanding of the facts.

Additionally, it is to be noted that the female drug users, though in significant numbers, are not reached by the programme. As most of them engage in sex work, the sex worker peer educator attempts to reach out to the female drug users, which is not acceptable to most female drug users. Similarly, the transgender community is reached by the MSM peer educators, which has reduced impact. The data regarding the female drug users and the transgender community thus is captured under female sex workers and MSM component, respectively.

As for overall coverage and performance a snapshot of the programme is presented in the below table.

Coverage and Peer Educator Analysis			
Female Sex Workers	**2013**	**2014**	**2015**
Estimate	**14132**		
Reach	2322	2980	4603
Peer Educators in Position	183	219	271
Peer Educators Trained on BCC	140	130	80
Peer Drop-out Rate	2%	17%	16%
Peer Educators to Peer ratio	13	14	17
Coverage (taking reach numbers in 2015 to be cumulative)	**33%**		
Men- sex-with-Men	**2013**	**2014**	**2015**
Estimate	**7552**		
Reach	2127	3203	3638
Peer Educators in Position	180	300	400
Peer Educators Trained on BCC	168	117	61
Peer Drop-out Rate	8%	16%	17%
Peer Educators to Peer ratio	12	11	9
Coverage (taking reach numbers in 2015 to be cumulative)	**48%**		
Drug User	**2013**	**2014**	**2015**
Estimate	**12618**		
Reach	851	1556	2346
Peer Educators in Position	126	285	302
Peer Educators Trained on BCC	225	182	91
Peer Drop-out Rate	7%	15%	20%
Peer Educators to Peer ratio	7	5	8
Coverage (taking reach numbers in 2015 to be cumulative)	**19%**		
Beach Boys	**2013**	**2014**	**2015**
Estimate	**873 (Off Season) - 2001(Peak Season) Average Estimate - 1874**		
Reach	230	484	622
Peer Educators in Position	50	64	85
Peer Educators Trained on BCC	59	55	12
Peer Drop-out Rate	24%	17%	18%
Peer Educators to Peer ratio	5	8	7
Coverage (taking reach numbers in 2015 to be cumulative and average of Off-season and Peak season Estimates)	**33%**		

3. Human Resources, Training and Capacity Building

The peer educators are essentially a member of the community for which they are working. Each peer educator has to provide services to a minimum of 10 to 20 peers from his/her community. These numbers may vary according to the KAP group concerned. The selection criteria for the peer educator include personal information including their national ID card number, and their response to specific questions regarding their understanding of the programme and willingness to provide

specific services including escorting the peers to the STD clinics. The peers who wish to be peer educator fill out a form given to them, which is verified and signed by field supervisor, programme coordinator and then head of the SSR. Further, based on its merits it is approved and confirmed by the SR and the PR.

Sarvodaya, the earlier PR had developed a training module to train the trainers who in turn trained the Peer Education team using the same module in the field in 5 days residential training workshops. The same training module was reviewed by the FPASL and its concise version was produced by the FPASL in 2013. The peer education team now was trained in 2 days residential training workshop. The training module is comprehensive and uses short lectures and participatory methods to educate peers. It covers various aspects of peer education in 15 sessions.

In 2 days' training workshop the participants are trained through lectures and participatory methods. The topics covered on the first day of the training include STI and HIV, sexual health , sexuality, communication skills, BCC, peer education, life skills, hot spot mapping, planning access to peers, counselling and HIV and risk assessment. Second day the participants are trained on peer education and prevention package, special issues concerning KAPs in Sri Lanka (such as legal environment, ordinances), reporting requirements and monitoring and evaluation of the programme. Review of the training module reflects that most sections are adequately comprehensive, but other sections, especially on sexual health, communication and skill development are quite technical and require more time to help participants understand and absorb it. However the module doesn't have or suggest any training material that could have been used by the review team to understand the quality of the training.

The programme's single training module is used for training of all cadres of workers. Since the beginning of the programme only two training have been organised for each component and/or district. The number of trainings depended on the number of trainees for a particular component in each district. First one was for 5 days while the second one was for two days. Except for these two, there were no training for any cadre of workers on programmatic issues and service delivery. There have however been other trainings for the management team members on programme management, finance, etc.

As stated earlier the peer educators were initially trained in 5 day residential workshop which later on reduced to 2 days. The reduction in the number of training days was influenced by the presence of the participants. As most peer educators were engaged in other livelihood activities it was difficult for them to stay over for 5 days residential training. Hence many were irregular in the training while some left the training in between. The reduction in the number of days to 2 resulted in reduced amount of discussion/interaction between the trainers and trainees which led to the low level of knowledge gain in 2 days training as compared to that in 5 days training. The trainings were organised component-wise, and average number of trainees in each training varied between 25 and 40. Only one round of training was conducted for each component. Since the training workshops were done only once, new peer educators receive hands-on training from other peer educators and field supervisors. The pre and post knowledge and skills assessment of the trainees showed substantial positive increased change it was low in 2 days training sessions as compared to 5 days training sessions. The effectiveness of hands-on training was not assessed.

The retention of peer educators by the programme is quoted as a significant challenge as most are engaging in other activities for their regular income. The programme continues to pay the peer educators and other team members the same amount when it was started, which is not enough to meet their daily expenses. In one of the FGDs it was mentioned that – "*When programme started*

the coconut was selling at Rs. 10. Now the price of the coconut is increased to Rs. 60 but we are paid the same amount."

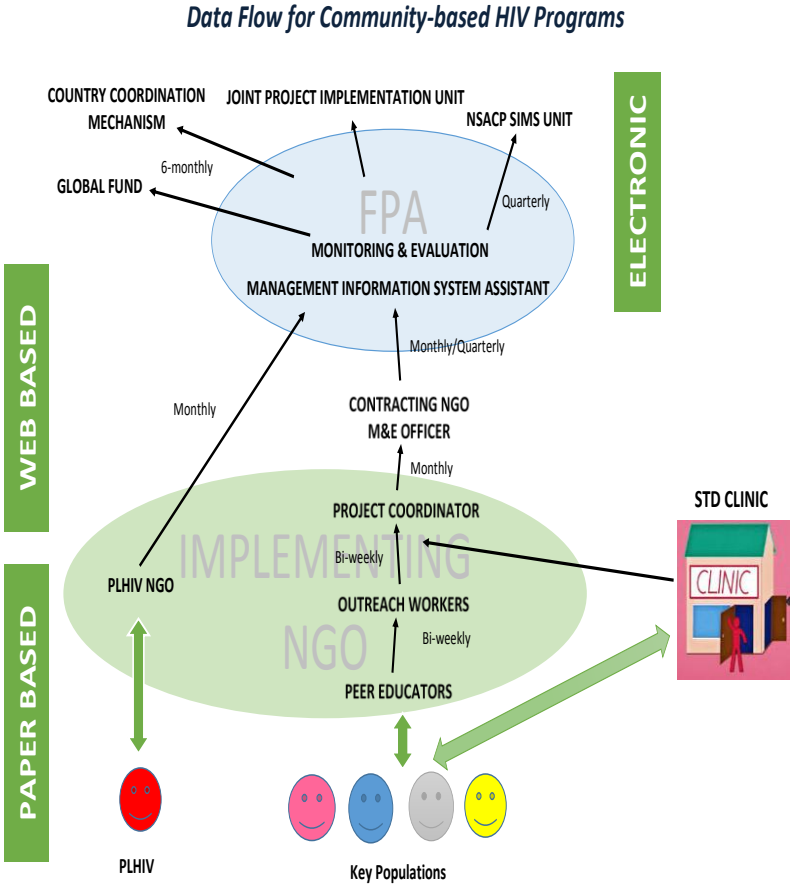
The programmatic pressure to meet the activity targets, increased burden of reporting, delayed payments, random calling for meetings and data verifications, are quoted as major hindrances to continue working as peer educator, as it affected their regular job. Most peer educators also mentioned that they had to pay for transport and many a time for refreshments of the peers when accompanying them to the clinics. Some of the peer educators working with the drug users also mentioned that they were forced by the peers to buy them drugs soon after visiting the clinic. This was mostly as the DU peers couldn't be taken to the clinic when they were intoxicated. They had to remain sober in the morning or before visiting to the clinic so they wanted drugs immediately after the visit. This was corroborated by the field supervisors as well as the coordinators. Among the MSM and beach boys high mobility due to various socio-economic reasons was cited as a reason for high burnout. The peer educators also noted that many a time several of the peer educators were blackmailed by the peers as they knew their presence was required for data verification. Unless the data provided by the peer educator was verified by the SR and PR monitors, the peer educators didn't receive their remuneration. Even field supervisors complained of spending more than double of the transport allowances they received for field work, as they had to cover a large area to reach to the target for the programme.

The requirement of the regular training, capacity building and mentoring in such a situation therefore becomes much greater. This requirement was met through on-the-job training, which most respondent thought was not enough. The managers quoted lack of funds as a reason for not organising the capacity building sessions for the peer educators. The review team did not find any system in place that can mobilise, encourage, and support the peer educators to help them reach their target in qualitative manner.

4. Monitoring and Evaluation

The programme managed by the PR-1 has computerised comprehensive monitoring and evaluation (M&E) system in place where the data flow is well designed; responsibility at each level is defined and the system is able to point out any deviation in data supplied. The PR-1's M&E system can also be used to generate data reports for each component separately as well as for overall programme.

The reporting systems have a layered data flow and feedback mechanism from the SSR to PR level. Reporting to the PR1 and the donors happens on the key performance indicators and impact indicators on a quarterly basis. Programmatic updating



happens every 15 days from the SSRs. Adhering to the performance based remuneration model reporting mechanisms are linked to the payment of salaries and incentives.

The M&E plan of PR-2 captures the service package for all KAP (FSW, MSM, BB and DU) groups interventions in the manner the program is designed. The service package remains same for all KAP groups hence the indicators reported upon are set uniformly. The M&E system captures the following - 1. Reach, 2. PE Training, 3. Escorts, 4. PE on board 5. Clients service provision 6. Peer Educator status 7. Visits (No. of contacts with peers within the month), and 8.Services (IEC events and condom distribution).

The M&E Plan for the KAP intervention of PR2 is an efficient system combining both manual and web based tools to record progress of the programme. One of the interesting and competent feature of the M&E plan is its capability to highlight duplications in terms of recording. The system has an inbuilt feature to analyze the progress of the program. The tool also is linked to the financial aspects in terms of incentives and allowances to the PE. Thereby a performance based remuneration system has been established. Physical verification systems are in place.

The peer educators collect primary data in various formats and templates, which is collected and collated by the field supervisors on monthly basis. Field supervisors provide necessary support to the PEs in data collection and ensuring its completeness. The collated data is verified and compiled by the respective coordinator at the SSR and fed into the central data processing system at FPASL through interface provided to the SSRs. The responsibility of final verification and collation of data lies with the SR and PR. Following the verification of the data fed into the main system, it is collated, analysed and data reports are generated in various formats for the consumption of the programme management as well as for reporting to the GFATM at the end of each quarter. There is also a system for data quality assurance and on-site data verification which takes place periodically through field visits by the SRs and PR1. The targeted activities linked with financial incentives receive major focus of the data verification system.

However, the PUDR for three years have indicators of Syphilis, HIV tests conducted and Results known to the KP, Risk behaviour, Condom usage in the last sexual act (PR Programmatic Progress 1A), Reach and condoms distributed, Home based care (presumed) (PR Programmatic Progress 1B). Although there is a mention in the package of services - escorting of 30%--40% KAPs to STI clinic, it is not reflected in the list of indicators. Interestingly, the source of data for the PR Programmatic Progress 1A and sometimes in 1B are the Sentinel Surveillance and BSS reports, in addition to the patient records, ART registers, and ART cohort report.

Mid-Term Review of the national HIV and AIDS programme 2015 reveals that the PE model restricts the number of condoms that can be given to each peer. This is done to mobilise and encourage the targets to buy condoms from the open market, which also indicates the effectiveness/impact of BCC. The mid-term review report also states that the present PE model is 'insensitive' to the needs and behaviours of MSMs as it also places the transgender community under MSM group. It is also reported in the IBBS 2014-15 that the KPs that are in contact with the PEs, mostly are street based. It is true especially for FSWs. Those who operate individually or through parlours etc. are seldom accessed by the PEs with the services. Similarly the MSM that are married and live with their family are difficult to be reached by the PEs.

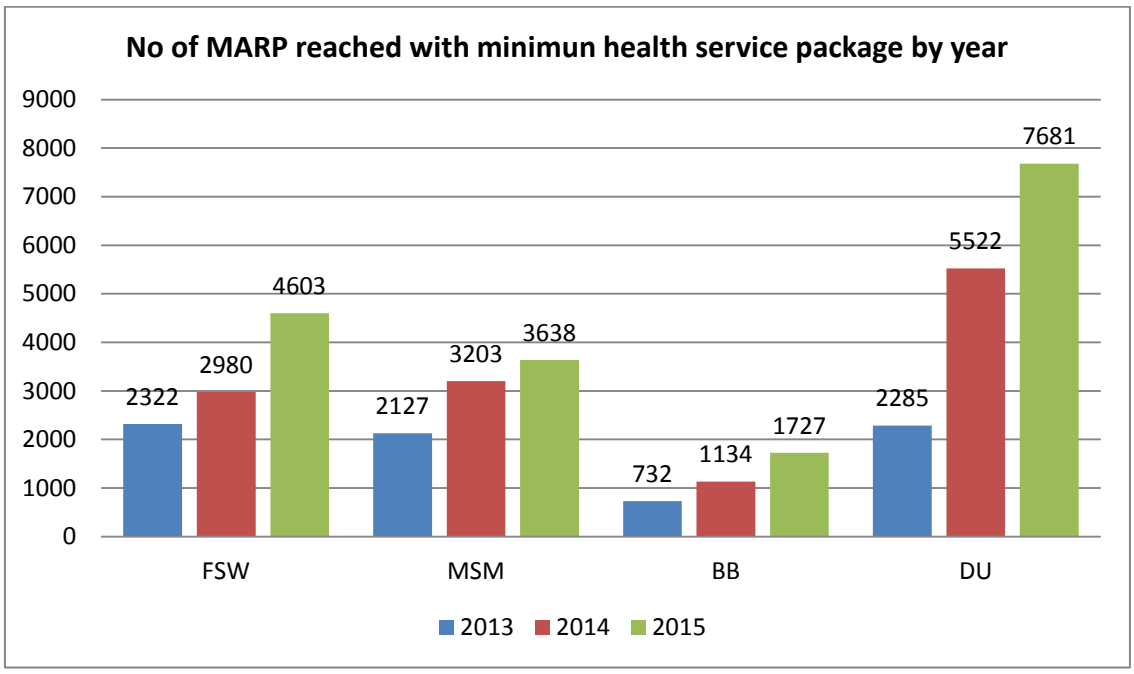
It is important to mention that there are separate reporting mechanisms for PR1 (NSACP) and PR2 (FPASL) and due to different technologies used it is difficult to bring two set of data together in one system for comparison and analysis. It is only during the Joint Project Implementation Review

Meeting that data are compared, issues discussed and resolved. The national programme is yet to develop the comprehensive list of indicators and system for data compilation. The review team also noted that there is insufficient human resource available at the NSACP to collate and compile the data from both the PRs and other programmes in the country.

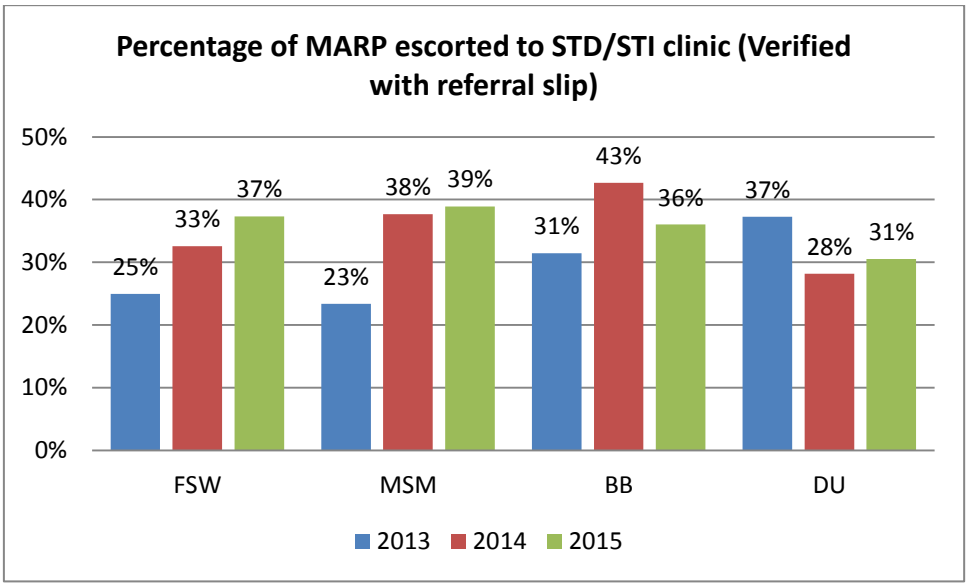
Other M&E issues are also highlighted such as poor reporting and errors in recording of data, discrepancies etc. which may be improved by more frequent trainings and mentoring of the team members at all levels of monitoring and reporting, especially the peer educators with poor literacy. It is also noted that in some months a large number of peers are escorted to STD clinics (reported incidences of STD clinics turning away of escorts) especially close to reporting cycles. Some PEs subsequently have also escorted the peers to other clinics in order to avoid the clinics with issues (Kalubowila, Negombo, etc.), which is reflected in the minutes of the programme review meetings. PEs do not have a plan to span the escorting over the year to avoid such situations.

The field supervisors and peer educators though appreciate the monitoring and reporting mechanisms they are concerned that increasing burden of data recording and several reporting formats are difficult to be carried in the field at all times. This also exposes them and their peers as people are curious to know what is it they are working on when they are seen with papers and diaries in hand and meeting "*special*" people. It also delays and impedes the rapport and confidence building with the peers in the field. Additionally the data verification approaches and methods were mentioned as factors that also negatively influence the work of the peer educators, as most peers do not wish to come in contact with the data verification officials of the programme.

A glance at the performance of the PR2 reflects that the peer led activities assisted in scaling up HIV interventions among the MARPS. Over the project period PR2 has been able to cover 33% FSW, 48% of MSM populations, 19% Drug users and 33% Beach Boys from the estimated populations (National Size Estimation, NSACP 2013). In the three years of programme implementation, coverage of KAPs increased substantially in 2015, which is evident in the below paragraph.



However, escorting by peer educators to the peers to STI clinics has remained a challenge and stands at 33% of the reached populations on an average for the entire project period. Escorting among the BB component has been the highest at average 37% between 2013 and 2015. Attributable explanations provided by PEs and field supervisors for low percentage of total reach converted into visit to STD clinic include stigma and discrimination by the lower level staffs, peers do not disclose their risk behaviours in front of clinical staffs, do not like clinical staff asking questions about sexual behaviours, and at times long waiting time at the clinics. It is specifically true in case of MSM and FSWs who do not wish to disclose their identity for several reasons. Inadequate planning at all levels also hinders systematic mobilization of peers for testing and treatment services that result in overcrowding at the clinics sometimes.



The coverage of MARPs has been less than half of the size estimated. And escorting for testing, treatment and care services has remained at 33% on an average for all the KAP groups. Lack of data (continuum data) on the above mentioned aspects impedes a comprehensive analysis of the gamut of reach, testing, treatment and care. It is to be noted that reasons of PE recruitment, training and varying PE to peer ratios could be attributed to the low coverage apart from the socio-cultural and economical contexts. Similarly the peer dropout rate which is at 15% needs to be seen in the contexts, above mentioned.

5. Enabling Environment

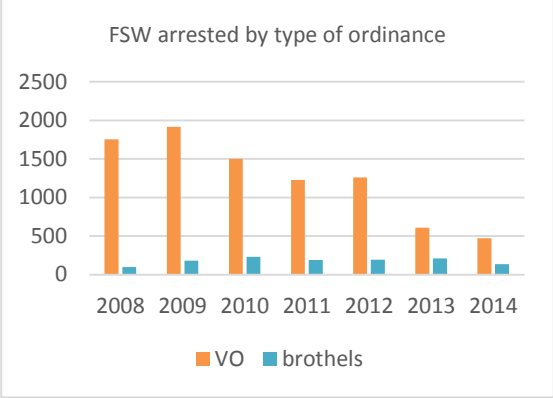
Enabling environment is the first and foremost requirement to implement a successful targeted intervention for KAPs as in most parts of the Asia there is a significant stigma and discrimination against KAPs. Sri Lanka is no exception, which like several other countries has punitive laws against the sex work, homosexuality and drug use. The laws include, Vagrants Ordinance, Brothels Ordinance, Contagious Diseases Act, Quarantine and Prevention of Diseases Act, , etc. Although sex work, MSM and drug use are open secret in Sri Lanka as in several other Asian societies, the law is used sometimes to harass the KAPs such as arresting FSW carrying condoms, verbal harassment of MSM and TGs. Additionally the society looks down upon the KAPs and most often this is reflected in severe social discrimination and violent actions against persons engaging in practices that already places them at risk. One such case was quoted by the peer educators that when they were returning after on-site data verification exercise some people from the community stopped their vehicle and threw dirty water and rubbish on them.

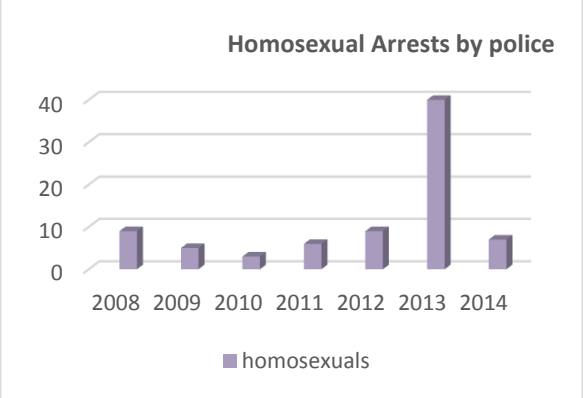
Much of the intense stigma, harassment, and brutal violence faced by *nachchi* or transgendered/gay men are generated by the fact that although they are biologically men, they adopt a culturally devalued feminine gender identity. The organization and circumstances of sex work increase their vulnerability and deny them access to legal recourse when victimized. Violence against women, especially FSW is construed as justifiable because they violate normative expectations of proper sexual behaviour; and violence against *nachchi* because they willingly embrace a lesser, subordinated, feminized identity[3].

The general environment of commercial sex in Sri Lanka, including criminalization and criminal justice practices in enforcing the law, serve to disempower sex workers. It makes sex workers more dependent and vulnerable and ensures the presence of violence and coercion in all aspects of the industry.[4]

Although there have been some sporadic efforts without adequate follow-up, the programme does not have any planned component within its framework that addresses the stigma and discrimination against any of the KAPs in any settings. There are though different programmes in the country working with the public systems to help establish a supportive environment for KAPs to enable their access to care, support and treatment services.

Advocacy and creation of an enabling environment for the KAPs is the mandate of the NSACP, which has been organising advocacy and sensitisation workshop with a focus on law enforcement authorities. Police officers were made aware that *"possession of a condom does not illustrate in commission of any offence. Condoms are considered as a medical device and not a tool to prove prostitution"*





Source: Police advocacy training Mr. Ajith Rohana (Senior Superintendent of Police)

Above figure shows the trend of arrests under Vagrant Ordinance and a steady decline of arrests, also acknowledged by PE/Peer during FGD. However data is not available district-wise to asses the situation in the implementing districts. Arrests of MSM seems to be low however a sharp increase in 2013 may have been due to adverse media publicity against distribution of lubricants to MSM during the initiation of phase 2 of Global Fund grant. It is also influenced by personal and other issues involving MSM registered with the police by aggrieving party.

[3]Miller, J. (2002), "Violence and coercion in Sri Lanka's commercial sex industry: Intersections of gender, sexuality, culture, and the law," Violence Against Women, 8:1044–1073 accessed at https://www.ncjrs.gov/App/publications/abstract.aspx?ID=196629 on 04 March 2016
[4]Miller, J. (2002), "Violence and coercion in Sri Lanka's commercial sex industry: Intersections of gender, sexuality, culture, and the law," Violence Against Women, 8:1044–1073 accessed at https://www.ncjrs.gov/App/publications/abstract.aspx?ID=196629 on 04 March 2016

Complementing the efforts towards an effective response to HIV epidemic in the country, FPASL was selected as a Sub-Recipient under the Multi–Country South Asia Global Fund HIV Programme – a regional programme addressing HIV epidemic among the men who have sex with men and transgender people in south Asia.

The programme is functional only in five districts of Sri Lanka with peer education interventions for the MSMs and TGs. The design of the grant programme is based on the national advocacy framework of the FPASL. While creating an enabling environment for the KAPs to access service for HIV prevention community involvement and strengthening in terms of institutional building is sought under the grant. The key focus areas under the grant are strengthening community systems to improve coordination with local governments and health care providers, deliver concentrated and quality capacity development support, and provide technical assistance to ensure high intervention impact and sustainability.

The regional grant team conducted community consultations and workshops at the national level involving the judiciary, law enforcement agencies and the media, sensitizing them towards KAPs' issues. On the other hand, community strengthening activities such as provision of seed grants for capacity building of community based organizations, conducting trainings and workshops for staff on HIV prevention programmes were implemented.

The following are some of the activities implemented by the FPA under the Regional grant.

i. CSS (Community System Strengthening) – 5, 1 day Training workshops for CBO staff working with MSM/TG HIV prevention programmes on SBCC, Human rights, governance, Advocacy –covered 187 CBO members/staff
ii. CSS – 2 -2 day Workshops on Treatment Literacy for PLHIV community x 25 participants in each workshop
iii. HSS (Health System Strengthening) – 2 – 3 day reduction of stigma at workplace workshop for Health care staff – targeting government and private sector hospital staff working in OPD, surgery, Medical wards etc and GPs - 30 X 2
iv. HSS – 2 – 3 day workshops on STI syndromic management targeting IMPs, GPs, AMPs, State Medical practitioners, PHIs – 30 X 2
v. Legal and law enforcement – 2 – 1 day workshops targeting lawyers and law students from law college, legal Aids commission, law society, Human rights commission, Law and society Trust and both Katukurunda and Ja-ela Police training school
vi. Media – 5 Media workshops including one as the national Media conference – 20 Media fellows who are registered with the project and another 10-15 members working closely – covering print, electronic and social media
vii. Judiciary – 1 exposure opportunity to a supreme court Judge and a president's counsel to Nepal to learn about issues related to LGBTIQ community and 1 Judicial consultation including judges, AGs department, Senior private bar, Junior private bar, Ministry of Justice, Parliamentary secretaries office, Deputy speaker's office, Prime Minister's office
viii. 1 National stakeholder sensitization meeting conducted with resource persons such as Justice Thilekawardena
ix. One day national M&E workshop

The following studies have also been undertaken through the regional grant support:

i. Seven city study on service delivery by capital city authorities
ii. MESS report
iii. Violence study – a qualitative study

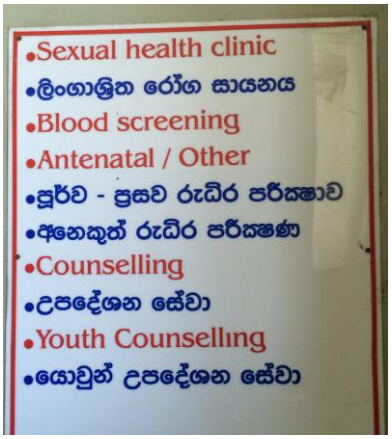
iv. National level Legal and Policy review
v. Service provisions to MSM and TG - a qualitative study

The grant also had the component of a CSS and Advocacy Seed Grants Programme. The Sub-sub recipients are Saviya Development Foundation and Heart to Heart Lanka. Their activities supported by the seed grant programme included one sensitization workshop for 60 key decision makers in public service institutes (Bankers, members of private transport); Stigma reduction workshops for staff of MOH Habaraduwa, Hikkaduwa, Ambalangoda, and Galle; stigma, discrimination and human rights awareness programmes for police officers of Hikkaduwa and Galle police stations; a public awareness campaign through a sports event; re-activating the District AIDS Committee; consultative meeting with MSM, TG and PLHIV members and management of H2H Lanka and Lanka Plus; youth group leadership workshop; etc.

Overall, an effort towards creating an enabling environment has been initiated through the Regional Grant. However, it is restricted to the MSM/TG populations and to five districts of Sri Lanka with interventions for KAPs and seems an independent programme working with communities beyond the PE led interventions. Advocacy pursuits at the moment are focussed on familiarization of KAP issues with other stakeholders at the national level managed by the FPASL with the support of NSACP. A significant step was that the stigma and discrimination module developed by the FPASL was included into the health care providers training curriculum in the country. Sporadic activities of community strengthening have been undertaken however this may not be considered as pilot activities as a continuum is yet to be planned. Community involvement under the current grant has been only in terms of participation in training and workshops. The KAP groups participated in the FGDs mentioned that there has been reduction in stigma and discrimination within health care settings but not completely rooted out. There are lesser police arrests. However, the programme is yet to develop systems to document the same.

6. STD Clinic

Sri Lanka has one central STD clinic located in the premises of National STD AIDS Control Programme in the capital city of Colombo and 33 STD clinics (at least one peripheral STD clinic) in each of the 25 districts of the country. The peripheral STD clinics are managed by the provincial administration while the central STD clinic in Colombo is run by the central administration. All STD Clinics are located in the hospital setting. As informed most STD clinics located in the hospital setting are adequately equipped and staffed. Such STD clinics also have laboratories to conduct most of the basic required tests, including for HIV and syphilis. Pre and post-test counselling is done by the doctors who are trained in counselling, but lack of a suitable space is a limitation to offer counselling in some STD clinics. There is no dedicated counsellor to counsel the patients visiting the clinic for treatment and testing. The registered patients receive some information from the treating doctor but it is not an essential feature in the STD



clinics for KAP, and mostly depends on the patient load on the day of visit. All services, including condom education and distribution on demand, test and treatment at the STD clinics are offered free of cost to the clients.

All STD clinics are named STD and AIDS Clinic which most participants quoted as stigmatising. Demonstrating their sensitivity towards stigma attached to AIDS some clinic managers have erased or covered the AIDS word on the signboard for the clinic. There is also initiative to name all STD clinics as sexual health clinic with a list of services offered in the clinic. The team observed one such sign board already placed in one of the STD clinics.

The STD clinics are also end point of the peer led intervention programme where the peer educators are expected to bring the peers for testing and further treatment.

The STD clinics do not share any patient related information of the KAP escorted either with the peer educators or the programme under review, in order to maintain the confidentiality. However, in case the client do not return for follow up in spite of all their efforts the trusted peer educators are approached by the STD clinics to help the lost client.

The staff at the STD clinic appreciates that the peer educators are helping them do their work by escorting the clients to the clinic. Although community outreach is one of the tasks for the STD clinics STD clinic staff could manage to reach only few KAP through NGOs and CBOs. They found it very difficult to mobilise and encourage the KAPs to attend STD clinics. The staff at the STD clinic acknowledges that they have not been able to link KAPs to the clinics as desired. The senior doctors realise the need of sensitisation session with the STD Clinic team members at regular intervals as that would reduce the problems that KAPs, especially MSM and FSW face at the clinics. It is also noted that there is a skewed gender balance at the STD clinic. One STD clinic that was visited by the team had only one male doctor and 3 female doctors. Majority of staff members at the clinic were women. It was noted that most male including MSM, clients of the clinic were hesitant to talk to the female staff and waited for the only male doctor available. However there was little that could be done at the clinic level as the staff at the STD clinics was transferred every three years.

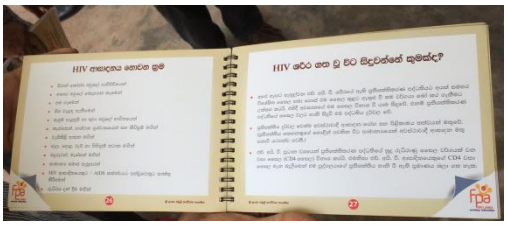
The discussion with the peer educators and peers, specifically from MSM community indicated that they faced stigma and discrimination at the STD clinics, especially when interacted with the public health inspectors and other support staff. Several of the KAPs avoided visiting the STD clinics as they were discriminated and harassed besides placing their sexual identity at risk of exposure. Several of the MSM also complained that the doctors and nurses asked them uncomfortable questions that were not related to the disease or treatment, such as "*do you also have oral sex*". Such attitude and behaviour of the STD clinic staff also forced many a time, to the FSWs and MSMs to hide their real identity and they refused that they engaged in any risk behaviour. However, the STD clinic staff complained that the peer educators brought and presented anyone as MSM or FSW when they were pressed to meet their target number for escorting.

The SSRs participated in the review noted that they met with the STD clinic in-charges and staff frequently and in one case the doctor at the STD clinic was invited in the awareness session organised for KAPs and also for school students. However this was not a regular or planned feature of the programme to improve and strengthen the linkage between the programme and the service provider. The need of confidence building exercise between the programme and the STD clinics was also felt and communicated by the participants at all levels who also felt that such an exercise on regular basis would help improved coordination with and sensitisation of the STD clinic staff.

7. IEC, BCC, Communication and Condom Promotion

Most peer educators had only one set of small booklet and a supply of leaflets to provide IEC and BCC services to their target peers. Additionally they had a plastic model of a penis (dildo) and some condoms to carry out condom use demonstration for the target peers. The IBBS 2014-15 indicates that a significant number of MSM, FSW, beach boys and drug users receive their supply of condoms form the peer educators, though a significant proportion of those in contact with the peer educators were street based. It was also reported that several of KAP received condoms from STD clinics and also bought from the market.

The booklet and leaflet given to the peer educators across all KAPs are same in their design and content and do not address specific issues of different groups and sub-groups of the KAPs. The booklet had all relevant information regarding STI and HIV and AIDS. It explained in detail how the infection spread and how it didn't. It also informed the ways to prevent the spread of the STD and HIV infections and that what should one do when exposed to the infection. The peer educators as well as the field supervisors and coordinators noted that the booklets and leaflets had too much of text and less pictures which made it difficult for a less literate peer educators to explain and help their peers understand. Additionally such leaflets that were heavy on text were less attractive and interesting for common members of the KAPs. Overall it was felt that the IEC materials and communication aid given to the peer educators didn't help and thus was not effective. Indeed, it was used since it was part of the target.



The condom supplies were reported as adequate and except once no stock out was reported. It is important to note that the peers receive condoms as per demand, which was communicated by the programme managers as well as the peer educators. However, demand calculation needs to be relooked into in order to provide for any gaps between the current demand and supply.

8. Drop-in Centre

A drop in centre in the context of HIV and AIDS is a safe space where the members of the KAPs can access the basic facilities such as information, counselling, referral for treatment; basic care and support etc. In some places, the DIC also provides food and facilities for bathing, and resting etc. besides needle-syringe exchange, condoms, lubricants etc. Social welfare organizations have used this concept more as a means to gather scattered communities/populations for more organized/convenient service delivery. DICs have been extensively used world over to provide STI, HIV and AIDS related services, especially in high prevalent countries to provide services directly in a KAP friendly environment**.**

About the concept of Drop in centres (DICs), functionaries above the SSR had heard of it and also understood its utility for enhancing the outcomes of KAP interventions. However, they lacked clear understanding of its operational aspects. Some of the PEs from DU interventions in one of the

FGDs had experienced the services and advantages of the DIC piloted by the UNODC supported intervention and immediately consented for its establishment.

Nevertheless, when the concept and functioning of DIC was explained to other members of KAP during FGDs, there was general acceptance that such places should be established to facilitate easy access to care, support and treatment services. However, there were several concerns, especially regarding the confidentiality and the provider of the services at such DICs. It was also felt that the DIC for different population groups should not be operated together. It was interesting to note that the PEs could relate the effective use of DICs for community based testing.

9. Community Based Testing

In several countries of the world, one of the biggest challenges in the HIV response is identifying people living with HIV who do not know their HIV status. These people are often identified late in the course of their disease or only once they have fallen ill, and therefore are not always linked to appropriate care. Late diagnosis leads to late initiation of treatment and care, which can result in unnecessarily high morbidity and mortality. Those who test negative are not always provided with appropriate prevention and other community-based support services, nor are they encouraged to retest at a later time.[5]

Although key populations are at higher risk of contracting HIV infection, they are often least likely to access HIV services. For example, in many countries, HIV testing and treatment access is substantially lower for people who inject drugs than for other people living with HIV.[6] A global survey found that only 14% of men who have sex with men living in low-income countries reported having meaningful access to HIV treatment services.[7]

Situation of HIV epidemic in Sri Lanka is quite similar to what is discussed above. The coverage of the KAPs through the peer led intervention programme indicates that there is a large proportion of the estimated population yet to be reached.

In the post-2015 era when the world is aiming to end the AIDS epidemic by 2030, the UNAIDS has set up following targets to be attained by 2020.

- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

In order to attain the first target of the 90-90-90 by 2020 it is critical that Sri Lanka adopts various methods to bring people out for HIV testing, especially those at higher risk of contracting the infection, such as FSW, drug users, MSM, and transgender population. The country requires several campaigns specifically designed to meet the expectation of the communities to help and

[5] "What do the 2013 guidelines say? what does this mean for my country?" Series of modules supporting a community response to the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Produced by the International HIV/AIDS Alliance, Global Network of People Living with HIV (GNP+) and STOP AIDS NOW!

[6] Arreola A et al., Access to HIV prevention and treatment for men who have sex with men: Findings from the 2012 Global Men's Health and Rights Study (GMHR), Global Forum on MSM & HIV, 2012. As quoted in "90-90-90 An ambitious treatment target to help end the AIDS epidemic, UNAIDS, 2014"

[7] Gender Dynamix, amfAR, Transgender access to sexual health services in South Africa: findings from a key informant survey, 2012. As quoted in "90-90-90 An ambitious treatment target to help end the AIDS epidemic, UNAIDS, 2014"

encourage them access the testing and treatment early. For such campaigns to be effective, extensive community consultations, strong logistics, and effective marketing are essential.[8]

Community based testing of HIV is one such method to take the HIV testing closer to the community and increase the percentage of the KAPs who test for HIV on regular basis. In several countries where it is being implemented HIV tests are conducted using rapid test techniques at the hot-spots, drop-in-centres, etc. Such community based testing are supported by confidentiality, pre and post test counselling and strong referral linkage with the care and treatment centres. It is important that before such campaigns are initiated the easy accessibility of the clients to the care, support and treatment programme is ensured.

The review team explored the possibility of the community based testing at all levels of its data collection efforts. At the decision making and management level officials are quite supportive to the idea of community based testing and feel that it can be done effectively through public-private-partnership approach where the involvement of the KAPs is essential. The requirement of building the capacity of the CBOs and NGOs was strongly felt by the decision makers and managers at the national level as this can only ensure the success of the community based testing initiative. The service providers at the STD clinics feel this will do good at large scale as people who know their HIV status are more likely to access the treatment. This will also help reduce the burden on the STD clinics for HIV testing.

The members of the programme team, peer educators and peers felt that it was a good idea as it will save KAPs from going to the clinic for testing and waiting for long hours. However, they appeared concerned about the confidentiality of the tests, places in the community where such test will be conducted, and the mechanism of disclosing results and maintaining records and report delivery. There was also a general agreement that such tests should be conducted in the community preferably by a doctor or by a trained medical laboratory technician. The members of the PR2 programme team as well as the peers in community were against the idea that the community members are trained to conduct the test as this would compromise their confidentiality.

10. Performance Based Incentive

The grant received for the programme from the GFATM under New Funding Model for the period from 2016 through 2018 proposes to pay the field supervisors and peer educators based on their performance against their respective targets. The acceptance and effect of the performance based incentive was explored by the review team.

Not increasing the monthly remuneration and allowances during last three years in line with the increasing cost of daily life is already a concern among the peer educators and field supervisors as has been discussed in earlier section. Additionally they feel this is another way to deviate the attention from their demand for increment. But this will eventually harm the programme as most PEs and FS among the experienced and trained team members will start looking for other ways to compensate their remuneration and gradually shift to other professions. In one FGD it came up that by offering performance based incentive the programme was negating the basic concept of peer education, as the peer educators will have to reach out to other areas and new groups in order to increase and meet their targets. This will also reduce the effectiveness of the peer educators. The peer educators wondered as to what would be the mechanism to ensure that the better quality work was encouraged since some peer educators could gather the numbers but lacked quality work.

[8] 90-90-90 An ambitious treatment target to help end the AIDS epidemic, p.16, UNAIDS, 2014

Additionally, they wished to know if there would be any mechanism to reimburse the expenses they incurred in meeting the needs of the peers while providing them services and escorting to the clinics.

It was suggested that the basic monthly payment to all field supervisors and peer educators in the programme should be fixed at market rate along with the basic target. Payment for any additional number should be incentive based and all extra expenses incurred in providing the services to the peers should be reimbursed as actual. However, there is a general feeling that it is ideal but will not be done for several reasons.

Based on discussion regarding performance based incentive the review team felt that:

- There should be more discussion between the managers and field supervisors and the peer educators in this regard to reach to a consensus regarding the best payment mechanism.

- The system and mechanism should be designed to retain top-performers, motivate the desired performance, and control the cost.

- In order to pay for performance, the performance must be defined in very specific, objective, quantifiable terms and followed by a strong mechanism to measure and track it. The current mechanism has a payment for a range of numbers, which may be avoided in order to make it effective.

- In Congo a similar system was studied where it was found that while pay-for-performance facilities invested more effort in attracting patients, this increase did not translate into higher levels of service utilization or better health outcomes. Health workers in pay-for-performance facilities became less motivated and satisfied with their jobs compared to their counterparts in fixed payment facilities.[9]

- However another similar but improved system when implemented with well-defined indicators and tracking methods gave good results in India while implementing its National Rural Health Mission in rural India. In Burkina Faso the early involvement of health workers and other stakeholders in designing an incentive scheme proved to be valuable. It ensured their effective participation in the process and overall acceptance of the scheme at the end.[10]

[9]https://www.povertyactionlab.org/sites/default/files/publications/496_paper_DRC_March2015_1.pdf accessed on March 5, 2016

[10]Maurice Y, Diboulo E, Kagoné M, Sié A, Sauerborn R, Loukanova S: Health worker preferences for performance-based payment schemes in a rural health district in Burkina Faso available at http://www.globalhealthaction.net/index.php/gha/article/view/29103 and accessed on 5 March 2016

CHAPTER-3: RECOMMENDATIONS

The recommendations of the review team are based on the strengths and challenges of the programme identified from the review of the documents, as well as the in-depth interviews and focus group discussions held with the stakeholders in the field. The review team has also consulted several documents and published evidences while discussing various recommendations in this report. The recommendations are placed under similar categories as in the chapter 2 for findings, in the below section of this chapter.

The review team has also prepared a summary of recommendations in a tabular form against the findings and observations of the study, which is presented as annexure 5 of this report.

1. Policy and Strategy

1. **National Programme Guideline for Peer Led Targeted Intervention**: In the larger interest of the national programme it is important to have a national level programme guideline for peer led targeted intervention which follows the national strategic directions. The general guideline for the programme should have specific sections for programming, including the selection of PEs and specific service packages among different groups and sub-groups of the key affected population groups. Such a guideline should be provided to all agencies and their managers involved in the implementation of peer led targeted intervention which they can use as a reference book. Drawing a national programme guideline with separate section for each of the KAP groups would address operational disparity and strengthen outreach.

2. **Reference Booklet for Field Teams**: There should also be a small booklet summarising the national programme guideline and service package, responsibilities of a peer educator, separately done for each group and sub group of KAPs, based on field experiences. Such booklet should be more pictorial and explain the service delivery methods, indicators, reporting and also *dos* and *don't* for the service delivery, small in size and should not exceed 30 to 40 pages. This will be used by the peer educators and field supervisors as a reference booklet to ensure quality standards.

3. **Capacity Building of Community Members / CBOs**:A policy and strategy should be developed to support and build the capacity of the community based organisations of KAPs as they are the only link between the national programmes and the KAPs. This is required also to facilitate scaling up and sustainability of the peer led targeted interventions in the long term, without external (donor) support. Community led programming has always yielded better results rather than charity. Wherein charity programmes have been one time efforts, community involvement brought in sustained changes and transfer of knowledge and skills to communities thereby empowering them. Inclusive approaches are to be designed involving the community and community leaders in planning and decision-making with real time experiences rather than perceived understanding of KAPs.

With the grant support from the Global Fund and other donors India, the neighbouring country has implemented some of the successful programmes to mobilise and strengthen the capacity of the KAPs which may be visited by the key planners and decision makers of Sri Lanka to develop its own programme for capacity building of the community members and CBOs. One good example can be taken of India HIV/AIDS Alliance Pehchan Curriculum Guide which has been developed to build necessary competencies of KAPs CBOs and its staff members on outreach, organisational development, leadership and governance, Resource Mobilisation, and also covers all the technical

areas related to HIV/AIDS. While these modules have been developed for the Indian context, they can be adapted for different environments and cultural contexts as well.

4. **Enhanced Coordination between National Level Programmes**: The policy and strategy to facilitate and ensure interaction and coordination between different national level programmes should be established for optimum utilisation of available resources and increased effectiveness of different programmes. The synergy thus generated will help enhance the quality of output and outcome of different programmes. The first and foremost step in this direction would be the integration of all M&E and reporting mechanisms of large scale programmes. This can be started with linking of the National M&E System with that of the FPASL to report on peer led targeted intervention programme on regular basis. This will also help establish a system for better coordination and feedback mechanism to improve the quantity and quality of the service delivery.

   PR2 as a process of transfer of knowledge and technology to PR1 could consider assisting them in establishing central information management system in collaboration with the Strategic Management Department. Data analysis on a comprehensive set of service provision and uptake is essential at the PR1 level. E.g. testing for HIV; No. of Peers escorted for testing (PR2); No. of Peers tested (PR1); No. of Peers Positive (PR1); No. Peers registered for ART (PR1); No. of Peers tested for CD4 count (PR1); No. of Peers on ART (PR1); No. of Peers followed –up for ART provision (PR1)

   This provides for a whole gamut of service uptake as well as status of progress. It is recommended that PR1 and PR2 should consult each other to arrive at a comprehensive list of indicators including dashboard indicators for improved overall monitoring and coordination of the programme.

5. **Sustainability of the Peer Led Targeted Intervention:** In order to sustain the programme past GFATM grant it is recommended that:
   a. The PR2 plans and starts organising the CBOs and build their capacity for community mobilisation and positive communication in order to enable them to communicate for their own rights and access to the services once programme concludes.
   b. Build the capacity of the CBOs to manage their own programmes and resource mobilisation for HIV prevention and enhancing access to the care, support and treatment services.
   c. Adopt approaches to promote the recognition of the PEs in the community as knowledge and support provider so that when programme concludes they are still recognised and approached by the community members for correct information and support to access the services.
   d. Provide training and build capacity of the PEs to develop their leadership and communication skills so they are able to gather their peers even after the programme period in order to provide them knowledge and support the access to the services.
   e. Undertake advocacy efforts to mobilise the NSACP to approach the national government to support the NGOs and CBOs to continue their effort of HIV prevention through peer led interventions. PR2 may consider supporting the NSACP to prepare a plan to support the efforts of the CBOs/NGOs, to support it to mobilise funding support from the national government.

Supportive Supervision and Mentoring: In order to help peer educators reach their targets it is important they are supported in their work, mentored on regular interval and encouraged through facilitation. The current system of only monitoring, supervising and checking of the peer educators' work should give a way to confidence building by the coordinators and managers of the programme. They should be well trained, more supportive and facilitating; and be able to demonstrate the work expected of the peer educators so the targets are reached in high quality manner. Other mechanisms to promote and motivate the peer educators should also be explored. This may include branding champions, best PE of the month award, etc.

Enhancing Community Capacities: The PR2 programme should have a component with funding support for community system strengthening and active involvement of the KAPs in the service delivery. Current practice of only giving small funds for the management of the SR and SSR organisations should also include the capacity building and handholding of the small community based organisations. There should also be efforts at the PRs level to maximise the utilisation of the existing capacities of the current SRs and SSRs since there has already been significant investment. PR2 is suggested to make advocacy efforts to mobilize the Government and relevant bodies to allocate funds to support NGOs involved in peer led community based interventions.

Service Package: It is recommended that the operationalization of the service package needs a different treatment with each of the KAP groups. For eg. Introducing community led structural interventions (Collectivization, community led advocacy, crisis management, addressing violence and other such issues) especially with the FSW and MSM/TG/Nachchi could be added within the service package to bring in elements of community empowerment that gives a voice to community issues in accessing sexual health services and facilities apart from non-sexual health needs. World over it has been recognized that addressing KAPs other needs has improved service uptake of HIV prevention services.

The suggested service package for each target population is noted in below table:

#	Service package component	FSW	MSM	DU/FDU	BB
1	Safe sex and sexual hygiene education	√	√	√	√
2	Enable consistent correct condom use – demonstration and distribution	√	√	√	√
3	Use of lubricants – education and distribution		√		√
4	Condom-compatible lubricant choices – education	√	√	√	√
5	Consistent use of clean needle and syringe for IDU			√	
6	Harm Reduction Services : Opioid Substitution Therapy (OST), Over Dose management introducing Naloxone, Abscess care (*This can be implemented with the consent of the government stakeholders involved post rapid assessment of drug use in Sri Lanka)*			√	
7	Risk behaviour assessment and tailor-made safe behavioural practices	√	√	√	√
8	Provision of HIV Counselling and testing through referral	√	√	√	√
9	Couple counselling and testing through		√	√	

	referral (when available)				
10	Community-based services in safe spaces (including drop-in centres)	√	√	√	
11	Interventions to address gender-based violence	√	√	√	√
12	Education on symptoms of STI and increased vulnerability to HIV infection	√	√	√	√
13	Referral and follow-up for treatment of STIs – presumptive treatment/syndromic management and regular screening	√	√	√	√
14	Clinical care and antiretroviral treatment	√	√	√	√
15	Follow-up and adherence to ART	√	√	√	√
16	Community-based care and support for resilience – formation and capacity building of community support groups	√	√	√	√
17	Empowering peer-led outreach (including targeted behaviour and social norm change approaches)	√	√	√	√
18	Support to address gender-based violence	√	√	√	√
19	Legal and human rights education	√	√	√	√
20	Referrals for screening diagnosis and treatment of HIV/tuberculosis co-infection	√	√	√	√

The above package is based on the study of various experiences of programming across the globe. Many of these programmes are supported by the Global Fund and USAID. This recommended package is most effective when implemented with structural interventions and community mobilization approaches. A sustained key population response is one where services are of high quality and can be accessed by sex workers, MSM, transgender persons and people who inject drugs. It is one where sustained responses are driven through the community, organizations, groups and networks to ensure that the rights of key populations, including those living with HIV and AIDS, are respected[11].

1. **Professional Counselling**: Counselling is a weak link in the programme although some doctors at the STD clinics actively engage in counselling of the clients. However, itis not available from a professional counsellor even at the STD clinics. In order to maintain the contact with the peers even after they did not test positive, it is important that they are counselled well. As revealed in the FGDs, many time the peers do not return to the clinic to collect their reports since they did not feel the need of it as there was no symptom. In order to help them return to collect the report even when they do not have any symptoms, it is critical they are well counselled about the need of regular testing. It is thus recommended that the peer education programme recruits and trains adequate number of counsellors. The training should be conducted by professional counsellors who are trained in STI, HIV and AIDS related counselling. This is envisaged to enrich the quality of outcome of the programme. They could preferably be the member of the target communities which will help win the community's confidence faster.

[11] Key Populations: Targeted Approaches Toward an AIDS-Free Generation - https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/key-populations-targeted-approaches-toward#section2

2. **Female Drug Users and Transgender Peer Educators**: The Female Drug Users and Transgender form a substantial part of the target community. The programme should therefore, recognise the female drug users and transgender community which are equally at risk of contracting HIV infection. These sub-groups should not be mixed with FSW and MSM respectively, as it is being done presently. The programme should care to address their needs by recruiting enough number of peer educators from among the sub-groups of female drug users and transgender community. The current efforts are inadequate to address their needs and many a time do not reach them at all.

Human Resources, Training and Capacity Building

1. **Investment for Capacity Development**: In order to increase the retention of the peer educators it is important that they are strengthened through regular efforts of training and capacity building for high quality service delivery and quality communication. A well planned and ongoing investment in building their capacities and continuous mentoring will help improve the quality of programme output and outcomes. This will also help improved communication capacities and service delivery skills among the peer educators.

   It is recommended that the PR2 organises initial basic training of 3 days where PEs are equipped with knowledge and skills to deliver quality HIV and STI prevention services including condom promotion and behaviour change communication. Training on community mobilisation is also essential which would enhance the skills of ORWs, PEs and other project staffs in outreach and involving the KAPs in the program. Trainings on thematic areas like M&E, finance management, program management would also help the organisation in implementing the GF programs more effectively.

   Additionally it is recommended that initial training is followed with decentralised refresher training and updating of knowledge and skills of the PEs every 6 month. The SRs and SSRs are provided some financial support to conduct periodic assessment (through interactions and discussions) of knowledge and skills of the PEs, preferably during monthly/bi-monthly progress review meetings and provide focussed training on identified gap areas. The availability of budget will support the SRs and SSRs to organise training at local levels where they can also invite the doctors from the STD clinics to impart training.

2. **Re-visit the Human Resources Structure at the SSR level**: As the programme contemplates the possibility of rolling out DIC and community based testing it would be important to revisit the structure of human resources at the SR and SSR level with a focus to include a trained counsellor and to cater to the services at the DIC. Such activities require continuing fund support either from the Government or other sources for its sustainability. A TOT on counselling can be provided at the SR and SSR level for cascading the skills and the staff turnover would not affect the program.

3. **PE-Peer Ratio:** As experiences from different South Asian countries indicate, the PE to peer ratio should be based on the types of social/sexual networks among the target population group and programmatic setting. However, an ideal ratio is 40 to 50 peers per PE which can be managed comfortably. In India National AIDS Control Organisation's Training Module for Peer Educators[12] recommended 60 peers per PE in case of FSW and MSM and 40 peers in case of IDU. In several peer led interventions for FSW, MSM and IDU

[12] Training Module for Peer Educators - National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India

in the countries of Thailand, Cambodia, and Myanmar the PE to peers ratio ranges between 30 peers : 1 PE to 50 peers : 1 PE.

For MSM and FSW component in Sri Lanka a recommended PE to peers ratio is 1 PE: 35 FSW/MSM as the population is hidden and their operations and networks are quite complex and highly mobile. For drug user component this ratio should be 1 PE:40 DU peers and in case of beach boys it could comfortably be 1PE: 50 peers.

Additionally, it is recommended that a rapid assessment of sexual and social network of target population and factors affecting it in the programme areas should be carried out in order to determine the PE to peer ration in country specific context/situation for it to be most effective.

Monitoring and Evaluation

1. **Re-Visiting the Mapping and Size Estimation**: As the current programme is based on mapping and size estimation of KAPs done some years ago there is a need to re-visit and undertake a fresh size estimation and mapping of KAPs, particularly in the districts where the programme is being implemented. The discussions in the field indicate that the hotspots identified earlier have changed, besides increased number of KAPs coming out to access the services than the originally planned, it is essential that the programme design is based on most recent mapping and size estimation data. The facts since earlier mapping and size estimation exercise have changed as the services have become accessible which has encouraged hidden populations to avail the facilities.

   Hence, a study to validate or re-establish correctness/remap the KAPs is recommended. PR1 could consider collaboration with GFATM/other donor agencies for an independent mapping and re-estimations of KAP and their sub-categories.

   In the report dissemination meeting it was concluded that a mapping is due now and should take in to consideration past data including profiling of STD clinic information to establish and revalidate if mapping and estimations were realistic. New groups and trends needed to be identified and NSE which is due in 2016 take this in to account and TORs framed accordingly. New sub groups estimation (e.g MSM and TG's and Nacchi) be looked at separately for estimations. Further hot spot based estimations which has been followed in the past but it needed to be seen that based on PHC data if one needed to investigate and map other populations who do not hit the streets.

2. **Facilitate Easier Data Collection and Reporting**: Although the data collection system and reporting mechanism developed by the FPASL meets the high quality standards there is a requirement of easier data-collection and reporting system at the levels of peer educators. Currently the peer educators feel high burden of data collection and reporting which can be reduced by providing them combined forms with better training for filling them. The management can also consider removing some of the forms which do not have much value. One such form can be the format that peers need to sign after they have received a leaflet. PR2 is also suggested to review the PE Daily Dairy and make it PE/KAP friendly with illustrations / pictures that would encourage and simplify filling information on activities implemented. It is strongly recommended that before rolling out such formats it is field tested for efficacy, correctness and end-user friendliness.

3. **Community Friendly Data Verification Methods**: The approaches and mechanism for monitoring, supervision and data verification should be more community friendly and respect the confidentiality and privacy of the peers. The data verification method should be developed in consultation with each of the target community and their peer educators. The data verification in public places must be avoided. One such recommended method was to verify data in group/pocket meetings. The PEs and field supervisors suggested that it would be easier if the data verification team coordinated its visits with the group meetings and such events where members of the KAPs gathered without inhibitions and were safe.

Enabling Environment

1. **Coordination of Advocacy Efforts**: The current efforts for advocacy and creating enabling environment are sporadic and focussed on a particular community group. There is an urgent need of well-planned and integrated effort towards creating enabling environment for all KAPs. This could be done by improving the interaction and coordination between various advocacy and capacity building programmes and the peer led targeted intervention for the KAPs.

   This can be started with a joint planning sessions for the implementation of the advocacy efforts and sensitisation workshops. The NSACP's leadership in this regard could be catalytic and most useful, which may be mobilised by the FAPSL in the larger interest of the success of the peer education model.

2. **Capacity Building for Community Level Advocacy:** It is recommended that small steps for advocacy are essentially planned and embedded in the current intervention design, such as legal literacy, building communication skills and developing negotiation skills of vocal community members and leaders for different groups of KAPs. This will help build their skills to deal with the situations on their own and in the process they will become empowered, which will also contribute to the sustenance of the programme outcome.

3. **Community Mobilization**: The facilitation of community interaction programmes and involvement of key community leaders to talk about the situation and rights of the KAPs at the local levels will help build supportive environment for the KAPs. The team may draw on the experiences of the INP+ and AVAHAN programme in India that used several such methods for community mobilisation. The next level could lead to community mobilization and empowerment by organizing and collectivizing the communities. This could be planned and undertaken through further consultations with relevant stakeholders and communities with an objective to develop a community led structural interventions. The FPASL with a support from the NSACP is suggested to explore additional funding support to carry out such activities.

4. **Capacity building of CBOs to build supportive environment:** With support from the UNAIDS and other agencies the networks and NGOs of KAPs such as Asia Pacific Transgender Network (APTN), Asia Pacific Network of Sex Workers (APNSW), India HIV/AIDS Alliance etc. have engaged in building the capacity of the small CBOs to undertake the implementation of the programmes and engage in advocacy activities resulting in building of supportive/enabling environment for KAPs. The organisation like Pathfinder continues to develop and build the capacity of CBOs in several African countries, using its "Straight to the Point - Capacity Building Tools in multiple languages. The Global Fund also recommends the use of Community Systems Strengthening Framework in order

to build the capacity of the CBOs to engage them in service delivery and creating enabling environment.

It is recommended that the PR2 team refers to several such documents available on internet and develops a context specific community system strengthening plan to build the capacity of the CBOs to engage them in service delivery and creation of enabling environment.

STD Clinic

1. **Sensitization and Capacity Building of Clinical Staff**: The staff members especially those at lower ranks at the STD clinic required to be sensitised regarding stigma and discrimination, the privacy and confidentiality of every client that visit them. Though the responsibility of building STD clinic staff's capacity lies with the NSACP, it is important for the FPASL as PR to mobilise and follow up with the NSACP. The capacity building is required especially in the areas of dealing with members of the KAP, especially MSM,TG, female drug users, and sex workers.

   The capacity building of the STD clinic staff, especially that is working directly with the clients required to be built to ensure that their behaviour in any way do not deter the clients from returning for follow up or to hide their identity.

2. **Advocacy for Updating of STD Clinics**: The review team also recommends that the PR for the peer led intervention programme makes sustained advocacy efforts to mobilise the government to update and strengthen the STD clinics especially in terms of space, human resources, and logistics to facilitate efficient functioning and to motivate staff.

IEC, BCC, Communication and Condom Promotion

1. **IEC, BCC and Communication Strategy:** The programme requires an effective communication strategy addressing the specific needs of IEC and BCC for different segments of target population. However this should be done in the larger context of national level communication strategy on HIV and AIDS and can be harmonized with the "Social Behaviour Change Communication for HIV Prevention: Guide for Public Health Officers"[13]. Hence, while PR-1 is recommended to re-visit its mass communication strategy with a focus on normalisation of HIV and AIDS and demand generation for the available services, it should be complemented by the PR-2 by re-designing the IEC and BCC strategy at the ground level. There is an immediate requirement of a national level audio visual campaign, billboards, mid–media campaigns and relevant activities, which should be strategized and conceptualized by the PR1.

   The ground level communication strategy for IEC, and BCC recommended to be developed by the PR-2should focus on specific information requirements for target population groups and must address the contextual issues and concerns besides demand generation for services. This must carry forward and reinforce the messages from national level campaigns towards demand generation for sexual health services and normalizing STI/HIV/AIDS. The strategy should take into account the fact that the risk varies with typology, higher the client load higher the risk and with the new entrants into location or profession. It should also

[13] Social Behavioural Change Communication for HIV Prevention: Guide for public health officers: National STD/AIDS Control Programme, Ministry of Health, Government of Sri Lanka in Partnership with the United Nations Population Fund, 2014

intensify messaging towards behaviour change communication including safe sex practices, negotiation skills, decision-making skills for condom use, etc. Messaging dosage needs to be designed for effective communication towards improved risk perception and behaviour change as well.

PR2 should also review and redesign the BCC messaging and dosage to include a campaign mode – reinforcing the national level campaigns for effective mobilization of KAPs to access sexual health services. E.g Week1 –STIs, Week 2 – HIV/AIDS, Week 3 – Sexual Health services Week4 – Community mobilization strategies.

In order to measure the output and outcome of the above discussed recommendation, specific indicators must be included in the M&E plan and MIS to assess and support the implementation of the IEC and BCC strategy, especially at the community levels.

2. **Pocket Meetings to be Modified into Group Meetings:** Pocket meetings should be considered to be converted into group sessions which should be conducted at the hotspot or at the DIC as they are developed. In such group sessions IEC material could be distributed along with information aids that infuse curiosity to know more about STI/HIV/AIDS as well as normalizing it. The group sessions should be conducted by FS and PE together once a week in each hotspot. KAPs from the groups could be identified by the FS to ensure serious participation in the group sessions.

   Considering the social stigma and discrimination against KAPs, it is recommended that the places for group sessions should be identified in consultation with the target groups, in order to ensure their protection.

3. **Revise IEC Material and Communication Aid**: It is recommended that the communication materials used by the peer educators in the field should be more pictorial and interesting rather than being heavy with text. The peer educators should also be given some communication aids such as edutainment games and flip cards to be used for IEC and BCC sessions with the peers. Such materials should be developed separately for each group with specific information concerning to a particular community group. There are several such examples and prototypes are available which should be considered for adaptation while encouraging innovation in this regard.

4. **Buffer Stocking of Condoms**: Although there has always been adequate supply of condom to the clients, it would be in the interest of the programme to maintain a buffer stock of condoms at each level of the management. Also there has to be an alert system in place which raises flag as soon as the stock goes below a certain limit. This is envisaged to avoid any stock out at any point of time in future.

5. **Demand-Supply Study**: It is recommended that a study should be undertaken to assess the gap between the demand and supply of condom, lubes and needles-syringes for IDUs preferably at the SSR level. This will also serve as a documented evidence for demand and supply and assist in strengthening the systems.

Drop-in Centre

Reflecting the general acceptance to the concept of Drop in Centre and given the Sri Lankan context of low prevalence and size of KAP, the review team suggests the implementation of DIC approach. The designs should be based purely on the primary focus of the intervention.

The DICs should be rolled out with a minimum recurring cost of house/ room rent and DIC maintenance and a one- time cost of bare minimum furniture (dressing table, IEC material, audio visual aids – TV and few other essentials). DIC space could be used for group meetings, pocket meetings, information dissemination, and resting place. Considering the situation in the field visited by the review team the two possible models of DIC are suggested as follows:

Option A: DIC – Attached to STD clinics Managed by MoH

Option B: DIC - Attached to SSR

Option A: DIC – Attached to STD clinics Managed by MoH

Management Responsibility and location: With the intervention design focused on enhancing the access to clinical service of the KAPs, the DICs could be attached to the STD clinics, with the management responsibility given to the clinical staff. A DIC for each of the population should be started separately, which of course would require additional staff at the STD clinics. However, it should be located within the reach of the respective KAP, preferably close to the major hotspot.

Facilities and Services at the DIC: A stigma free and non-judgmental environment at the DIC needs to be created by appropriate branding and messaging package. The DIC should have basic hygienic and health facilities for the peers to utilize. DIC space could be used for group meetings, pocket meetings, information dissemination, and resting place. This place could be used for small community events and community mobilization activities. The hours of visiting at the DIC should be relaxed but well-regulated and the premises must not be used for soliciting clients, or drug use, etc.

Human Resource: Such a DIC should essentially have two personnel at least, in addition to other visiting staff of the STD clinics - a professional counsellor and a DIC Administrator. Additionally, DIC could be provided with a para-medical staff that can be trained to carry out HIV testing when community based testing is rolled out.

Resources for Roll Out: In this case, the viability of public private partnership can be explored. For example Some other agency could provide funding support for an additional PHN/PHI with the same qualification to operate as a counsellor or Para Medical staff at the DIC. This could be monitored and assessed by the MoH and NSACP. This could be retired nurses as was done for IBBS. Based on the value addition by such a staff at the DIC towards care and support services, the MoH may decide to absorb the staff in the main-stream on contractual basis, which is a sustainable choice for the government organization.

Option B: DIC - Attached to SSR - The location, human resource, responsibilities remain the same for the SSR attached DIC as in the MoH attached DIC. However, the management of the DIC rests with the SSR and the PR2. The GFATM has already made provisions for DIC in the PR-2 budget for the same.

The services to be provided under option 2 are recommended to be same as in option 1, mentioned above. Additionally, the SSR can use the DIC as an extension for outreach activities and use it as an information centre. The DIC has been seen as an effective means for community mobilization and collectivization activities such as group meetings, support groups meetings, advocacy meetings, structural interventions, etc.

The number of DIC may depend on the population size, preferably one per 1500 to 2000 peer community. Each SSR should be given at least one DIC per KAP in their operational areas.

The advantages of the option are that the management being that of SSR any changes needed, can be made easily and with immediate effect. Staff recruitment and monitoring the quality of services are faster as well. Community mobilization activities could add to the organizing of communities thereby assisting enabling environment for the KAPs to participate in the programme activities in a stigma free atmosphere.

In the review report dissemination meeting it was agreed that 6 DIC's were budgeted and will be set up – 2 each for FSW, DU & MSM. The DICs earlier supported by the UNODC have been discontinued as funding support ended. A DIC for PLHIV will also be supported though they are not part of the peer led targeted intervention. As suggested above the rules for use and manning of DIC should be finalised. Drawing on the ADIC's experience of implementing DICs for DUs with a support from UNODC will certainly help better design the intervention. Depending upon effective strategic location needs either the DIC be adjacent to STD clinic or near hotspots. Technical assistance and Clinical support be provided by NSACP, however it's manning and administration should be determined by the PR2 through SRs and SSRs.

In Asia and Pacific region, a large number of drop-in-centres are managed and run by NGOs and CBOs with following objectives:

- To improve and update the knowledge and skills of KAPs for prevention of HIV and AIDS
- To create an enabling environment for the KAPs and to protect and promote their rights
- To provide KAPs basic care, support and treatment services in timely and quality manner
- To establish linkages with the existing health services, NGOs, CBOs and other welfare and development programmes.

The costing of such DICs are however substantial and require ongoing funding support to continue to provide services. Such DICs are usually manned by a DIC Coordinator, counsellor, field outreach workers and support staff.

The budget for the DIC besides salaries and running expenses includes the expenses for emergency services, communication materials, advocacy events, stakeholder meetings, refreshments, weekly/bi-monthly recreational programmes, and in case of DIC for drug users, it also has the budget for food and hygiene for homeless DUs and those requiring treatment.

The focus of the DIC in most situations is same, which includes:

- The provision of correct information about HIV transmission, prevention, safe sex and substance use.
- The promotion and provision of condoms and lubricant, along with information, education and communication materials (IEC), on sexual transmission and the role of substance use in HIV transmission, especially among young people.

- The promotion of positive attitudes towards condom use and developing condom use and safe sex negotiation skills and promotion of sterile injecting equipment.
- Promotion of the need for regular STI check-ups and the need to treat STIs as a means of reducing HIV risk, with referral to STI services.
- Encouragement of HIV testing and promoting the benefits of knowing one's HIV status, with referral to testing sites.
- Encouraging those reached by peer education to influence their peers and clients to adopt safe sexual and drug use practices and to access STI and HIV testing and counselling services.
- Promotion of monitoring one's health status for those who are HIV-positive.
- Assisting peers dealing with sexual harassment and developing skills for avoiding violence and rape.
- Discussion and support relating to sexuality, including social, emotional and psychological aspects of having a sexual identity, behaviour or preference which is different from the mainstream, with referral to support services.
- Assisting peers in dealing with stigma and discrimination based on sexual identity or practice, HIV status or involvement in sex work.

Weblinks to some of the standard operating procedures for the DIC is provided below which can be used for further reference.

1. http://pdf.usaid.gov/pdf_docs/PA00HT6K.pdf - DIC for FSW
2. https://www.unodc.org/documents/southasia/publications/sops/drop-in-centre-for-injecting-drug-users.pdf - DIC for People Who Use Drugs
3. http://www.fhi360.org/sites/default/files/webpages/India_SOPs/drop-in-cente1.html

Community Based Testing

1. **Inclusion of community based testing in the National Counselling and Testing Guideline:** Considering there is a positive response at all levels regarding the acceptance of the community based testing, it is important that the country uses the momentum to include it in the national guideline for HIV counselling and testing to streamline the operational guidelines, SOPs for transportation, use and storage of kits, transportation of blood sample, delivery of report, client follow-up etc**.** as has been done in several other countries to attain 90-90-90 target. Testing has been the mandate of the national program hence it is suggested that the PR2 makes advocacy efforts to mobilise the NSACP to undertake the above task.

2. **Consultations for Strategy and Protocol Development:** The inclusion CBT in the National Counselling and Testing Guideline should be done in consultation with the experts, CBOs/NGOs and members of the KAP groups, as has been done in several other countries including the Asian neighbours of Sri Lanka. Such consultations to develop a community based HIV testing guideline and protocol will ensure that all important concerns at all levels are addressed effectively as well as the fear of the KAP groups are alleviated. Community consultations should be held to derive a best suitable strategy for the country to roll out CBT in collaboration with PR1.

The community based testing requires a careful planning, sufficient funding, good training, ample coordination, proper oversight, and the involvement of civil society which can play a critical role in ensuring accountability, confidentiality, and prevention of human rights abuses. Without these elements, the programs risk failing to achieve its ambitious goals or worse, damaging the cause it is intended to serve[14].

3. **Design and Development of Referral Systems and Linkages:** Besides community mobilisation and IEC campaigns the community based testing programme must be supported with strong system of counselling, report delivery and strong linkage, referral and follow-up system with the STD and ART clinics. It is recommended that the community based testing uses consent mechanism for testing and utilises the existing system of reporting to hand-out the report to the clients. The clients testing positive should be referred and linked to care, support, and treatment services, and those testing negative but have risk behaviour should be motivated to stay connected and return for follow up testing after 3 to 6 months.

4. **Coordination of the roll out of the Community Based Testing:** As the mandate of the testing lies with the NSACP, it should be taking the responsibility of coordination and monitoring of the roll out of the community based testing at the national, provincial and district levels. The PR2 should assume a supportive coordination role to support the roll out of the community based testing among the KAPs through the peer-led intervention. This should essentially start with the community mobilisation which can follow the above discussed community consultation to roll out the community based testing.

   The strategies that have been adopted in other countries to roll out the community based testing and reaching out to communities include mobile vans/clinics, meeting at individual KAP or PE house, health camp at a satellite clinics or sub-centre as in some Southern states of India, use of community halls, schools on holidays and many others for community gathering and testing. In countries where DICs exist as a part of KAP interventions testing have been initiated in the DIC as piloted in India.

5. **Supply Chain Management of Testing Kits:** An effective supply chain management of the testing kits is a key to the success of the community based testing. The program thus requires having regular stocks of rapid testing kits which are supplied across the country at once or in phased manner. Appropriate stocking with essential buffer of the rapid test kits at the district levels will ensure its regular availability for people, provided enough warehousing facilities for medical consumables available at the district hospital. This may also require additional human resource for logistic arrangement, documentation, transportation, and delivery.

6. **Strengthening of Existing Testing Services**: The community based testing programme should be used as an initiative to reach out and mobilise unreached and hidden population for HIV testing. Hence it is suggested that the programme is envisioned and planned for a long term. In the meanwhile the existing VCTC system must be strengthened to sustain the increased client load and deliver the quality services as weaning out of the

[14]Human Rights Watch: A Testing Challenge; The Experience of Lesotho's Universal HIV Counselling and Testing Campaign, available at https://www.hrw.org/report/2008/11/18/testing-challenge/experience-lesothos-universal-hiv-counseling-and-testing#page, as accessed on 04 April 2016

populations from CBT starts. However, testing at the VCTCs will continue to provide services and KAPs may still access those services concurrently to CBT.

Performance Based Incentive

1. **Participatory Design**: It is recommended that there is a wider consultation with the peer educators and field supervisors to design the mechanism for performance based incentive as has been done in many other countries. This will help earn their confidence in the system and programme. The review team has enough reasons to suspect that many of the well trained peer educators and field supervisors may leave when performance based incentive system is implemented, and with them the programme will be loosing the investment made in past years in building their capacity and connecting to the KAPs.

   The PR2 should consider the provision of both non-monetary (e.g. bicycles, T-shirts, other materials) and financial incentives (e.g. access to credit and compensation for expenses) to motivate peer educators. The Unicef also suggests considering incentives for peer educators to attract and maintain their participation. For example, recognize their contribution through: public recognition; certificates; programme T-shirts; food; money/credit stipends; or scholarships.

2. **Suggestion of consultation:** The relevant stakeholders at the review report dissemination meeting discussed a suggestion to be considered for consultation for performance based remuneration schemes. It was discussed that a certain amount for a fixed number of target should be determined and should essentially be paid to all PEs. In order to encourage additional reach out and coverage the PEs should be paid based on additional targets reached. The amount for essential number of targets would vary according to the KAP group.

   The PEs working with MSM, FSW, TG, and Nachchi groups would be required to reach a minimum of 15 peers for which they will be paid SLR 6000 per month. This works out to be SLR 400 per peer per month to be paid to the PEs. For reaching out to additional 5 (15+5 = 20) peers, the PE for MSM, FSW, TG, and Nachchi groups would be paid additional incentive of SLR 1000, (which means SLR 200 per additional peer). If the PEs are able to reach to 10 more peers in additional to essential 15 (15+10=25 per month) they will be paid SLR 8000. However, in case of DU community the basic essential number of peers would be 30 for which the PEs will be paid SLR 6000. To earn SLR 7000 and SLR 8000 per month the PEs will have to reach additional 10 and 20 numbers of peers, respectively.

   A summary is presented below.

   The incentive patterns for MSM, FSW, TG and Nachchis is as follows:

   a. Reach – 15 Remuneration – SLR 6,000/-
   b. Reach – 20 Remuneration – SLR 7,000/-
   c. Reach – 25 Remuneration – SLR 8,000/-

   However in the case of Drug User KAPs

   a. Reach – 30 Remuneration – SLR 6,000/-
   b. Reach – 40 Remuneration – SLR 7,000/-
   c. Reach – 50 Remuneration – SLR 8,000/-

It is to be noted that the above are recommendations that need to be finalized in consultation with the KAP members of each of the group once again.

ANNEXURE -1

Terms of Reference for the review

Title: In-depth review of current HIV prevention and STIs strategies and implementation models for sex workers (SWs), men who have sex with men (MSM), beach boys (BB) and people who use and/or inject drugs (PWUD/PWID) in Sri Lanka

I. Background

Sri Lanka has maintained low adult HIV prevalence of less than 0.01% for the past decade with 3,000 (range 2,000 to 5,000) estimated adults of living with HIV in 2014. Based on the draft 2014 NSACP Annual Report, a cumulative total of 2,073 people were diagnosed with HIV. The proportion of male cases increased from 46% of cases in 2003 to 73% of cases in 2014 with majority in the age groups of 25-49 years. Heterosexual non-commercial sex was reported with the highest share among the modes of transmission in the period 2009-2014. Sri Lanka is one of four countries in the Asia Pacific region that has shown up to a 25% increase in new HIV infections in the period 2001-2011. The increasing number of new cases diagnosed each year is likely to be the result of increased case detection through intensified HIV testing rather than an actual increase in HIV incidence.

Identifying key populations driving the epidemic in Sri Lanka is challenging, as no particular population group has higher rates of infection than any other, and HIV prevalence has remained below 1% in the last ten years. However, key populations engage in behaviours that would increase their exposure to HIV if the virus were to enter their sexual networks. These include female sex workers (FSWs) and men who have sex with men (MSM), both of which exist in fairly large numbers in Colombo, and to a lesser degree in other larger cities. Beach boys (BB) are also a population with risky behaviour, but they are a relatively small group. There are a large number of people who use drugs (PWUD) in Sri Lanka, but the vast majority of them do not inject drugs or share needles, which is the main risk behaviour for HIV transmission in this population. If this population shifts to injecting, the potential for HIV to spread would be more of a threat, therefore the situation must continue to be monitored.

In the beginning of 2015, a Mid-Term Review (MTR) of the 2013-2017 National Strategic Plan (NSP) was conducted to assess the overall course of the national response to HIV/AIDS and sexually transmitted diseases (STIs) and the progress towards NSP objectives and targets as well as documents achievements, lessons learned and challenges ahead. The MTR examined the five thematic areas of the NSP (Theme 1 - Prevention; Theme 2 – Diagnosis, Treatment and Care; Theme 3 – Strategic Information; Theme 4 – Supportive Environment; Theme 5 – Health Systems Strengthening and Supply Chain Management)

To complement the findings and recommendations of the 2015 MTR, an in-depth review of the current HIV and STIs prevention strategies and implementation models sex workers (SWs), men who have sex with men (MSM), beach boys (BB) and people who use and/or inject drugs (PWUD/PWID) in Sri Lanka will be conducted. The in-depth review shall include but not limited to outreach peer education model, HIV testing and STIs diagnosis and treatment, HIV care and ARV treatment), enabling environment to facilitate reaching of key populations (KPs) and increase uptake of STD clinic services, advocacy to support capacity building for NGOs, CBOs and communities contributing to the national response for HIV and STIs. The assessment of the need to reprogram will be further complemented by a study to better understand drug use patterns in the country and assess specific issues with risk reduction strategies and interventions for PWUD/PWID. The findings and recommendations from this in-depth review, together with

operational research, the assessment of the condom and lubricants programming, the drug use study and other strategic information will be used to develop a National HIV and STIs Prevention Strategy for Key Populations.

II. Objectives

1. To assess the scope, scale, comprehensiveness of , quality of service delivery, level of integration and coordination of the interventions and different service delivery modalities for FSWs, MSM, BB and PWUD/PWID (hereinafter Key Populations). Interventions and services to be assessed include but not limited to
   - Outreach peer model including effectiveness of the escorting of key populations members to STD clinics for HIV testing and STIs diagnosis and treatment;
   - HIV testing and counselling and feasibility of establishing alternative models such as testing in the community at NGO sites or NGO-controlled mobile sites ;
   - Increased access and linkages to STIs diagnosis and treatment;
   - Increased access and linkages to HIV care and ARV treatment;
   - The need for establishing drop-in centres;
   - Need for complete reprogramming of the interventions for PWUD/PWID to include harm and risk reduction services;
   - Enabling environment and access to HIV prevention, treatment and care services;
   - Advocacy for community systems strengthening and capacity building of NGOs, CBOs and communities, etc.
2. To assess specific programmatic achievements and areas requiring improvements in the above interventions for KPs as well as prioritize those most likely to lead to impact. Areas to be assessed include but are not limited to access and utilization of services, effectiveness of behaviour change communication and information, education and communication (IEC) messages and channels, peer support, addressing stigma and discrimination, etc.
3. To assess strengths and identify specific operational aspects for improvement in the current peer model implemented by NGOs as the Principal Recipient (PR), Sub-Recipients (SRs) and Sub-Sub-Recipients (SSRs),including recruitment, training and retaining peer educators; organizational development of NGOs and CBOs; target setting at the national and sub-national level to ensure geographical and population coverage, service quality improvement strategies, etc.
4. To identify opportunities for sustainability and continuation of interventions and programs that reach key populations in the community beyond Global Fund grant span to maintain the low prevalence of HIV in the country.
5. Provide concrete recommendations that will inform the development of a National HIV and STIs Prevention Strategy for Key Populations as well as reprogramming implementation modalities for KPs interventions to be supported through the Global Fund Funding Model grant in contribution to the national HIV and STIs response.

III. Scope of work

The Consultants shall coordinate with NSCACP SL and FPASL and undertake the following tasks but not limited to:

- Desk review (list of documents attached as Annex 1 to this Terms of Reference).
- Conduct of interviews/focus group discussions/meetings with stakeholders /field observations with targeted key populations including those who are NOT accessing the current interventions
- Present all evidence and all the findings of the in-depth review and assessments to stakeholders
- Dissemination workshop of the draft review report
- Submission of the final review report

IV. Deliverables of the consultants

1. Desk review of existing documents related to the project

2. Inception Report with detailed schedule of activities and detailed budget for each activity.
3. In-country field visits for primary and secondary data collection.
4. Activity report on the conduct of focus group discussions, interviews and meetings.
5. A comprehensive final review report in hardcopy and electronic form.
6. Field visits, focus group discussions, meetings, consultation and dissemination workshop.
7. Other deliverables as agreed upon during coordination meetings with NSACP SL and FPASL.

V. Assignment Duration: Four (4) weeks

VI. Implementation Arrangements: Contact details

1. **For administrative matters**
   FPASL:
   Thushara Agus, Executive Director. FPA Sri Lanka, 37/27, Bullers Lane, Colombo 7. T/P - 2555455
   NSACP:
   Dr Sisira Liyanage, Director, NSACP, 29 De Saram Place, Colombo -10
2. **For technical matters**
   NSACP:
   Dr Janaki Vidanapathirana, Consultant Community Physician, NSACP, 29 De Saram Place, Colombo -10

VII. Roles and Responsibilities

Consultants:

1. Conduct all activities with due diligence and competence and produce technically sound deliverables in line with the Terms of Reference and the Contract(s).
2. Coordinate with the NSACP and the FPASL focal points with regard to the organization of meetings and other activities under this project.
3. Submit final documents in line with the schedules agreed upon with the Terms of Reference, the Contract(s), the Inception Report, as well as agreed upon during debriefing meetings with the NSCAP and FPASL.
4. Submit final documents with specific and practically feasible recommendations.
5. When taking strategic decisions as recommendations to involve all relevant stakeholders. Ensure consultation of strategic and operational level recommendations with all relevant stakeholders in line with the principles of country ownership.
6. All outputs developed by the Consultant under this project shall remain the property of the NSACP.

National STD/AIDS Control Program (NSACP):

1. Facilitate the access to all desk review documents.
2. The NSACP technical panel shall take part in the selection and the initial and follow-up debriefing of the Consultants.
3. Facilitate with available data, arranging interviews, field visits, stakeholder meetings with consultants
4. Facilitate community interactions and interaction with other sectors, eg. The National Dangerous Drugs Control Board (NDDCB).
3. Organise joint meetings on status updates as well as final dissemination meeting.
4. Assess the deliverables for technical soundness and compliance with the Terms of Reference.

Family Planning Association of Sri Lanka (FPASL):

1. Participate as a member of the stakeholder group taking part in the selection and the initial and follow-up debriefing of Consultants
2. Prepare the Contract(s) and implement the contracting procedures.
3. Furnish available records, data and facilitation of interviews with FPA staff.
4. Facilitate community interactions, i.e. liaise with SRs, SSRs and key population and community representatives, scheduling interviews and visits with community actors.
5. Extend support and assistance to carry out field visits.
6. Jointly organize the dissemination meetings together with NSACP.
7. Upon delivery by the Consultant of the agreed outputs within the agreed schedule and upon approval by the NSACP, pay the Consultant's fees (inclusive of airplane fare to and from Colombo and per Diems).
8. Cover costs of local travel in Sri Lanka for the Consultants and the local staff joining the Consultants with regard to participation in meetings, field visits, focus groups, community consultations and other project activities as specified in the Terms of Reference, the Contract and the Inception Report.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM):

1. Provides financial support for conducting the in-depth review.

VIII. Reporting obligations and approval process

1. Reports are based on expected outputs and deliverables as indicated
2. All reports shall be submitted to FPASL and NSACP for review and comments, and for appropriate endorsements.

IX. Required qualification of consultants

Area	Key team members - international consultants
a. Education, training	• Doctor of Medicine/ Sociology with Master Degree/advanced degree in Public Health or any field related to public health
b. Experience, skills and competencies	• Has extensive experience working in health program planning, management, and M&E of programs for key populations. • Has previous experience in evaluation and/or assessments of programs for the targeted key populations. • Has good working track record with government, NGOs and international agencies • Must have at least 10-year experience in working with HIV-related areas

X. Technical evaluation criteria for the international TA provider

Criteria	Weight
I. Applicable experience of the consultant	
a. Experience working in health programme planning, management, and M&E for key populations	30%
b. Previous experience in conduct of evaluations of programs for the targeted key populations	30%
II. Qualification of Team Members	
a. Education, training	20%
b. Expertise, skills and competencies	20%
TOTAL	100%

The consultants shall be evaluated based on the following criteria and using the corresponding percentage weights indicated in the table above:

1. Experience and capability of the consultant which include track record and performance of previous assignments in similar and in review and evaluations; relationship and coordination with previous and current clients; and overall work commitments, geographical/country experience gained with current and forthcoming projects and attention to be given by the consultant to the project shall consider both the overall experience of the firm and the individual experiences of the key staff members and key staff including when employed by other consultants; and

2. Proposed methodology and plan of activities to conduct the assignment including clarity, practicality and completeness of the plan and understanding and interpretation of project problems, risks and suggested solutions.

XI. Proposed terms of payment by major deliverables

The Consultant/s hired is expected to deliver the following at an agreed schedule:

Schedule of instalments	**Percentage**	**Deliverables**
First Release	30%	Inception Report
Second Release	40%	Activity reports
Third Release	30%	Final technical report

XII. Total budget: Will be shared after adjustments(detailed budget by activities included as Annex 2 to this Terms of Reference)

ANNEXURE -2

Key Questions

In-depth Interview - POLICY MAKERS	
S No.	**QUESTIONS**
1.	What does the incumbent know about the Peer Education Strategy?
2.	What are the policy documents that place the PE strategy for prevention programmes in Sri Lanka?
3.	Have any changes been made to the strategy? (to suite the populations/location/cultural milieu) If Yes. What are they? If No. Why no changes were made?
4.	Is there a common understanding of the strategy at all levels? If Yes. How was it achieved? If No. Why?
5.	Is the PE model working for KAPs? Yes. Why? What worked Well? No. Why? What did not work well?
6.	Is there a need to change the PE Strategy or abandon the strategy? If Yes. What needs to change? What can be done to improve the PE strategy? If abandoned, what would be the alternate strategy?
7.	Are you aware of community based testing? Are you aware of the different methods practiced around the world? Do you think it is feasible to have community based testing in Sri Lankan context? Who do you think within the Peer Education interventions should do the testing? What do you think could be the modalities to undertake such testing?
8.	What is a performance based incentivization? Do you think it will be appropriate for performance based incentivization to be applied to the peer educators? What models can be suggested?
9.	Explore issues of incentivization, DIC, accompaniment for STI treatment, distances between the facilities, planning a common PE system for all Populations and any others.

FGD with the IMPLEMENTERS	
S No.	**QUESTIONS**
1.	What does the group know about the Peer Education Strategy? What is the strategy? Why the strategy? Among which populations is this strategy being implemented? Why?
2.	Have any changes been made to the strategy? (to suite the populations/location/cultural milieu) If Yes. What are they? If No. Why no changes were made?
3.	What is the structure of PE system in a SR /SSR location Recruitment process Training Processes. Internal? External? Training Material Planning &Reporting systems

FGD with the IMPLEMENTERS	
S No.	**QUESTIONS**
	Monitoring systems PE Turn Over Understanding of PEs on HIV issues
4.	Are the above followed and what is the opinion of the group on the above?
5.	Explore issues of incentivization, NIC, accompaniment for STI treatment, distances between the facilities, planning a common PE system for all Populations, PE for Transgender Populations, legal issues, Enabling Environment activities (local Advocacy) and any others.
6.	Is the PE model working for KAPs? Yes. Why? What worked Well? No. Why? What did not work well?
7.	What do you have to say of the PE performance among the FSW, MSM, IDU and BB ? Good? Why do you think it has been good among a particular population? Not Good? Why has been not good among a particular population?
8.	What are the factors affecting PE performance? Internal Factors? External Factors?
9.	Are you aware of community based testing? Are you aware of the different methods practiced around the world/region Do you think it is feasible to have community based testing in Sri Lankan context? Who do you think within the Peer Education interventions should do the testing? What do you think could be the modalities to undertake such testing?
10.	What is a performance based incentivization? Do you think it will be appropriate for performance based incentivization to be applied to the peer educators? What models can be suggested?
11.	Is there a need to change the PE Strategy? If Yes. What needs to change? What can be done to improve the PE strategy?
12.	Should the PE strategy be continued? Why? What is your view about DIC to be included in the PE strategy?

FGD TOOL – MANAGERS	
S No.	**QUESTIONS**
1.	What does the incumbent know about the Peer Education Strategy?
2.	What are the policy documents that place the PE strategy for prevention programmes in Sri Lanka?
3.	Have any changes been made to the strategy? (to suite the populations/location/cultural milieu) If Yes. What are they? If No. Why no changes were made?
4.	Is there a common understanding of the strategy at all levels? If Yes. How was it achieved? If No. Why? Which level needs a better understanding of the PE strategy?
5.	Is the PE model working for KAPs? Yes. Why? What worked Well? No. Why?

FGD TOOL – MANAGERS	
S No.	**QUESTIONS**
	What did not work well?
6.	What do you have to say of the PE performance among the FSW, MSM, IDU and BB ? Good? Why do you think it has been good among a particular population? Not Good? Why has been not good among a particular population?
7.	What are the factors affecting PE performance? Internal Factors? External Factors?
8.	Is there a need to change the PE Strategy? If Yes. What needs to change? What can be done to improve the PE strategy?
9.	Are you aware of community based testing? Are you aware of the different methods practiced around the world? Do you think it is feasible to have community based testing in Sri Lankan context? Who do you think within the Peer Education interventions should do the testing? What do you think could be the modalities to undertake such testing?
10.	What is a performance based incentivization? Do you think it will be appropriate for performance based incentivization to be applied to the peer educators? What models can be suggested?
11.	Explore issues of incentivization, NIC, accompaniment for STI treatment, distances between the facilities, planning a common PE system for all Populations, PE for Transgender Populations and any others.

FGD TOOL – FIELD SUPERVISORS & PEER EDUCATORS	
S No.	**QUESTIONS**
1.	What does the group know about the Peer Education Strategy? What is the strategy? Why the strategy? Among which populations is this strategy being implemented? Why?
2.	What is the role of Peer Educators? Do you think it is an important role?
2.	Have any changes been made to the strategy? (to suite the populations/location/cultural milieu) If Yes. What are they?
3.	What is the structure of PE system in a SR /SSR location Recruitment process Training Processes. Internal? External? Training Material Planning &Reporting systems Monitoring systems PE Turn Over Understanding of PEs on HIV issues
4.	Are the above followed and what is the opinion of the group on the above?
5.	Explore issues of incentivization, NIC, accompaniment for STI treatment, distances between the facilities, planning a common PE system for all Populations, PE for Transgender Populations, legal issues, Enabling Environment activities (local Advocacy) and any others.
6.	Are you aware of community based testing? Are you aware of the different methods practiced around the world? Do you think it is feasible to have community based testing in Sri Lankan context? Who do you think within the Peer Education interventions should do the testing?

FGD TOOL – FIELD SUPERVISORS & PEER EDUCATORS	
S No.	**QUESTIONS**
	What do you think could be the modalities to undertake such testing?
7.	What is a performance based incentivization? Do you think it will be appropriate for performance based incentivization to be applied to the peer educators? What models can be suggested?
8.	Is the PE model working for KAPs? Yes. Why? What worked Well? No. Why? What did not work well?
9.	What are the challenges in terms working as a PE? Internal Factors? External Factors? How do you propose to overcome the challenges
10.	If the peer education system for that specific group needs to change what changes should be made?

ANNEXURE -3

TIMELINE

Date/Day	Activity
25 February 2016/ Thursday	Review team arrives in Sri Lanka
26 February 2016/Friday	Meeting with the ED, FPASL and Director, NASCP with a purpose of - Introduction of the team in person - Finalise on-site review plan - Finalize list of key respondents - Finalize point persons and translators for on-site FGDs - Finalize coordination mechanisms for the onsite review
26 February 2016/Friday	IDI and FGD with management staff from FPASL
27 February 2016 / Saturday	FGD with SR & SSRs (location to be discussed and finalized with FPASL)
	FGD with Field Supervisors
28 February 2016/Sunday	FGD with PE (location to be discussed and finalized with FPASL) Need to discuss if the Community members will be willing to come on a Sunday
28 February 2016/Sunday	Review and sharing of Notes and documentation by consultants
29 February 2016 / Monday	KI Interviews with NSACP, Discussion with the M&E team at the FPASL and visit to the STD Clinic
1 March 2016/Tuesday	Visit to STD Clinic and Documentation and preparation for Debriefing
2 March 2016/Wednesday	Debriefing to relevant stakeholders on the review and sharing of major findings and finalization of the report structure

ANNEXURE -4

List of Documents for Review

	IBBS Survey in Sri Lanka - Report print version, BSS 2006, prison survey
	Annual report of NSACP 2012-WebVersion 25.3.2014
	Annual Report-2013
	GFATM Procedure Manual-11 (FPA)
	OSDV Report_BB
	OSDV Report_DU
	OSDV Report_FSW
	OSDV Report_MSM
	PE assessment _FSW 2014
	PE Assessment Report _BB 2014
	PE assessment_DU 2014
	PE assessment_MSM 2014
	PU Jan-June 2015 SRL-913-G16-H FPA R9 HIV 15-08-2015
	PU July-Dec 2014 SRL-913-G16-H FPA R9 HIV 15-02-2015
	PU Jan-June 2014 SRL-913-G16-H FPA R9 HIV PU 15-08-2014
	PU July-Dec 2013 SRL-913-G16-H FPA R9 HIV correct 03-07-2014
	Peer educator Training module (local language)
	srilanka_2010_country_progress_report_enUNGASS
	SRL-R09-HA_Proposal_0_en1224055975
	SRL-913-G16-H Explanatory Notes SR districts targets and PE training 2015 (3)
	Report of the Mid-Term Review (MTR) of the 2013-2017 National Strategic Plan (NSP). Findings and Recommendations 2015
	NSP 2011-2015, 2007-2011
	National HIV/AIDS M&E Plan 2013-2017
	National HIV/AIDS Policy 2011
	External review of national response 2006, 2011
	Situation assessment of condom programming in Sri Lanka – 2015
	Latest HIV/AIDS Surveillance Data -Sentinel surveillance HSS 2008, 2009, 2011,
	Annual Report of NSACP 2014/2015 & 2014
	National size estimation of MARPs in Sri Lanka 2013
	Report on pop size estimation-2010
	Social mapping of BB, DU, FSW &MSM in Sri Lanka http://www.aidscontrol.gov.lk/web/images/web_uploads/Research_Documents/Social%20Mapping%

	200fbb.du.fsw.msm%20in%20Sri%20Lanka%202012.pdf
	Situation Assessment of women & Children infected and affected by HIV/AIDS in Sri Lanka
	National Condom strategy
	Sri Lankan ART guidelines for prevention and treatment of HIV-2014
	JPIU minutes 2014, 2012 (GF project staff)
	Design, standards and guidelines for Peer Educator Model
	Reply to TRP review of the concept note on KAP (testing algorithm, indicators, proposed surveys to address data gap DU/TG)
	Prison survey

ANNEXURE -5

Report Matrix

Based on the study an analysis has been carried out of the existing status, perceived risks or concerns and recommended actions of the Programs under implementation. This has been tabulated below as per the thematic classifications in the National Strategic Plan and as was also reviewed as part of the Mid Term review undertaken in 2015. The following would be elaborated upon in the final report for submission.

Theme 1 - Prevention;

EXISTING STATUS	PERCEIVED GAPS/WEAKNESS/RISKS/CONCERNS	SUGGESTIONS /RECOMMENDATIONS	ACTIONS TO BE CONSIDERED FOR IMPLEMENTATION
The main plank for prevention in the program is Peer education. The first strategic direction of Prevention is *Behavior change modification through outreach and peer education*. **The NSACP** has implemented PE model for Prisoners and Plantation workers and the same is well captured by the Mid-term Review 2014-15. FPASL the PR2 has extensively worked on PE led targeted interventions among KAPs. **There was agreement that KAPs can be best reached effectively through CBOs and NGO's.**	Validating and establishing correctness of the mapping of Key affected populations or MARPS. (especially the Transgender and Female Drug Users) The PEs for drug users indicated that certain peers in their geographical locations received services but not through them. This was on account of considerable overlap between the DU-Prison inmates -MSM-BB. Some DUs are also Beach Boys as well. Sometimes DU involved in drug peddling are caught by police and are exposed to MSM activity in the prisons. BB also entertains FSWs. Given the coverage of KAP groups standing at 33% with the existing	A study to validate or re-establish correctness/remap the KAP's. Systems developed by PR2 for absolute coordination between SR/SSRs for continuum of services without duplicating the number of KAPs whose sexual behaviour could be aligned to more than one group. Extend the scope of PR2 in terms of coverage numbers Or More for sustainability reasons, PR1 to initiate peer led interventions with KAPs in new locations. A system of check including physical verification/personal interview of identified samples to be conducted through independent audit for ensuring the correctness of the	The PR1 could consider collaboration with GFATM/other donor agencies for an independent mapping and re-estimations of KAP and their sub-categories Consultative meet with peers, PEs, FS, and experts in the field to address dual identity in different groups. Joint decision to be taken by PR1 and PR2 on the extension of scope of geographical and numerical coverage for a saturated reach. Subsequently recruit the SSRs. A joint team of the PR1 and PR2

	number of SSRs calls for revisiting the scope for the existing PRs to do a saturated coverage and effective prevention. The present model links the field supervisor with Peer educator and each Peer educator with the Peer. Adequacy of peer to PE ratio, frequency of meetings, drop out rate are matters to be addressed to establish no weaknesses exist. Span and effectiveness of control in the linked chain FS – PE – P are to be established. System of internal check and quality control of preventive services being offered are areas to be focused for upgrading the effectiveness of the program.	data/services provided and capacities of PE's and FS's needs to be continued however in a new model. (currently, being carried out by the LFA and has drawn much criticism for the manner in which verifications have been conducted)	comprising of technical officers could do a random sampling of 20-30% of population under each SSR for verification on a half yearly basis
NGO's as SR's /SSR's are entrusted the responsibility of prevention through Peer Educators Currently, the PEs are provided a 2 days induction **training** to the program. Earlier batches were given a 5 day comprehensive class room training which the older PEs expressed to be more visual	Capacity of SRs & SSRs as NGOs is limited which need support for making them competent. Seems direct support, including seed money/financial resources for creation of and running of NGO's is unavailable. Gaps and lack of trust between Government and NGO sector is another concern. Review of the training module reflects that most sections are adequately comprehensive, but other sections, especially on sexual health, communication and skill development are quite	Government Role to help create appropriate mechanism for developing the NGO sector. Creating a system for imparting Training to members of NGO's and tying them up through an all-encompassing body/Association will be useful In terms of prevention interventions planning for cascading capacity building would assist in follow up of central trainings as well as assist in improving the quality of	Approaching the Government to fund support NGOs involved in such interventions. Systems approach and organization development of SRs/SSRs to be included in capacity building of SRs/SSRs Creation of Pool of ToTs and Trainer by the PR2 Capacity building and on job training aspects to be included into SR /SSR operations

and helpful in understanding the program and their role. Exposure visits were organized to neighbouring countries The retention of peer educators by the program is quoted as a significant challenge as most are engaging in other activities for their regular income	technical and require more time to help participants understand and absorb it. Issues like Pressure to meet the activity targets, increased burden of reporting, delayed payments, random calling for meetings and data verifications, are quoted as major hindrances to continue working as peer educator, as it affected their regular job. Most peer educators also mentioned that they had to pay for transport and many a time for refreshments of the peers when accompanying them to the clinics are seen as risks. Delayed payments of incentives coupled with blackmailing by peers for data verification resulted in drop outs of PEs	intervention. Rewards and Recognition at the provincial level by the local govt. authorities or any other linkage for social welfare benefits may inspire PEs to remain in the program Intensified messaging to instil perception among the peers that they are at high risk to HIV infection may draw their attention to their own health seeking behaviour rather than PE incentives	PR1 being the national coordinating authority may conduct concurrent or post training assessment to see the translation of training into implementation PR1 may collaborate with any other donor/organization for capacity building of SRs/SSRs Cadre specific Training modules could be developed for effective capacity building of personnel at all levels of PR/SR/SSR PR2/SR to collaborate with provincial govts. Or identify stakeholders such as Police, Military officers for the rewards and recognitions to be done. PR/SR to develop systems to assess performance of PE/FS for selection of Best Performing PEs/FS. Intensified sessions to be provided on risk perceptions during trainings to PEs and through supportive supervision. Pocket meetings utilized to highlight risk perception and address issues of blackmailing. Sessions could be taken by PO/FS.

			BCC materials emphasizing risk perception to be developed by the PR. Effective use of material for messaging by PEs.
It is important to note there is a sharing of same understanding of the program and service package from the top officials at the FPASL and NSACP to the peer educator in the field. This is a unique strength of the programme.	Though there is common conceptual understanding across, disparity exists in terms of utilization of resources at the SSR level. For e.g Currently, among FSW interventions visited women above the age of 45 years were seen in considerable numbers as PEs and some of them were not practicing sex work. Having active population saves on time to reach the populations as well as the effort of the elder sex workers. Lack of understanding on certain aspects such as incentives was observed. They were used for commutation while escorting, food for peers and sometimes in the case of drug users to buy drugs for use after the visit.	Drawing guidelines for each of the KAP groups would address operational disparity and strengthen outreach.	PR2 should draw up Operational Guidelines for each of the KAP groups and Peer Educators Manual based on the field level experiences that would include dos and don'ts, selection criteria for PEs – acceptable by their own KAP groups, above 18yr of age, currently active KAP members, preferably who are in the same behaviour categories, roles and responsibilities of PEs and Field Supervisors, reporting mechanisms and more.
All the key population groups, FSW, MSM, DU and BBs receive a common service package. Few features such as the number of peers to be reached by a given peer educator and the number of condoms to be provided are the only differences among these	There is a same set of programmatic activity and service package for all categories and sub-categories of KAPs in all places. The peer educators though modify messages and services according to the situation and sub-category of the peer. This is	Service package to be designed specific to the needs of KAP group and their sub-typologies.	Operationalizing the service package needs a different treatment with each of the KAP groups. E.g., introducing community led structural interventions (Collectivization, community led advocacy, crisis management, addressing violence

packages.	good as well as carries a significant risk, as the variation in messages and services are based on their own perception and understanding of the facts. Additionally, it is to be noted that the female drug users, though in significant numbers, are not reached by the program. As most of them engage in sex work, the sex worker peer educator attempts to reach out to the female drug users, which is not acceptable to the female drug users. Similarly, the transgender community is reached by the MSM peer educators, which has reduced impact. The data regarding the female drug users and the transgender community thus is captured under female sex workers and MSM component, respectively.	Drug User Groups to include Female Peer Educators for Female Drug users. Similarly, based on the numbers from re estimation ***separate interventions*** to be designed for TG/Nachchi community. Otherwise, TG-PE to reach out to only TG members of the KAP and MSM-PEs to reach out to MSM-KAPS.	and other such issues) especially with the FSW and MSM/TG/Nachchi could be added within the service package to bring in elements of community empowerment that gives a voice to community issues in accessing sexual health services and facilities apart from non-sexual health needs. World over it has been recognized that addressing KAPs other needs has improved service uptake of HIV prevention services. Female Peer Educators for female Drug Users recruited at SSR level.
The number of peers to be **reached by each peer**	The outreach structure of PEs and Field Supervisors at the SSR level	Modify the intervention to increase peer reach.	Conduct community consultations explain the gaps

educator is between 10 and 20 depending on the type of the key population. There is also target number of the peers for each PE which has to be escorted to the clinics (30 to 40% of the reached peers) and has limitation on the number of condoms to be distributed per peer, per month.	suffices the requirement of an outreach team within the intervention. However, the number of peers reached by the PEs by design is extremely low considering the fact that the coverage of KAPs in Sri Lanka through the program has not reached more than 33% of the estimated numbers. Thereby increasing the intervention cost	The suggested PE: Peer ratio could be 1:20-25 for the FSW/MSM/BB populations. With the DU populations the reach numbers could remain at 1:25-35 due to the high mobility of the populations and the most difficult to reach populations	and advantages of increasing reach combined with encouraging words for committed peer education. PR2 to provide for the identification and selection of PEs with list of 6-7 core criteria in the PE Manual.
<u>Selection of PEs</u> The details of the PE led intervention program and the services package for KAPs is available across several documents, the grant document, periodical reports, training modules, procedure manual for implementation of GFATM (Round 9-phase II HIV program), mid-term- review report 2015, report of the IBBS 2014 and monitoring and evaluation plan for the program. There is also a set procedure and format to facilitate the selection of the peer educators. The selection of PEs is done by Project Officer (from PR), Project coordinator, and Field Supervisors at the SSR level. The PR team also has drafted the service definition which helps understand the program.	Though the selection process of PEs seems close ended and secure from speculations, it is cumbersome and takes away valuable time from the POs.	Selection of PEs could be made the responsibility of the SSR Director, PC and FS based on the selection system provided by the PR	Procedure Manual for the SRs/SSRs to include selection method of PEs and to be made SSR's responsibility.
According to the information	Messaging is done mainly	Currently the outreach activities	Procedure Manual for the Safe

available across the documents mentioned above the PE intervention model is delivering basic/minimum service package for sexual health and HIV prevention via a trained peer educator. The package has three principal components:	through interpersonal communication and Pocket meetings. Pocket meetings are designed to reach out to groups of registered populations within the interventions. However, have been used for review and feedback mechanisms. Pocket meetings are held in the SSR office	focus on providing information on STI, HIV, AIDS, Prevention and treatment services. However, need to intensify their messaging towards behaviour change communication.	Sex practices, negotiation skills, decision-making skills for condom use need to be included into messaging package. Messaging dosage needs to be designed for effective communication towards Risk Perception and behaviour change.
IEC and BCC - education on sexual health/HIV prevention, understanding of risk behaviour, distribution of leaflet and other IEC materials etc.	The IEC/BCC material used for outreach is common for all KAP groups and does not address KAP specific issues and may not reach the sub-typology specificities.	Pocket meetings may be converted into groups sessions not in the office but at the hotspot (where in IEC material could be distributed along with information aids that infuse curiosity to know more about STI/HIV/AIDS as well as normalizing them)	Modify pocket meetings to be held in general public. Build capacities on holding pocket meetings
	IEC about STI/HIV/AIDS for the general population too was observed to be minimal. With very few billboards speaking about the issue normalization of sexual health services can be hampered.	Pocket meetings could be conducted by FS and PE together once a week in each hotspot. KAPs from the groups could be identified by the FS. Re design KAP specific material Re-designing the IEC strategy at the country level and the KAP intervention level will complement efforts of each other on the ground towards demand generation of sexual health services	PR1 and PR2 jointly develop visual materials to be used both for interpersonal and group sessions that are KAP specific Normalizing STI/HIV/AIDS and sexual health services - national audio visual campaigns, billboards, mid –media campaigns/activities may be conceptualized by the PR1 PR2 may strategize BCC messaging and dosage in a campaign mode – reinforcing the

			national level campaigns for effective mobilization of KAPs to access sexual health services. E.g Week1 –STIs; Week 2 – HIV/AIDS; Week 3 – Sexual Health services; Week4 – Community mobilization strategies
Condom promotion – condom use demonstration, explaining the steps in condom use, and condom distribution. The condom supplies were reported as adequate and except once no stock out was reported which is commendable. Condoms are supplied by the NSACP across the interventions.	Knowledge and skills required for Condom promotion among PEs appear adequate. The NSACP provides for 80% of condom demand to encourage social marketing and purchase of condoms by the KAPs.	A Condom Gap analysis is recommended to arrive at the correct demand of condoms Buffer stock of condoms to be maintained at the SSR/SR level	Condom and lubes, demand, supplied and gap therein is to be assessed and to be aggregated at the SR/PR level for each of the KAP groups as documented evidence for demand and supply and assist in strengthening the systems. Although there has always been adequate supply of condom to the clients, it would be in the interest of the program to maintain a buffer stock of condoms at each level of the management. Also there has to be an alert system in place which raises flag as soon as the stock goes below a certain limit.
Escorting to a state STD clinic for voluntary and confidential counselling and testing services.	It is to be noted that 40% of KAPs to be escorted to STD clinics. However, there is minimal	Prioritization is highly essential and needs to be ingrained into service provisions right from	Risk varies with typology, higher the Client load higher the risk and with the new entrants into

The programme escorted 33% on an average of target populations to the STI clinics while the indicator mentions of 40% of reached KAP to be brought to clinic.	prioritization as to which 40% population needs to be escorted. The PEs or FS teams lacked understanding of Prioritization to mobilize to clinical services. None of the PE could explain prioritization and planning. The role of PE ends with the escorting of Peer to the clinic. However, this impedes the follow up of STI patients.	mobilization – treatment – care – follow-up cycle based on the risk. Risk profiling is done at the SSR level. However, prioritizing needed to be strengthened also in terms of follow up of STI patients.	location or profession. This could be included as an indicator to be achieved at the PR/SR/SSR level that essentially needs to be monitored.
Proposed Establishment of Drop in Centres (DICs)	In the absence of DICs in the current intervention strategies reaching out to the different sub typologies of KAPs was found to be difficult at the PE level. Outreach activities were coordinated on roads that was a challenge in itself in terms of service provision	Reflecting the general acceptance to the concept of Drop in Centre and given the Sri Lankan context of low prevalence and size of KAP, the review team recommends two models of DICs. Option A: DIC – Attached to STD clinics Managed by MoH Option B: DIC - Attached to SSR Details of staffing, management, service provision through DIC have been detailed out in the attached note.	The DICs may be rolled out with a minimum recurring cost of house/ Room rent and DIC maintenance and a one- time cost of bare minimum furniture (Dressing table, IEC material, Audio visual aids – TV and few essentials) DIC space could be used for group meetings, pocket meetings, information dissemination, and resting place. This place could be used for small community events and community mobilization activities. The hours of visiting at the DIC should be relaxed but well-regulated and the premises must not be used for soliciting clients, or drug use The DICs could be funded either by PR2 or preferably by PR1 for sustainability reasons. However,

			it could be piloted and initiated by PR2 and handed over to PR1. PR1 may take up the budget costing in the next financial year.
Proposed Community Based Testing among KAPs indicates at a rapid test for HIV in non-clinical settings	Community based testing has its own pros and cons. Given the WHO guideline of test and treat and UNAIDS reaching 90 90 90 by 2020, high prevalent countries have attempted at screening for HIV. Where it has increased HIV testing considerably thereby reducing future burden of HIV in the country	National guideline for HIV counselling and testing should include the Operational guidelines, SOPs for transportation, use and storage of kits, transportation of blood sample etc. for community based testing of HIV, as has been done in several other countries. Testing has been the mandate of the national program.	Community consultations may be held to arrive at the best strategy to roll out CBT in collaboration with PR1. Of the various strategies that have been adopted are Mobile vans, KAP's house (as Satellite clinics as happens in South Indian States, in one of the community members house or PE house) college/ community halls, Schools on Holidays and many other in countries where DICs existed as a part of KAP interventions, testing have been initiated in the DIC as piloted in India. The national program may require having stocks of rapid testing kits to supply across the country at once or in phased manner. Or decentralize the testing with the existing district level structure. This may require human resource for logistic arrangement, documentation, transportation, Counselling. Coordinating Authority at the

			national, provincial and district levels for roll out and monitoring. And also at the PR2 level. Coordination with PR/SR/SSR for community mobilization. IEC and BCC material to normalize and mobilize testing. Above all develop reporting systems for accurate reporting. Envision the program for at least next 4 years after which PR1 and 2 may be ready with mobilization strategies to the existing infra-structure of VCTC for testing and weaning the populations from CBT. However, testing at the VCTCs will continue to provide services and KAPs may still access those services.
Proposed Performance Based Incentive for Peer Educators The Field Supervisors remunerations have remained fixed over the last three years. The Performance based Incentive is proposed to be introduced shortly.	Discontentment will lead to shift of FS and PE's to other engagements and soon give up this work. In order to indicate target fulfilment etc, cook up data. If genuine attempts at achieving growth are worked upon, quality of service may be compromised. Dodging of their responsibility in meeting the Peers needs.	In Congo a similar system was studied where it was found that while pay-for-performance facilities invested more effort in attracting patients, this increase did not translate into higher levels of service utilization or better health outcomes. Health workers in pay-for-performance facilities became less motivated and satisfied with their jobs compared to their counterparts in fixed payment facilities.	It is appropriate that compensations are fixed at market rate along with the basic target. Incentives should be for surpassing basic accomplishable targets. A system to identify other expenses that are essential and payment of the same with due proof of spending may also be built in.

	De-motivation may result in low efficiency.	However another similar but improved system when implemented with well-defined indicators and tracking methods gave good results in India while implementing its National Rural Health Mission in rural India. In Burkina Faso the early involvement of health workers and other stakeholders in designing an incentive scheme proved to be valuable. It ensured their effective participation in the process and overall acceptance of the scheme at the end	Further, since the perceptions of the FS and PE's are very negative a very purposeful communication exercise where all details are discussed in detail should be taken up to retain the experienced resource. A system and mechanism should be designed to retain top-performers, motivate the desired performance, and control the cost. In order to pay for performance, the performance must be defined in very specific, objective, quantifiable terms and followed by a strong mechanism to measure and track it. The current mechanism has a payment for a range of numbers, which may be avoided in order to make it effective.

Theme 2 – Diagnosis, Treatment and Care;

EXISTING STATUS	PERCEIVED GAPS/WEAKNESS/RISKS/CONCERNS	SUGGESTIONS /RECOMMENDATIONS	ACTIONS TO BE CONSIDERED FOR IMPLEMENTATION
Strategic direction 4, of NSP states "*Community, home and peer support is one of the important areas of support for people living with HIV whose medical needs are being met. While the STD/HIV public health programme can do outreach and follow up patients, home and community support by peers is important to reinforce long term compliance to care and treatment.*"			
The peer educator's role ends with escorting the peers to the STI clinics. There are 33 STD clinics mostly based in the Govt. Hospital settings. The Govt. hospitals are equipped with a Laboratory for basic tests including HIV and Syphilis, (RPR/VDRL). Hospitals associated with Medical Colleges are well equipped and well staffed. Many of the peripheral clinics are short staffed in terms of para medical staffs. The peripheral clinics have a Medical Officers, Public Health	Barriers to health seeking behaviour. The MSM clients informed of discriminatory attitude of the lower staff. They were called out "as all those who are involved in MSM activities come here…" this was for diagnosis Post diagnosis and tests the patient is asked to come the next day for reports which rarely is picked up by the peers. And many a times never return to the clinic. The concern is that PEs mobilizes 3-5 KAP members given the large number of hotspots they operate in. once the clinic load goes up the peers are asked to return the next day. And mostly the project witnesses drop outs.	Sensitization of local hospital staff by the NSACP/SR/SSR A collaborative system between the Clinic and the NGO may be established with a clause of shared confidentiality. Where the FS can collect the test reports and hand them over to the same peer who is registered with the project. Collaborative planning is suggested here for systematic mobilization Clinic timings to be designed according to the convenience of BB groups.	Hold Sensitization meetings for lower staff, para medical staff and doctors within the hospital premises. FS visits the hospital once a week to collect test reports and distribute to the KAP through a trained counsellor who ensures the counselling of the client before handing over the report. Joint mobilization plan is developed for the convenience of timely diagnoses and treatments (including immediate recruitment of health staff in the STI/STD clinics.

Nurse, Public Health Inspector. Not all clinics have filled in positions Counselling services are provided by the Medical Officer and counselling is done in the doctors consultation rooms	In terms of Beach Boys, they have to accompany their clients to late night parties, and sometimes have drugs together due to which they are unable to wake up early. Even as they wake up with hangovers are unable to visit the clinic during the day. The concern is with a high load of patients the doctor is unable to provide adequate time for counselling the KAP patients. With the doctors room teeming with PG students, PHN/PHI for various reasons, disturbing the counselling sessions that may not be effective. As counselling services are upon the doctors adding to the burden of diagnosis and treatment, counselling cannot be said are effective. Given the Clinic load and minimum staff at the peripheral clinics visited by the review team, as informed by the doctor, physical examination for STIs though is the protocol is minimal as the peers refuse many times and are unprepared for it.	Position of a profession counsellor may be made within the Govt. STD clinics Separate counselling room could be designed within the govt hospital providing for audio visual privacy Trained professional counsellor may be placed within the clinical setup Preparation of peers for physical examination as a part of treatment to be a part of the messaging dosage also	PR1 may look into the feasibility of having clinic timings in the evening, Ex PHN/PHI may be considered to provide counselling services/ Recruitment of counsellors to be decided upon by the PR1 PR1 may decide on provision of a separate room for counselling in consultation with MoH. Ex PHN /PHI may be considered for the position and recruited by the MoH PEs could lead by example. Necessary additions into messaging design may be made by PR2 to emphasize on physical examination at the clinic
HIV testing is done at all the Govt. Clinics and is a state mandate. The reports of KAPs are	Though peer led, PLHIV management includes general population in the programme. It	Establishment of DICs for PLHIV and Formation of Support Groups for PLHIV	Identification of at least one DIC per province for PLHIV management that operates as a

not shared with the PEs or any other form with the interventions under any circumstances and maintain high level of confidentiality of STIs and HIV infection.	also seems to be a separate project within the programme focusing on test and treat with the general population. Lack of safe space such a DIC in the program for the PLHIV impedes any kind of support group formation. Loss to follow up an issue	Use of technology for follow up of HIV services	safe space. This space could be utilized for information dissemination, referral point for accessing all HIV related services. One of the prominent steps towards community based care. The DIC could be budgeted and operated by SSRs. ART provision and care and support still remain the state's mandate. Mobile based apps could be considered that enable follow up services (like the monitor in India) as well as saves on cumbersome documentation for the PEs.

Theme 3 – Strategic Information;

EXISTING STATUS	PERCEIVED GAPS/WEAKNESS/RISKS/CONCERNS	SUGGESTIONS / RECOMMENDATIONS	ACTIONS TO BE CONSIDERED FOR IMPLEMENTATION
National Framework does not have any indicator that reflects the efforts related to peer education. Work Plans/Implementation plans and targets are very clearly available for GFATM programs	Linkage of efforts on prevention, care and support cannot be very clearly established to results	Integration of data at the national level to include PR 2 as also any other agency/organization implementing specific activities would be very useful. Data triangulation on prevention activities for better understanding of status of prevention in the country.	PR2 as a process of transfer of knowledge and technology to PR1 could consider assisting them in establishing central information management system in collaboration with the Strategic Management Department. Data analysis on a comprehensive set of service provision and uptake is essential at the PR1 level E.g testing for HIV

			No. of Peers escorted for testing (PR2) No. of Peers tested (PR1) No. of Peers Positive (PR1) No. Peers registered for ART (PR1) No. of Peers tested for CD4 count (PR1) No. of Peers on ART (PR1) No. of Peers followed –up for ART provision (PR1) This provides For a whole gamut of service uptake as well as status of progress PR1 and PR2 to arrive at a comprehensive list of indicators including dashboard indicators
PR2 has **elaborate Procedure Manual and a robust and efficient systems** of data capture and reporting. The aspect that could be highlighted is mechanism that enables removal of duplicate entries made at the SSR level. However this is done at the PR level Planning and prioritization only seemingly visible at all levels	However, the PEs during the FGDs have reported that documentation for them is cumbersome. It was also found that the reporting tool was not pictorially enabled which made it difficult for illiterate PEs to fill the format for documentation. It is time consuming and any wrong entries require corrections that leads to delays in reporting. As the reporting is linked to incentives eventually lead to delays in payments. Thorough Data Entry verification is done at all levels –SSR –SR – PR by the Project Officers making	Simplify reporting at the PE level Speedy and authenticated layered verification systems to be established	PR2 may relook into the PE Daily Dairy and make PE/KAP friendly with picture that would encourage and simplify filling information on activities implemented Systems of data entry verification may be established at the SSR level, and authenticated at the SR level and reported to PR staff. PR staff may do an online monitoring and onsite verification during field visits.

	the process time consuming and arduous. Though community knowledge exists, feeble planning restricts prioritization as a consequence most at risk within the KAPs are left from service provision	Micro planning at the PE level needs strengthening	PR2 to engage community based program management experts in training all cadres of SSR/SR/PR on micro planning systems
The FPASL implements the PE led targeted interventions for KAPs through CBOs and NGOs for FSWs in 10 districts, for MSM in 7 districts, in 8 districts for drug users, and in 7 districts for beach boys. The selection of the districts made by the NSACP is based on the high numbers of each key population as estimated by the Behaviour Surveillance Survey and Size Estimation carried out in the country. District wise targets for each KAP have been set, taking into account the estimated size of the concerned populations in each district.	Understanding is that behavioural Survey does not clearly establish differentiation in risk behaviours in different population categories. The MARPs identified e.g SW, MSM, BB, PWID, Prisoners & Plantation workers are the only identified high risk behaviour groups. However, a deeper study needs to be undertaken to look at other groups like those travelled abroad for work, cross border migrated populations etc. to take up more focused prevention and testing activities.	Already discussed in prevention	
Re-programming of DU/PWID interventions	**DRUG USERS:** The assessment of the need to reprogram will be further complemented by a study to better understand drug use patterns in the country and assess specific issues with risk reduction strategies and interventions for PWUD/PWID.	Re assessment of population overlap to be done among DU-BB-MSM populations. And within the DU assessment for populations with drug dependency and substance abuse may justify for an OST centre in a particular district	An intensive advocacy effort is to be made to mobilise the Government of Sri Lanka to accept and approve the OST approach in the country. Given that OST centres are cost intensive districts with high number of Intravenous Drug Use may be piloted. District with not less than 250-300 IDU

			population presence coupled with IDU-HIV prevalence may be prioritized. Or Given the Sri Lankan situation of low prevalence an OST centre for two districts may be explored. However, the costs of treatment would be more on the individual. Feasibility of OST for the state as well as at the individual level may be assessed.
		Similarly, HIV –TB co infection, HepC are areas to be assessed among the DU populations	PR1/PR2 may collaborate with WHO/other donor agencies to conduct the study in the intervention sites.
		Apart from the core service package, interventions may look at other needs such as nutrition, admission into detoxification centres, legal literacy, homelessness	Collaborations with other NGOs/organizations for other needs may be explored

Theme 4 – Supportive Environment;

Existing status	**PERCEIVED GAPS/WEAKNESS/RISKS/CONCERNS**	**SUGGESTIONS /RECOMMENDATIONS**	**ACTIONS TO BE CONSIDERED FOR IMPLEMENTATION**

The NSACP with a focus on the Law enforcement agencies has been able to conduct advocacy and sensitization meeting with them at various levels.	With sporadic efforts of advocacy at various levels there have been attempts to address stigma and discrimination against KAPs and PLHIV populations.	There is an urgent need of well planned and integrated multi-pronged right based inclusive effort towards creating an enabling environment for all KAPs.	Community consultations at district, provincial and national levels may be conducted to arrive at the framework. Advocacy experts in the field may be involved for the same. To create a larger level impact the NSACP is suggested to organise multi-sectoral coordination meetings at least bi-annually. The legal and ethical committees/working groups at the NSACP should meet more frequently to discuss and address relevant issues.
Completing the efforts towards an effective response to HIV epidemic in the country, FPASL was selected as a Sub-Recipient under the Multi – Country South Asia Global Fund HIV Programme – a regional programme addressing HIV epidemic among the men who have sex with men and transgender people in south Asia	The current efforts for advocacy and creating enabling environment are focused on a particular community group within the grant.	There is a need for an **Advocacy framework** that would provide for a pro-active agenda for creation of an enabling environment for the KAPs. This could be done by improving the interaction and coordination between various advocacy and capacity building programs and the peer led targeted intervention for the KAPs. The next level could lead to community mobilization and empowerment by organizing and collectivizing the communities	Structure Interventions such as formation of district level Advocacy groups crisis action teams which should comprised of members from various advocacy programmes and key stakeholders in the district, especially from the law enforcement departments and district hospital. Capacity building of such groups and teams to address community issues could be envisaged It is recommended that small steps for advocacy are essentially planned and embedded in the current intervention design, such as legal literacy, building

			communication skills and developing negotiation skills of vocal community members and leaders. However need to extend to all KAP interventions. This will help build their skills to deal with the situations on their own and in the process they will become empowered, which will also contribute to the sustenance of the program outcome. The facilitation of community interaction programs and involvement of key community leaders to talk about the situation and rights of the KAPs at the local levels will help build supportive environment for the KAPs. This could be planned and undertaken through further consultations with relevant stakeholders and communities with an objective to develop a community led structural interventions. The FPASL with a support from the NSACP is suggested to explore additional funding support to carry out such activities.

Theme 5 – Health Systems Strengthening and Supply Chain Management

EXISTING STATUS	PERCEIVED GAPS/WEAKNESS/RISKS/CONCERNS	SUGGESTIONS /RECOMMENDATIONS	ACTIONS TO BE CONSIDERED FOR IMPLEMENTATION
Condom distribution is the mandate of the NSACP and	The NSACP provides for 80% of condom demand to encourage	A Condom Gap analysis is recommended to arrive at the	Condom and lubes demand, supplied and gap therein is to be

except for one instance there has been continuous supply of condoms to the programme. **Condoms and lubes are supplied on a quarterly basis**.	social marketing and purchase of condoms by the KAPs.	correct demand of condoms Buffer stock of condoms to be maintained at the SSR/SR level	calculated and to be aggregated at the SR/PR level for each of the KAP groups as documented evidence for demand and supply and assist in strengthening the systems. Although there has always been adequate supply of condom to the clients, it would be in the interest of the program to maintain a buffer stock of condoms at each level of the management. Also there has to be an alert system in place which raises flag as soon as the stock goes below a certain limit.
In depth interviews across the system – health service providers, peer educators, intervention managers are in **agreement that there has been considerable increase in the service uptake.** There by indicating at an improved demand generation. The Peer Education system has **assisted the health system** to reach out the unreached KAP populations. According to the MoH directive the PHN/PHI are to visit hotspot identify KAP and mobilize them for sexual health services.	Follow up of STI cases, HIV positive KAP and collection of reports post testing due to confidentiality issues are areas that need tactical management. And given the professional competition between KAP members is a difficult aspect.	Under shared confidentiality within the project one of the SSR functionary is made responsible for the follow up and collection of post-test reports to be distributed to the concerned KAP through a trained counsellor who ensures appropriate counselling of the client.	The counsellor/Auxiliary nurse midwife who is a part of the intervention is given the responsibility. However, in Sri Lankan context, the Project Coordinator/Manager or one of the Field Supervisor should be trained in counselling of the clients and assigned the responsibility of handing over the report. This needs to be weighed well before it is implemented.

Drop in Centres

Reflecting the general acceptance to the concept of Drop in Centre and given the Sri Lankan context of low prevalence and size of KAP, the review team suggests two models of DIC. The designs are based purely on the primary focus of the intervention. The options are:

Option A: DIC – Attached to STD clinics Managed by MoH

Option B: DIC - Attached to SSR

Option A: DIC – Attached to STD clinics Managed by MoH - With the intervention design focused on enhancing the access to clinical service of the KAPs, the DICs could be attached to the STD clinics, with the management responsibility given to the clinical staff. A DIC for each of the population should be started separately, which of course would require additional staff at the STD clinics. However, it should be located within the reach of the respective KAP, preferably close to the major hotspot.

A stigma free and non-judgmental environment at the DIC needs to be created by appropriate branding and messaging package. The DIC should have basic hygienic and health facilities for the peers to utilize. DIC space could be used for group meetings, pocket meetings, information dissemination, and resting place. This place could be used for small community events and community mobilization activities. The hours of visiting at the DIC should be relaxed but well regulated and the premises must not be used for soliciting clients, or drug use, etc.

Such a DIC should essentially have two personnel at least, in addition to other visiting staff of the STD clinics - a professional counsellor and a DIC Administrator. Additionally, DIC could be provided with a para-medical staff that can be trained to carry out HIV testing when community based testing is rolled out.

In this case options of public private partnership can also be explored. eg. Global Fund could budget for one more PHN/PHI (only retired nurses were taken for IBBS survey short term) with the same qualification to operate as a counsellor or Para Medical staff at the DIC. This could be monitored and assessed by the MoH and NSACP. Based on the value addition by the staff at the DIC towards care and support services, the MoH may decide to absorb the staff post GF, which is a sustainable choice for the government organization.

Option B: DIC - Attached to SSR - The location, human resource, responsibilities remain the same for the SSR attached DIC as in the MoH attached DIC. However, the management of the DIC rests with the SSR and the PR2. The GFATM would need to make provisions for DIC in the PR-2 budget for the same.

The services provided under option 2 will be same as in option 1 mentioned above. Additionally, the SSR can use the DIC as an extension for outreach activities and use it as an information centre. The DIC has been seen as an effective means for community mobilization and collectivization activities such as group meetings, support groups meetings, advocacy meetings, structural interventions, etc.

The number of DIC may depend on the population size, preferably one per 1500 to 2000 peer community. Each SSR should be given at least one DIC per KAP in their operational areas.

The advantages of the option are that the management being that of SSR any changes needed can be made easily and with immediate effect. Staff recruitment and monitoring the quality of services are faster as well. Community mobilization activities could add to the organizing of communities thereby assisting enabling environment for the KAPs to participate in the programme activities in a stigma free atmosphere.