STANDARD OPERATIONAL PROCEDURES FOR HIV/STI CARE AND PREVENTION

National Programme Level

National STD/AIDS Control Programme
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Foreword

National STD/AIDS Control Programme (NSACP) of the Ministry of Health of Sri Lanka works with a broad vision of providing quality sexual health services including HIV and STI related services for a healthier nation. Sri Lanka has taken the challenge of achieving ending AIDS along with global partners. As the pioneer government institution responsible for the national response to HIV in Sri Lanka, National STD/AIDS Control Programme provides the leadership and decisions to guide to reach this goal. NSACP has taken important steps towards achieving national and international goals. The country has achieved WHO certification for the Elimination of Mother to Child Transmission (EMTCT) of HIV and syphilis. National STD/ AIDS Control Programme further scaled up the roll out of its electronic medical record system named Electronic Information Management System (EIMS) during 2020. In addition, a new software named Prevention Information Management System (PIMS) is being developed to monitor the HIV prevention programme which is done in collaboration with the non-governmental stakeholders.

The Operational guidelines for HIV/STI care, prevention, and support of National STD/AIDS Control Programme, is a reliable source of reference to both programmatic and clinical services providers at the Programme level and its island wide network of STD clinics and other stakeholders. All the relevant details of these novel implementations that is necessary for each category of service providers, when functioning at the NSACP is consolidated into this publication.

Publication of this operational guideline would not have been possible without the continuous support from the national coordinators, consultants of the district STD clinics and the staff in NSACP. I would like to take this opportunity to thank all the contributors of this document. Their dedicated work and the staff of all reporting units of the NSACP are highly appreciated. The information available in this document would be valuable to strengthen the national response to HIV/STI in Sri Lanka.

Dr. R. Hettiarachchi
Director,
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Abbreviations and Acronyms

ADIC	Alcohol and drug information centre
ADR	Adverse drug reactions
ANC	Ante natal clinic
ART	Anti-retroviral treatment
ARV	Anti-retrovirals
BB	Beach boys
BCC	Behaviour change communication
BMS	Bio-medical services
CBO	Community-based organizations
CBT	Community based testing
CME	Continued medical education
DDGPHS	Deputy director general, public health services
DGHS	Director general of health services
ECS	Elimination of congenital syphilis
EIMS	Electronic information management system
ELISA	Enzyme linked immunosorbent assay
ELS	E-learning system
EMTCT	Elimination of mother to child transmission
FEFO	First expiry first out
FHB	Family health bureau
FPA	Family planning association, Sri Lanka
FSW	Female sex workers
GC	Gonorrhoea
GFATM	Global fund to fight AIDS/TB and Malaria
GoSL	Government of Sri Lanka
GP	General practitioners
GVAC	Global validation committee
HCW	Health care workers
HE	Health education

Abbreviations and Acronyms

HIV	Human immunodeficiency virus
HIV ST	HIV self-testing
HPB	Health promotion bureau
HSS	HIV sentinel surveillance
HTS	HIV testing services
IBBS	Integrated bio- behavioural survey
IEC	Information, education and communication
KP	Key populations
M&E	Monitoring and evaluation
MD	Doctor of medicine
MLT	Medical laboratory technologists
MoH	Ministry of Health
MOH	Medical officer of Health
MOIC	Medical officer in charge
MSC	Master of science
MSD	Medical supplies division
MSM	Men who have sex with men
NAC	National AIDS committee
NCS	National communication strategy
NGO	Non-governmental organizations
NMRA	National Medicines Regulatory Authority
nPEP	Post exposure prophylaxis after sexual exposure
NPTCCD	National Programme for Tuberculosis control & Chest Diseases
NRL	National reference laboratory
NSACP	National STD/AIDS control programme
NSP	National strategic plan
NVC	National validation committee
OI	Opportunistic infections
oPEP	Post exposure prophylaxis after occupational exposure
PEP	Post exposure prophylaxis
PEPSE	Post exposure prophylaxis after sexual exposure
PDHS	Provincial director of health services

Abbreviations and Acronyms

PHI	Public health inspector
PHLT	Public health laboratory technicians
PHM	Public health midwives
PIMS	Prevention Information Management System
PLHIV	People living with HIV infection
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
QSP	Quality standard procedures
RDHS	Regional director of health services
RDT	Rapid diagnostic test
RPC	Regional procurement committee
RVC	Regional validation committee
SIM	Strategic information management
SMT	Senior management team
SOP	Standardized operational procedures
SPC	State pharmaceuticals corporation
STD	Sexually transmitted disease
STI	Sexually transmitted infections
TEC	Technical evaluation committee
TG	Transgender
UIC	Unique identification code
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United nations population fund
WHO	World Health Organisation

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1 INTRODUCTION

1.1 Epidemiology of HIV/STI in Sri Lanka

Sri Lanka is a country with low-level HIV epidemic. According to the available statistics the main drivers of the epidemic are Men who have Sex with Men (MSM). In order to plan and implement the national programme effectively, it is paramount that all health care workers and other relevant stakeholders should have a basic knowledge about current Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STI) epidemic pattern. Annual report is available in the NSACP official web site for your reference.

1.2 Background of HIV/STI Services

Sexually transmitted disease (STD) services are well established in Sri Lanka with the history running back to a few decades. The National STD/AIDS Control Programme (NSACP) is the main government organization which coordinates the national response to sexually transmitted infections including HIV/AIDS in Sri Lanka with the mission of preventing new HIV infections and sexually transmitted infections and providing comprehensive care and treatment services.

The STD clinic operational guideline was initially prepared in 2012, to improve the quality of services provided by the STD clinics. Updating the standard operating procedure (SOP) fulfils a long felt need in the field.

The purpose of this SOP is to ensure the consistency of the service delivery in HIV/STI prevention, treatment and care and assure the standard of care provided in above services. This SOP is also intended to provide assistance in designing, implementation, and evaluation of services provided through programme areas of the NSACP. The standards mentioned in this SOP is in consistency with the National strategic plan and other national guidelines of the relevant programmed areas

1.3 Target audience

The main target audience for this SOP handbook are health care providers who are directly involved in providing HIV and STI prevention, treatment and care services. Health administrators in the central, provincial and regional directorates of health, programme managers attached to HIV/STI programmes, funding agencies and non-governmental organizations (NGOs)/community-based organizations (CBOs) and any other interested parties who are involved in HIV/STI care in the country would also benefit from this handbook in resource allocation and mobilization.

2 ADMINISTRATION AND PROGRAMME MANAGEMENT

2.1 Strategic planning

In health, strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way.

As the national focal point for coordinating HIV/STD services in the country, it is the responsibility of the NSACP to develop, conduct monitoring and evaluation (M&E) and re-develop/ edit the plan according to the recommendations of the M&E reports. STD clinics are expected to support the strategic planning cycle which is described in Figure 2.1.

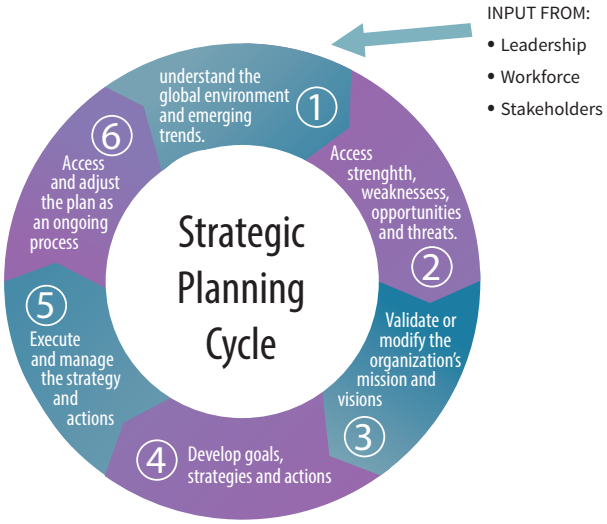


Figure 2.1: Strategic planning is a cycle.

2.1.1 Developing a strategic plan

Following steps need to be adopted during the development of the strategic plan:

. Decide the term or duration for the plan – National Strategic Plan (NSP) for the response to HIV/STI in Sri Lanka is developed for 5 years.

. Appoint a 'Steering Committee"

The steering committee should be consisting of

- o Representatives of health administrators at the national level
  - Director General of Health Service
  - Deputy Director General - Public Health Services I
- o Director - NSACP
- o Focal points of each programmatic areas at NSACP

- HIV treatment and care services
- STI treatment and care services
- Prevention of mother to child transmission services
- Laboratory services
- Strategic information management
- Epidemiology
- Multisectoral unit
- Key population interventions
- HIV testing services
- IEC, advocacy and condom promotion
- Training, capacity building, research and development

o Representatives from district STI clinics

o Representatives from the Sri Lanka College of Sexual Health and HIV Medicine

o Representatives from NGO/CBOs

o Representatives from people living with HIV (PLHIV)

o Representatives from key populations

. The steering committee need to,

o Appoint a team to develop the strategic plan.

This team should consist of local and international experts in the field. Technical guidance of World Health Organization (WHO), Ministry of Health and other agencies could be obtained in selecting the team members.

o Appoint supportive groups to assist the team developing the strategic plan

o Assist in situation analysis by providing the team with the background information, documents for the desk review, and arranging country dialogue with various stake holders.

o Provide inputs to identify the goals, objectives and thematic areas to the team.

o Arrange field visits and other meetings suggested by the strategic planning team under the main thematic areas identified.

o Arrange a forum for the draft strategic planning to be discussed with the stake holder groups before finalizing.

o Dissemination of the final strategic plan among all stake holder groups for implementation.

2.1.2 Monitoring and evaluation of strategic plan

- Once developed and implemented, monitoring and evaluation of the strategic plan has to be done at various points aligning with the indictor framework given in the national M & E plan, to assess how the programme has performed during a given period of time by the managers and other stakeholders.

Annual reviews

- Annual reviews need to be conducted by the main partners of the programme aiming to assess the progress in implementation and address the challenges that arise.
- These are carried out by national, provincial and district officials who are directly involved in the programme.
- The results of annual reviews should be used to improve on-going implementation, including modifying existing plans or developing new implementation plans.

Mid-term reviews

- Mid-term reviews need to be conducted around the mid-point of the programme cycle which is the beginning of the third year in current situation.
- Usually need to be conducted by a team consisting of local and international experts.
- A steering committee must be formed as described in section 2.1.1.
- This steering committee is responsible for,
    - Appointing a team to review the strategic plan.

      This team should be a combination of local and international experts in the field. (Technical guidance of World Health Organization (WHO), Ministry of Health Sri Lanka and other agencies could be obtained in selecting the team members).
    - Appointing supportive groups such as working groups for each thematic area to assist the review team
    - Assisting in situation analysis by providing the team with the background information, documents for the desk review,
    - Providing inputs to finalize the review framework provided by the review team
    - Arranging field visits and other meetings suggested by the review team under the main thematic areas.
    - Arranging a forum for the draft review report and recommendations to be discussed with the stake holder groups before finalizing
    - Disseminating the final review report among all stake holder groups for implementation of recommendations
- Recommendations from the mid-term reviews should be used to make adjustments to the strategic plan (reprogramming)

End-term reviews

- Should be conducted around the end of the programme cycle which is in the fifth year in current situation
- Usually need to be conducted by a team consisting of local and international experts.
- The review process is similar to the process described in midterm review.
- An end-term review will examine the impact of the NSP and identifies the areas need improvement in the programme and provides the recommendations to update the next NSP.

Specific reviews

These are the assessments of specific components of the national programme.

- These are not done regularly and planned at specific instances.
- They include
    - Thematic and project reviews such as
        - Antiretroviral therapy reviews,
        - Reviews on services to eliminate the mother-to-child transmission of HIV
        - Specific key population reviews
    - Project reviews such as
        - Initiatives with specific sources of funding like Global Fund to Fight AIDS/TB and Malaria (GFATM) and World bank

2.2 Organization structure

2.2.1 National/Central level organization structure

As a specialized public health programme under the Ministry of Health, the NSACP is the focal point for the prevention and control of STI, including HIV. The National Programme provides both preventive and curative services together with a network of 41 district STD clinics distributed island wide.

The NSACP operates directly under Deputy Director General Public Health Services 1 of the Ministry of Health.

Figure 2.2: Central level organization structure

2.2.2 District level organization structure

With the devolution of administrative powers under the 13th amendment of the constitution of Sri Lanka, the provincial health services including HIV/STI services became under the purview of the Provincial Director of Health Services (PDHS). The majority of district STD clinics are under the provincial administration with few exceptions which are under the administration of line ministry. District level HIV/STIs action plans are prepared through a dialogue between the central level planners and provincial stakeholders taking into consideration the risks and vulnerabilities and are implemented under the supervision of the PDHS and Regional Directors of Health Services (RDHS). The peripheral STD clinics which are manned by a Consultant Venereologist/ trained medical officer together with its public health team carry out preventive and curative services with technical guidance from the NSACP. The primary health care personnel and civil society organizations work in partnership with the STD team.

All district STD clinics are working closely with the National STD/AIDS Control programme to achieve the goals of the National strategic plan to end AIDS by 2025. Most of the STD clinics are based in the main hospital of the district except few clinics which are established separately or close to the RDHS office. Some districts have more than one STD clinic depending on the service need.

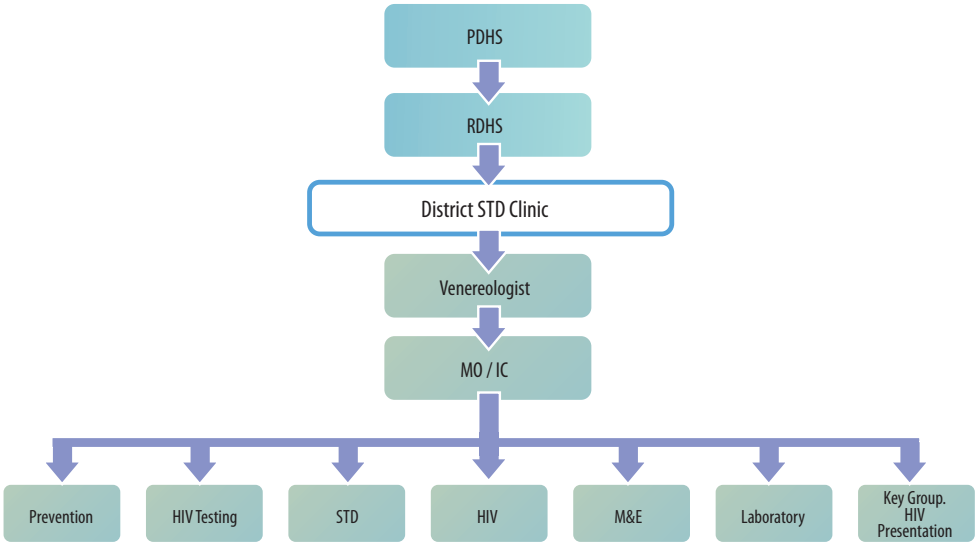


Figure 2.3:District level organization structure

2.3 Programme areas

The main activities of the NSACP are coordinated under 12 programme areas. Each area is under a consultant in the relevant field who is responsible for planning, coordinating and implementing activities related to the respective programme area. These units should be headed by the consultant who is the focal point for the respective programme area and should consist of, at least one medical officer, one public health officer, one management assistant, one health care assistant and other relevant officers.

All the coordinators chaired by the director, conduct monthly senior management team meetings in which the activity plans are discussed and reviewed, and major decisions related to the programme areas are taken. Description of each programme area is available under the respective chapter.

The programme areas are as follows:

1. STD treatment, care and support
2. HIV treatment, care and support
3. Prevention of mother to child transmission (PMTCT) services
4. Key population and prevention
5. Multisectoral collaboration and prevention
6. HIV testing services
7. Epidemiology
8. Laboratory services for STI care
9. Sexual health promotion
10. Education, training and capacity building
11. Strategic information management (SIM)
12. Global fund project

2.4 Minimum Standards for HIV/STI services

2.4.1 Quality of STI/HIV Service Delivery

- The services for HIV/STI have been established based on acceptability and the accessibility to the clients coming to the clinics.
- A client friendly services are catered in a suitable environment with appropriately trained staff with adequate facilities to provide the services to promote sexual health.
- The clinics are established in convenient locations.
- Opening hours are 8 am to 4 pm on Monday to Friday and 8am to 12 noon on Saturday. The services are provided through open access, self-referral, walk in clinics.
- All the services are provided free of charge to the citizens and resident visa holders.Further, resident visa holders who holds a valid Health protection plan (circular 01-37/2019) are to be given assessment, treatment and management and follow up with regard to HIV infection free of charge. Health protection plan will not cover the hospitalization other than emergency care in the government sector. For the non- permanent residents of the country, the circular 01-41/2017 is to be referred when providing inward care.

- Any form of stigma or discrimination based on gender, sexual orientation, HIV status, religion ethnicity or any other factors should be strictly avoided within the service system by appropriate training of all categories of staff. Confidentiality of information including verbal, written and electronic information should be strictly maintained within the system and the necessary facilities should be available to maintain confidentiality. Respectful treatment and non-judgemental attitudes of health care staff would make the client more comfortable.

- Anonymity and privacy of the person has to be respected at all times. Minimal necessary information is obtained from the client. All the clients attending to STI services are given a PHN number and a unique identification code (UIC). The clients are called by the number to ensure confidentiality. The electronic records are password protected to minimize unnecessary handling by the unauthorized persons. In all aspects, the basic human rights of each patient must be respected and given the utmost importance.

- A strong support and supervision system for all the staff categories need to be in place. Periodic training and regular supervision of STI service providers are being carried out by the consultants, senior registrars, medical officer in-charge (MOIC), nurse in charge and the public health staff.

2.4.2 Clinic operations

- Once a client enters the STI clinic, s/he is directed to the following stations in a sequence.

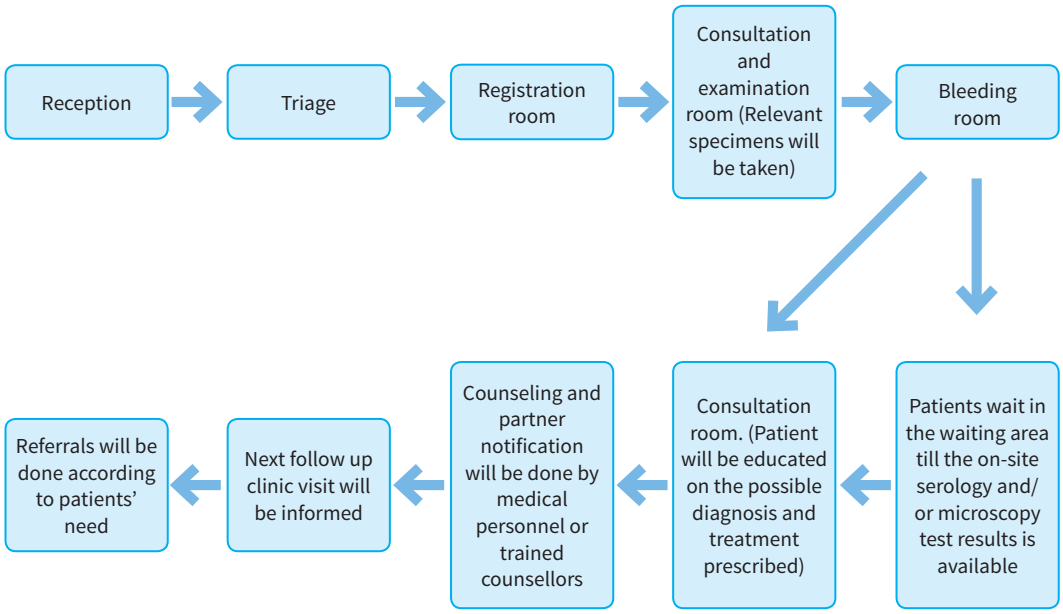


Figure 2.4: Clinic flow chart for HIV/STI care

2.5 Partnerships and collaborations

The NSACP spearhead the national response to HIV and STI, with all other stakeholders of the health and non-health state sector, private sector, non-governmental organizations, business community and people living with HIV through its multi-sectoral, decentralized approach. To achieve the goal of NSP, the NSACP continue to direct the national response through planning, monitoring and coordination of all stakeholders such as health sector organizations e.g.; Family Health Bureau (FHB), Health promotion Bureau (HPB), National Blood Transfusion Services (NBTS), National Programme for Tuberculosis Control & Chest Diseases (NPTCCD) and other government non-health, ministries such as Ministry of Labour, Education, Mass media, Youth and Sport, Department of Prisons, Sri Lanka Institute of Tourism and Hotel Management, Child protection authority National youth council, Sri Lanka Bureau of Foreign Employment and the Tri-Forces.

Family planning association (FPA) being the principal recipient-2 (PR2) of the global fund project is the main NGO which is in partnership with NSACP specially for the implementation of the Key population (KP) interventions. Other NGOs collaborating with NSACP are Community strength development foundation, Mithurumithuro, Saviya development foundation and Alcohol and drug information centre (ADIC). Several other CBOs are working locally in collaboration with district STD clinics.

In addition to these organizations, the people living with HIV(PLHIV) are working together with NSACP to provide supportive service for HIV infected and affected people.

3 STI CARE SERVICES

Comprehensive care for sexually transmitted infections is provided via a network of STD clinics across the country. At the moment there are 41 STD clinics and 27 branch clinics functioning island wide to provide the services.

3.1 National strategy for STI care

The strategy for STI care and prevention is planned under Strategic direction 1 and 2 of the NSP, Sri Lanka 2018-2022. In which the priority actions that need to be undertaken are as follows.

- Expand STD services to base hospital type A level
- Strengthen STI surveillance
- Strengthen antimicrobial sensitivity tests for cefixime for *Neisseria gonorrhoea*
- Monitor waste management procedures in the laboratory and STD clinics and ensure that the guidelines are followed strictly
- Upgrade all laboratories to the required standard needed for quality services for HIV and STIs

3.2 STI treatment and care unit

3.2.1 Roles and responsibilities of STI treatment and care unit at NSACP

The overall responsibility of this unit is to provide quality assured care for people infected or affected by sexually transmitted infections across the country.

- To support the treatment and care subcommittee of the National AIDS Committee to develop and regularly up-date national policies, strategies, guidelines, protocols and SOP for implementation of STI care services in Sri Lanka.
- To collaborate with senior management team (SMT) and other relevant authorities in decision making and carrying out of STI care services.
- To work with other NSACP units to develop comprehensive and coordinated plans for implementation of the National Strategic Plan and other relevant activities.
- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.
- Regularly updates of above documents in parallel to WHO guidelines and other relevant accepted international guidelines by teams of relevant experts in the field.
- Provision of technical assistance for supply and procurement of necessary items or services for STI care services.
- To maintain the provision of STI care services through STD clinics of the NSACP in quality assured manner.
- To coordinate with and support institutions within and outside the Ministry of Health in the expansion of appropriate, high quality STI care services.

- Training and capacity building of individuals/institutions in the public, private and civil society organizations on STI care services, in partnership with relevant programme areas in the NSACP.

- To supervise and monitor the quality of STI care services in the programme.

- Provision of technical support, assistance and guidance to provincial/district health authorities and other organizations and agencies to assure high quality, up-to-date services in a uniform manner.

- Development of strategies, guidelines SOPs and other relevant documents related to provision of STI care services

- Regularly updating above documents in parallel to WHO guidelines and other relevant accepted international guidelines by teams of relevant experts in the field.

- Provision of technical assistance for supply and procurement of necessary items or services for STI care services.

3.2.2 The roles and responsibilities of STD clinics

STD clinics are responsible for the provision of both preventive and curative services under the guidance of NSP.

1. Managing STI patients

Each STD clinic should follow latest STI management guideline published by the NSACP, to manage people with symptomatic STIs and for their sexual partners.

I. Provision of services to patients seeking STI care.

II. Early diagnosis of sexually transmitted infections and treatment.
By screening an asymptomatic individual
By appropriate and early testing of symptomatic patients.

III. Ensuring access to sexual health information, commodities (such as condoms and lubricants) and services (such as testing, treatment and care, vaccination and contraceptive services) to patients attending to STD clinics.

IV. Provide behavioural change interventions to STD clinic attendees for prevention of STI and HIV according to national guideline appropriate for each individual

Special attention is required to detect and manage pregnant women, key populations and vulnerable populations including youth with enhanced intervention for reaching sexual partners.

2. Reaching sex partners and offering them treatment.

Partner notification is integral to effective STI prevention and care.

- Inform the sex partners and offer them counselling, testing and treatment

- Use most appropriate method of partner notification; patient referral, provider referral, contractual patient-provider referral, and expedited partner therapy.

3. Health Education (HE) and Counselling services

- Provision of accurate and up-to-date information so that a person can be knowledgeable about the subject and could make informed choices.
- Explain the importance of health education and counselling in STI prevention and management to facilitate the clients to change harmful behaviour.
- All the symptomatic and asymptomatic patient should be provided with HE and counselling session with the medical officer/public health staff.
- Use available HE materials including relevant flipbook to provide information to the clients.

4.Condom promotion

- Explain about condoms/lubricants to the client E.g.: how they function and how effective they are.
- Demonstrate how a condom is used, including how it is accessed from its package and how it is disposed of.
- Inform clients on how to get condoms free of charge or purchase from pharmacy and supermarkets.
- Provide condoms to clients before they leave the clinic, especially those who appear to be shy or insecure about the whole situation.
- Provide materials such as brochures and booklets that will give clients additional information.
- Advice on water base lubricant use wherever relevant and provide.
- Help clients to overcome resistance to condom use, including negotiating with their sexual partners.

5. Eliminating mother-to-child transmission of syphilis and HIV.

All the STD clinics should facilitate and contribute to the elimination of mother-to-child transmission of HIV and syphilis by providing the necessary care and management for antenatal mothers by providing the services package (Refer chapter 7 for further details).

6. Cervical cancer screening service

PAP smear facilities should be provided to STD clinic attendees and HIV positive females according to relevant guidelines at the STD clinic setup to screen for cervical cancers.

- Follow the local protocol when managing patients with positive smears.
- Maintain the electronic patient records & registers, and report to the SIM unit/NSACP on due date.

7. Contraceptive services

Contraceptive facilities should be available for STD clinic attendees. Oral contraceptive pills (OCP) including emergency contraception and depot medroxyprogesterone acetate (DMPA) should be made available in all STD clinics while other methods can be provided depending on the capacity of the medical officers.

- All the relevant officers should follow the training conducted by FHB.
- Maintain the electronic patient records & registers, and report to the SIM unit/NSACP on due date.

8. Post exposure prophylaxis services

- Post exposure prophylaxis after occupational exposure (oPEP) to HIV
  - All STD clinics should provide PEP facility for the health care workers (HCW).
  - Latest PEP circular issued by the ministry of health should be followed in the management Starter pack should be made available in a place which is functioning 24 hours in the health care setting.
  - Registration of the clients and patient records need to be done in electronic format or registers/records.
  - Data related to oPEP should be sent to the SIM unit/NSACP quarterly.
- Post exposure prophylaxis after sexual exposure (PEPSE)
  - All STD clinics should provide this facility for the eligible STD clinic attendees.
  - Latest protocol/ guideline developed by the NSACP should be followed to manage the cases.
  - Registration of the clients and patient records are to be kept in electronic format or registers/records.
  - Data related to PEPSE should be sent to the SIM unit/NSACP quarterly.

9. Pre-Exposure Prophylaxis services

- Pre-Exposure Prophylaxis (PrEP) for HIV sero-discordant couples should be made available in all the STD clinics.
- When providing PrEP for KPs, the latest protocol developed by the NSACP should always be followed.
- Registration of the clients and patient records need to be done in electronic format or registers/records
- Data related to PrEP services should be sent to the SIM unit/NSACP quarterly.

10. Hepatitis B vaccination

- Hepatitis B vaccination should be offered to all the KPs attending the STD clinic
- Refer the local protocol when providing Hepatitis B vaccine.
- Registration of the clients and patient records are to be kept in electronic format or registers/records.

11. Provision of services for patients seeking sexual health related issues

- Sexual health services for male and female sexual dysfunctions should be provided according to the National guidelines.

12.Outreach programmes and the awareness programme for general public, vulnerable populations and key populations (Awareness, testing, counselling referral)

Outreach awareness and testing programs should be conducted by STD clinic staff by themselves or in collaboration of local NGOs prioritizing the high-risk populations and areas in the districts.

3.2.3 Minimum standards for STI services

Access

People who seek STI services, whether they have symptoms or not, should have rapid and open access to the available STD clinic services and confidentiality should be guaranteed. The clinic should be opened to all during working hours. Those with clinically urgent needs should be prioritized and provided the specialized services with the opinion of the consultant in the clinic.

Clinical assessment

Clinical assessment should be done according to the recommendations provided by the latest STD guideline

Diagnostics

Clients should have appropriate STI diagnostic test for each infection which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion to ensure that results are conveyed quickly and acted on appropriately.

Clinical management

Clients attend for STI testing should have access to their results within eight working days. Those diagnosed with an infection should receive treatment as early as possible and be managed according to current STD guidelines, including the provision of partner notification (PN).

Information governance

Services managing STIs must ensure information collected about service users remains secure and is only shared for legitimate reasons: in the service user's or public's best interest or, suitably anonymized, for mandatory reporting purposes.

Clinical governance

People should receive their STI care from high quality services that are safe, well-managed and accountable regardless of how and where the service is accessed.

Appropriately trained staff

Clients attending for STI services should have their care managed by an appropriately skilled healthcare professional.

Links to other services

People who need to be referred to other services should be referred early and there should be proper records and follow up plan to assure link to other services.

Patient and public engagement

People who use STI services, the public, staff and external partners should all be made aware about the delivery of services both face-to-face and online. Those using services should be encouraged to give feedback about them.

4 HIV TREATMENT, CARE AND SUPPORT SERVICES

HIV care services were established in Sri Lanka since the identification of the first person with HIV infection in the country in 1986. The services were gradually developed over time and the first guidelines for management of HIV infection was developed in 1998 and it was updated time to time since then. Free ART services for all eligible people living with HIV were commenced in 2004.

4.1 National strategy for HIV treatment and care services

The strategy adopted by Sri Lanka is to scale up HIV services to provide comprehensive care services including anti-retroviral (ARV) therapy to HIV positive persons who present to health facilities. The provision of comprehensive care requires a team based interdisciplinary approach.

The success of the comprehensive care services for HIV depends on the implementation of a seven-points policy package:

- Government commitment to ARV delivery.
- Detection of eligible patients.
- Training.
- Prevention of infections.
- Standardized combination ARV therapy.
- Regular, secure and uninterrupted supply of ARV drugs to treatment sites.
- Monitoring system for supervision of ARV therapy, effective patient tracing and follow-up and regular evaluation.

According to the National Strategic Plan 2018 – 2022, the priority actions that need to be undertaken to provide comprehensive HIV services include:

- Expanding anti-retroviral treatment (ART) services to all districts
- Upgrading the National Institute of Infectious Diseases to a Centre of Excellence in HIV care
- Following up the treatment cascade closely for better understanding and reduce loss to follow up
- Developing and installing an electronic information management system that can give instant updates on the status of HIV treatment cascade at the ART centres as well as at the provincial level
- Operationalising new equipment such as GeneXpert and CD4 machines for CD4 count measurements provided in districts and expand to other provinces as needed
- Strengthening capacity to perform pro-viral DNA estimations and HIV drug resistance in Sri Lanka to ensure sustainability.

4.1.1 Subcommittee for HIV care and treatment of National AIDS Committee (NAC)

Subcommittee for HIV care services of the NAC meet every quarter. The members of subcommittee include medical administrators, consultants, PLHIV, representative of the international funding agencies, and other relevant stakeholders. Major decisions related to HIV care, ARV therapy, supportive services and any issues of PLHIV are being taken considering the consensus from all the committee members.

4.2 HIV Treatment, Care and Support unit

The overall responsibility of this programme area is to provide treatment, care and support for people living with and affected by HIV/AIDS.

4.2.1 Duties and responsibilities of HIV treatment, care and support unit

1. To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, protocols and SOP for implementation of treatment, care and support services for people living with and affected by HIV/AIDS in Sri Lanka.

2. To collaborate with SMT and other relevant authorities in decision making and carrying out of HIV treatment, care and support services for people living with and affected by HIV/AIDS.

3. To work with other NSACP units to develop comprehensive and coordinated plans for implementation of the National Strategic Plan and other relevant activities.

4. To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.

5. To maintain the provision of HIV treatment, care and support services for people living with and affected by HIV/AIDS through the service delivery points of the NSACP or other relevant government health facilities in quality assured manner.

6. To coordinate with and support institutions within and outside the Ministry of Health in the expansion of appropriate, high quality HIV treatment, care and support services for people living with and affected by HIV/AIDS in Sri Lanka.

7. Training and capacity building of individuals/institutions in the public, private and civil society organizations on HIV treatment, care and support services for people living with and affected by HIV/AIDS.

8. To supervise and monitor the quality of HIV treatment, care and support services for people living with and affected by HIV/AIDS .

9. Provision of technical support, assistance and guidance to provinces, districts and other organizations and agencies in improving quality, supply and access to HIV treatment, care and support services for people living with and affected by HIV/AIDS.

10. Provision of technical assistance for supply and procurement of necessary items or services for HIV treatment, care and support services for people living with and affected by HIV/AIDS.

4.3 HIV care and support services

All STD clinics in the country are manned by trained medical officers. Medical officers attached to STD clinics are trained in counselling and testing for HIV and basic HIV care services. Further, they are expected to link with the Venereologist of the closest STD clinic, in case a Venereologist is not available in the STD clinic and manage patients accordingly. Initiation of ART is done by the Venereologist and medical officers can provide follow up care in consultation with the Venereologist at the district STD clinics.

Infectious Disease Hospital (IDH) is the only non-STD setting which provides ART services in addition to management of PLHIV with opportunistic infections.

4.3.1 Counselling services and psychological support

Human immunodeficiency virus infection affects the social, psychological and ethical aspects of individual more than the physical component. Medical officers who manage PLHIV are expected to provide counselling starting from pre-test counselling up to bereavement counselling.

PLHIV, who need psychiatrist services, are referred to the closest psychiatry specialist unit. At NSACP, psychiatry services are provided to clients at the HIV clinic, by a visiting psychiatrist.

4.3.2 Provide appropriate antiretroviral treatment to all the patients diagnosed with HIV infection.

National STD/AIDS control programme of the Ministry of Health (MoH) is the sole provider of ART in Sri Lanka. The Ministry of Health initiated the process to procure ARV drugs from 2016 through government funds and it was funded by GFATM before that. This can be considered as a major step in improving HIV care services in Sri Lanka. In addition, an allocation of LKR 500,000 per year has been approved by Ministry of Health for the local purchase of essential drugs for opportunistic infections or emergency ART requirements.

Refer to chapter 13 for further details on ART estimation and procurement process.

The objectives and targets of antiretroviral drug delivery are:

- To initiate ART for all diagnosed PLHIV irrespective of the CD4 counts or WHO clinical stage.
- To provide long term comprehensive care services to PLHIV with >90% of PLHIV on ART treatment and >90% of those on ART achieving viral suppression.
- To scale up services for ART and laboratory support to the district STD clinics
- To monitor and evaluate the HIV care programme through improved strategic information management system

The strategy is to scale up HIV care services to provide comprehensive care services including ARV therapy to HIV positive persons who present to health facilities. The provision of comprehensive care requires a team based interdisciplinary approach.committee.

4.3.3 Management of opportunistic infections (OIs)

Late diagnosis is still a concern. These patients present with severe opportunistic infections and the prognosis is poor. According to the country policy, patients with HIV who need inward services are managed in general wards. In special situations PLHIV are admitted to Infectious Diseases Hospital which provides services for OI under care of a consultant physician. Drugs for OI are provided through relevant services.

PLHIV with OIs are provided inward care services at the National Hospital as well as provincial hospitals by the respective consultants supported by the Venereologists. The latest guideline on the management of OIs has to be referred to facilitate the uniformity of care.

According to the circular issued in 1998 (General circular number 02/125/98) all PLHIV who need inward care facilities should be managed appropriately in the general wards without stigma and discrimination.

4.3.4 Management of non-communicable diseases (NCD) among PLHIV

Diagnosis and documentation of NCDs is carried out among PLHIV and appropriate linkages for care need to be provided within the existing health system. Patients are regularly screened for NCD and if necessary, referred to closest hospital physician for management.

4.3.5 Contact tracing and partner notification

A detail list of contacts including partners and children are taken after discussion with each index patient and contact tracing is done with the consent of the index case. Disclosure to partners is a concern and sometimes could delay the process of contact tracing. Partners are traced through either provider referral or patient referral with the consent of the patient. Contact tracing helps to identify the status of infected partners and children, and they could either be linked to treatment and care or appropriate preventive services depending on their HIV status.

4.3.6 Defaulter tracing

One major problem in the HIV care programme is few PLHIV who take adhoc treatment leading to development of drug resistance. To improve this situation defaulter tracing protocol has been developed. PLHIV who do not attend for services after 7 days of the scheduled appointments are considered as defaulters and they would be contacted through phone or letter by the PHI/PHNS or any other designated offices. Still If they do not attend, public health team make home visits.

Thus, dedicated public health staff is essential for all STD clinics which provide HIV care services to carry out contact tracing and defaulter tracing.

4.4 Other activity areas and partnerships

4.4.1 Tuberculosis /HIV collaborative activities

National STD/AIDS control programme works closely with the NPTCCD of Sri Lanka. All newly diagnosed PLHIV are referred to NPTCCD for screening to exclude tuberculosis using identified referral formats. PLHIV attending for services are regularly screened for symptoms of tuberculosis and if present are referred to NPTCCD.

According to the national Tuberculosis-HIV guidelines all patients diagnosed with tuberculosis are to be screened for HIV. NSACP and the NPTCCD cooperate in developing guidelines, training modules and reporting and recording formats. NPTCCD is part of the NAC and HIV care and treatment sub-committee.

4.4.2 PLHIV networks

Three PLHIV organizations are currently working with NSACP and provide necessary support for HIV care and treatment. These organizations provide following services to PLHIV with the financial support of the Global fund or any other funding agents.

- Work as a peer support group which provide counselling, psychological services
- Provide shelter for those who need long term or short-term shelter
- Financial support services: Travel allowance, financial support for investigations when necessary

All clients are offered the services of these organizations and they could be referred to these organizations if they are willing.

NSACP provide the necessary training for capacity building of these organizations regularly and provide technical guidance.

The contact details of these organizations are as follows.

Name	Address	Email	Contact No
Positive hopes Alliance	479/2 medawatta , road, weyangoda	Su.pha2009@yahoo.com	0713 586712
Lanka plus	55 Abhayarama lane, Naragenpita, Colomo 5	lankaplus2001@yahoo.com	0112 369069 0114 901692
Positive Women Network Sri lanka	864/6 Thalagaha junction, Gothatuwa new town, IDH	pwnprincy@gmail.com	0114 546244

4.4.3 Stigma and discrimination

All staff who provide HIV treatment and care services are given appropriate training to minimize stigma and discrimination and this area is included as an essential part in preservice and inservice training to assure all services are delivered without stigma and discrimination.

The opportunities to integrate HIV knowledge, attitude and skills within undergraduate and postgraduate education, pre-service and in-service trainings at the various levels have been identified. Refresher trainings using newer adult learning methods have been developed for selected personnel from all health facilities from the level of the base hospital and above. However, sustaining training has been difficult due to high staff turnover in the general health services.

5 LABORATORY SERVICES AT CENTRAL LEVEL

5.1 Introduction

The laboratory of NSACP, located in Colombo at NSACP headquarters is the National Reference Laboratory (NRL) for STI & HIV. The laboratory performs in few main working areas as the central hub of laboratory network for STI & HIV. In addition, the NRL contributes to many other activities at national level pertaining to lab services and patient management services.

5.2 Laboratory service through network of laboratories

The NRL is functioning in network fashion with the district clinic laboratories linking with 41 government STD clinic laboratories and with private sector laboratories. The apex laboratory –NRL and the other laboratories are linked technically. The NRL supports the district laboratories testing wise by providing referral services for diagnosis & monitoring of STI & HIV. The referrals are directed to the NRL for problem solving and confirmation of disease status when the peripheral clinics are in doubtful status.

All the standards, technical guidance, policy implementations in laboratory service have to go down to district laboratories from NRL in order to maintain a smooth service keeping the uniformity of activities in the network laboratories.

The laboratory reagents for the screening & confirmation of syphilis, screening of HIV, screening of gonorrhoea is currently distributed centrally through NRL to keep the uniformity of testing in the country.

Important equipment for microscopy and serology services are also assessed and supplied by the NRL for the whole country in order to improve the quality of testing.

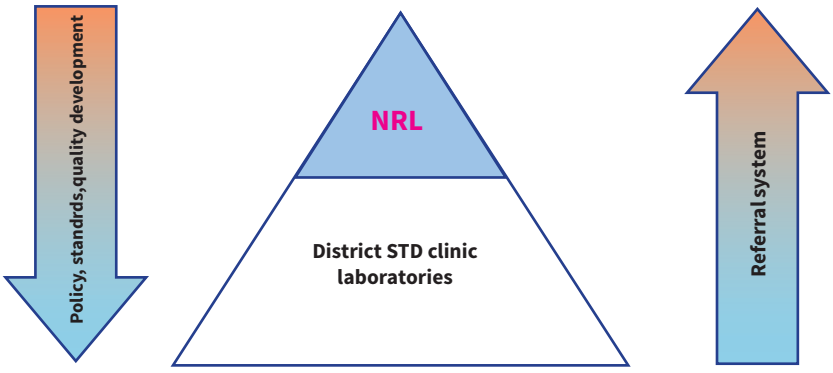


Figure 5.1: Organizational structure of laboratory services

5.2.1 General information one should know about the laboratory setting

The laboratory should possess a good directional workflow when functioning. This mainly for avoiding mix up of dirty and clean areas. The molecular level testing should be done in separate areas.

There has to be a separate sample reception area, sample processing area, staff working area with no contamination from specimen or testing materials. Storage area and a washing/ decontamination area should be in cooperated for laboratories.

The sample entry should be separated from the staff entry whenever possible. The staff should not eat, drink, smoke or apply make up in the laboratory.

The laboratory has many categories of staff such as consultants, medical officers, Medical Laboratory Technologists (MLT), Public Health Laboratory Technicians (PHLT), lab orderly's and labourers. Each one has a specific job to fulfil. The laboratory testing is performed by MLTs and PHLTs. It is expected from the lab users to liaise with the medical staff for matters of concern to patients.

The NRL has a Quality manual according to which the laboratory procedures are carried out. This Quality manual is prepared to be in par with ISO 15189 standard for medical laboratories.

The sample collection manual, SOPs and Quality Standard Procedures (QSP) are to be followed by all the users / staff of laboratory as and when necessary.

All those who are to work in the laboratories should first undergo preservice training prior to start work.

5.3 Broad working areas of NRL-NSACP

- Testing
- Technical guidance to district clinics
- Provide annual estimations and manage supply chain for laboratory equipment's, reagents and other consumables to district clinics through NRL
- Provision of reagents to district clinics and managing supplies
- Equipment management
- Quality assurance of laboratories
- Laboratory data management
- Teaching & training
- Provision of expertise for laboratory infrastructure development, taking policy decisions, testing development, quality improvement, supporting STI & HIV patient care services.

5.3.1 Testing

Testing wise the NRL provides services to the whole country in referral range for STI & HIV, for both public and private sectors. In addition, the routine diagnostic work for Colombo STD clinic is covered by NRL. Further, whenever necessary when district clinics are experiencing difficulties which dismantle the testing service, the NRL provides the mopping up service for all the tests.

The list of tests done at NRL is listed. The sample collection manual of NRL elaborates all the necessary information regarding to sample collection, transport, storage and reporting with turnaround times. Therefore, anyone who wishes to know about testing should go through the sample collection manual as well as STI guidelines for details of testing.

Testing services available in the lab network

- Microscopy - in all the labs for GC, Syphilis, BV, TV, HSV, Candida
- Screening for syphilis and HIV – in all the labs – RDT, VDRL& TPPA
- Depending on the availability of an ELISA machines - screening for HIV by ELISA method
- There is a CD4 machine in one STD clinic in each province to provide the CD4 testing services.
- There are facilities for viral load testing in Anuradhapura and Galle clinics from which the services can be obtained for a draining set of clinics.
- GC culture facility is available in a group of clinics. This is continuously developing and expanding based on the space and staff facilities available.
- In addition to above tests the NRL provides laboratory services for early infant diagnosis for HIV, HSV serology, PCR for HIV, chlamydia and HSV, GC ABST, hepatitis B & C
- The drug resistance to HIV is provided through referral services by NRL
- The testing for TB and opportunistic infections are also done through referral services by NRL
- Biochemistry and haematology testing available at NRL

5.3.2 Diagnosis of common STI & HIV

The laboratory diagnosis of a disease is dependent on the quality of the sample received and on the appropriateness of the sample. The collected samples should be stored in correct temperatures until the tests are performed. All the samples received at the laboratory should be registered and a unique laboratory number should be given and recorded for future references. Request forms for the test ordering are available in hard copies as well as with in the Electronic Information Management System (EIMS).

5.3.2.1 Role of Laboratory Standard Operating Procedures and QSPs in testing

Laboratory SOPs should be in place in all laboratories for tests carried out. Using SOPs reduces the chances of process variability. SOPs for all laboratory tests are available and adhered to in performing testing.

Apart from these, there are QSPs in a laboratory. e.g.: dispatch of reports, participation in EQA, internal quality control etc. It is very important to follow all those as per writing for the proper functioning of the laboratory.

5.3.2.2 Testing procedures

The testing is performed in the laboratory with adherence to standard operating procedures. In all instances the national algorithms are to be adhered to for test selection.

Any test is supposed to be performed as soon as possible after sample receipt. Microscopy is done with immediate effect and the results are issued without a delay to manage the patients. The rapid diagnostic test (RDT) of HIV is also performed upon receipt of the sample for needle prick injuries and for KP services. Urgent samples are attended on priority without any delay with red labelled indicator.

All the testing is subjected to internal quality control. The quality control material is prepared in NRL for serology. For the tests that do not have Internal quality control material, kit controls are used alone.

When the testing is over the reporting and recording is done by the technical staff and the verifications and authorizing of the reports are done by the medical staff.

5.3.3 Technical guidance to district clinics

The NRL provides all the necessary technical guidance to the district clinics covering the whole range of laboratory activities in pre analytical, analytical and post analytical phases. The guides are renewed periodically by the NRL to suit the changing practices.

5.3.4 Provision of laboratory reagents

The laboratory reagents for conducting tests for syphilis, HIV and gonorrhoea are procured centrally and distributed to the district laboratories by the NRL through MSD & SPC of MoH. The other reagents for the tests carried out at NRL for microscopy, serology and for molecular testing are ordered only for the NRL.

A central level lab should have adequate space for proper storage of reagents. Monitoring of storage for temperature control should be done on daily basis.

Proper stock management with complete set of inventories is a responsibility of the chief medical laboratory technologist of the lab.

The management of the supply chain and monitoring of the stocks in all the districts are done by NRL on regular basis. Preparation of the annual estimates for the country is done with participation of all district clinics.

5.3.5 Equipment management

Calibration of equipment and having service agreements for annual maintenance of equipment is to be attended by the laboratory.

The NRL issues the equipment management guidelines to all the STD/HIV clinic laboratories. These guides are meant to be followed in order to be in par with the laboratory standards.

The NRL conducts an equipment survey every year to understand the equipment status of the laboratories in the network. Some equipment needs for districts are attended by the NRL based on the analysis of the survey findings and depending on the availability of funding.

The laboratory equipment should be well attended for proper functioning of the equipment.

Main guides are listed down.

- Annual maintenance of the equipment should be under maintenance agreement in any STD clinic. The head of the institution need to take the appropriate actions to have all the necessary equipment to be under annual maintenance contracts. Further to this, continuous maintenance should also be in place.

- Periodic calibration of the equipment should also be an important factor deciding the accurate functioning of the relevant equipment. The calibration should be done by an accredited institute for calibration.

- The equipment which are non-functional should be labelled as such and should be sent for repair immediately. Once the repair is over the equipment should undergo performance check for testing before it is pushed back to service.

- All equipment should undergo the performance verifications on installation and after service and after any repair.

5.3.6 Quality assurance of laboratories

For quality assurance of laboratories, the NRL works at 3 levels in 4 plat forms.

1. Improving the quality of NRL to meet international standards. ISO 15189 for medical laboratories
2. Provision of technical guidance for district level and by hand holding for quality improvement
3. a) Conduct a National External Quality Assurance for serology of HIV & Syphilis in the district clinics and the other institutions

   b) Conducting external quality assurance for microscopy for STI

A central level lab should fulfil the advanced requirements in addition to the basics. A purposely built adequate infrastructure is a prime need.

- Adequate bench space for working appropriately separated sections for unrelated work are among essential needs for any laboratory at central level.
- There should be infrastructure facilities to conduct molecular level testing.
- Appropriate equipment which are well functioning and well maintained is also among the minimum requirements.
- With all these, a well-trained tailor-made staff should be available for a laboratory to optimize its functions.

5.3.7 Laboratory data management

Laboratory data management is partially manual and electronic at present. The lab doesn't have a laboratory information management system at the moment. But NSACP has The EIMS of which the data is fed. All the data generated by the laboratory should be well recorded and kept.

All the documents including SOPs, QSPs, other records and the report formats should be under document control. All the documents should have a unique document number as well.

Some important documentation related to laboratory & supply chain management

- Sample dispatch register
- Laboratory registers for tests
- Statistics related to testing –returns
- Archiving of documents is for 5yrs
    - There are formats for test ordering lab testing (work sheets), & reporting
    - There are formats for reagent ordering and provision, for collecting information for annual estimate preparation

The data of the NRL and the testing data of districts are analysed by the NRL for handing over to SIM unit for what they are asking and for practical uses such as M&E of supplies.

Data security - all the data of laboratory should be under security. No person should be able to approach the raw data except the people dealing with those. Only the processed data should go out of the laboratory. Breaching these will disqualify the laboratory in international standards of data management.

5.3.8 Teaching & training

The NRL has to participate in teaching and training in massive scale for many undergraduate and post graduate courses. This includes lecturing, lecture demonstrations and hands on training for certain categories. In addition, all MLT schools and PHLT course send the students to the lab for practical.

5.4 Role of the laboratory to implement programme activities

- Diagnostic testing/monitoring
- Quality improvement
- Surveillance
- Special community interactions
- Capacity building
- Research
- NRL – introducing new technology
- Data management
- Equipment management
- Supply chain management

The laboratory testing is required in many programmatic activities. This could be in the form of testing in laboratory premises or testing in field setting. In addition, participation in teaching and training has to be done on frequently. All these activities should well be attended by the

laboratory as the programme has the national tasks to fulfil and the activities are targeted for those.

5.5 Infection prevention & control

Infection prevention and control should be done in laboratory with strategic approaches targeting mainly the transmission of blood borne virus. Transmission of tuberculosis in HIV setting and the COVID -19 in current situation should also be paid attention.

The IPC should be achieved with

- Admin controls
- Engineering controls
- PPE
- Disinfection & sterilization
- Waste management
- Risk assessment and attendance to occupational hazards for infection risks with BBV and by client education

  (Refer infection control manual of Sri Lanka College of Microbiologist for details)

Whenever there are national guidelines those should be adhered to, and local guidelines should be in place in par with the national guides.

Eg: The NSACP has a waste management policy and guideline, and one should be abided by that for waste management in NRL.

6 HIV TESTING SERVICES

The early detection of HIV opens the gateway for appropriate services for HIV infected individuals, improve the survival and the quality of life of people infected with HIV and prevent the onward transmission. It also provides opportunity to initiate HIV prevention interventions such as behavioural change interventions, condom promotion and referral to PrEP and PEP services. Therefore, it is important for all program managers, staff members and other relevant stakeholders working for the HIV control of Sri Lanka to have a sound knowledge about HIV testing services (HTS) available in the country.

6.1 National HIV testing strategy

Nationally adopted testing strategies and algorithms are important to assure standardization of tests used in country, procurement and supply chain management, training and quality assurance.

The national HIV testing strategy is discussed under strategic direction 2 of the national strategic plan 2018-2022. In which the priority actions that need to be undertaken to improve HIV testing uptake were identified as

- Decentralized HIV testing and move towards adopting the rapid test kit algorithm especially in situations and places where access to STD clinics is difficult
- Ensure the algorithm is provided to private laboratories for adoption of rapid test kits for diagnosis
- Introduce rapid test kits for HIV and syphilis for community-based testing
- Expand testing to base hospitals, chest clinics, ante-natal clinics (ANC)
- Ensure counselling training at all STD clinics

6.2 HIV testing unit

HIV testing unit is established with the aim to scale up HIV testing services island wide to enhance early diagnosis of HIV infection to achieve 95-95-95 targets by 2025 by minimizing transmission rate.

6.2.1 Duties and responsibilities of HIV testing unit

1. To prepare and update guidelines, strategies, algorithms and other policy document related to HIV testing services with other relevant coordinators
2. To prepare annual action plan related to HIV testing services through GOSL and other international and local funding agents
3. To develop an annual training and capacity building plan for the relevant staff and other groups to maintain the quality and the sustainability of the HIV testing services by improving the human resource capacity
4. To plan and implement demand creation activities to promote HIV testing including conducting advocacy for health sector as well as other relevant sectors

5. To create conducive environment for HIV testing by addressing legal, social and cultural barriers and to gain political support by advocacy.
6. To prepare annual HIV test kit estimations, projections and distribution plans with the support of the laboratory, M&E unit and KP coordinators and assure uninterrupted HIV test kits
7. To coordinate smooth functioning of HIV testing services at NSACP and district STD clinics
8. To identify strengths, weaknesses and threats related to the currently available HIV testing services and to explore opportunities of expanding testing and upgrading the quality of testing services.
9. To introduce novel HIV testing strategies to scale up HIV testing service
10. To establish an effective relationship with the National Blood Transfusion Service in order to strengthen the prevention of transmission of HIV through infected blood.
11. To incorporate and strengthen HIV testing services to NPTCCD and provide training to their staff in order to diagnose HIV-TB co-infection early.
12. To support EMTCT unit to maintain sustainable HIV testing services within maternal and child health services in order to strengthen EMTCT services
13. To develop high quality, effective IEC materials focusing scaling up of HIV test uptake among targeted audience including key and vulnerable groups, youth and general population.
14. To ensure sustainability of the programme monitoring and routine reporting related to HIV testing services
15. To ensure regular review of the HIV testing services national and district level, based on the indicators and maintaining the standards of the HIV testing service in Sri Lanka

6.3 Provision of HIV testing services in Sri Lanka

All HIV testing services are provided following 5 Cs principle.

. Counselling
. Confidentiality
. Consent
. Correct results
. Connect

The testing could be initiated either by the client (Client initiated testing) or the care provider (Provider initiated testing).

6.3.1 Pre-test services

Following pre-test services are expected to provide quality HIV testing services.

1. Promoting HIV testing services

In order to increase the demand for HIV testing it is important to promote HIV testing in various settings. The demand generation activities for different HIV testing strategies could be different to one another. It is vital for programme managers and service providers to identify appropriate demand generation interventions suitable for different HIV testing approaches and pay adequate attention to implement those.

2. Creating an enabling environment

It is crucial to assure an enabling environment for HIV testing in various settings. This could be achieved by adequate staff training, advocacy, increase awareness and sensitization of law enforcement agencies.

3. Ensuring a confidential setting and preserving confidentiality

It is important to pay adequate attention to ensure confidentiality in all settings where HIV testing is provided. The facility should have enough privacy where patient can discuss sensitive issues when necessary.

4. Pre-test information

All clients who undergo HIV test need to be provided with adequate pre-test information. The information could be provided to clients in the form of individual or group counselling, videos, posters or leaflets. The depth of provision of pre-test information depends on the setting.

6.3.2 Post-test services

All HIV testing services should assure quality post-test services

Post-test services should include

- post - test counselling following HIV negative results
  - This should be brief and include information about the window period and recommendations for retesting if applicable. It should include discussion about HIV appropriate preventive services such as risk reduction counselling, condom promotion, PrEP and PEPSE where applicable.
- Post - test counselling following HIV positive results
  - Confirmed HIV positive individuals are always counselled adequately by a person who is well trained in providing post-test counselling.
- Post - test counselling following HIV indeterminate results
  - Disclosing indeterminate results is difficult to both provider as well as for the clients.
  - Therefore, it should be provided by a person who is experienced in providing post-test counselling.

Refer to HIV testing guideline for more information

6.3.3 Service delivery approaches for HIV testing

HIV testing is provided to clients through various settings. Each testing service should follow a distinct algorithm appropriate for the specific setting as mentioned in the National HIV testing guideline.

The following approaches are used for HIV testing in Sri Lanka

- Facility-based testing
- Community base testing
- HIV self-testing
- Index case testing (Contact testing)

6.3.3.1 Facility base testing

In facility base testing, the client attends to the testing services for HIV testing or for some other services. This service is available both in government and privet sector of Sri Lanka.

Following settings in government sector provide facility base HIV testing services:

- STD clinics
- TB clinics
- ANC services
- Government hospitals
- Healthcare settings where hepatitis B, hepatitis C are diagnosed
- Blood banks
- Donors of tissues and organs for transplant, In-utero insemination

a. STD clinic-based testing

- All STD clinic attendees are routinely offered HIV testing.
- Routine clinic attendees are tested with HIV ELISA and the results will be given to clients on the following clinic visit.
- All key populations attending for testing need to be tested using rapid testing and the results need to be conveyed to clients on the same day.
- Other indications for rapid HIV testing are
  - All clients who are referred for confirmation following positive screening test (If RDT is positive, the patient will automatically undergo second and third RDT for confirmation on the same day)
  - Clients attending for pre and post exposure prophylaxis
  - Patients who need urgent results such as ward referrals
  - Patients with HIV related symptoms
  - Testing of partners of known HIV positive patients (Index case testing)
  - Inbound migrants who are referred to NSACP for HIV care (newly diagnosed or known positives)
- In addition, NSACP and several district STD clinics provide after hour HIV testing clinics to improve the access to HIV testing. The clinic attendees could be referred by NGOs, online outreach workers or voluntary attendees. The clients should be provided with HIV rapid test and those who wish to undergo full STI screening need to be referred to the STD clinic.

b. HIV testing in TB clinics

- HIV testing is offered to all patients diagnosed with TB. TB clinics collect blood from the patients and send to nearest STD clinic for HIV testing. In addition, some TB clinics provide rapid HIV testing to patients within the clinic itself.
- If a client becomes positive, they are referred to nearest STD clinic for confirmation and further follow up.

c. HIV testing in ANC services

- HIV testing is routinely offered to all pregnant mothers in their first booking visit and the

blood samples are collected and send to nearest STI clinic for serology. HIV positive pregnant mothers are immediately traced by the STD clinic with the support of the relevant MOH. Mothers are linked to care as soon as possible to initiate ART without delay.

d. HIV testing in government Hospitals

- HIV testing facility is available in majority of base hospitals and above, in government sector and mostly it is rapid test. In majority of hospitals, the test is performed in the laboratory and, in some hospitals the test is available at labour rooms and ETU for emergency use.
- If the rapid test becomes positive either the client or a second sample of blood will be sent to STD clinic for further testing and confirmation.

e. HIV screening of Hepatitis B and C patients

- All patients who are diagnosed with hepatitis B and C are referred to STD clinics for HIV and STI screening. However, the hepatitis B and C patients who are diagnosed through PWID outreach clinics are offered HIV rapid testing at outreach clinics itself.

f. HIV screening for donated blood

- All donated blood samples are routinely screened for HIV in blood banks using serological tests or NAAT tests.
- Screening positive samples are excluded from blood donations. These clients are traced by the blood bank and send to the nearest STD clinic.
- Once the clients attend STD clinic, they should be first registered in STD clinic and should be retested before registering into HIV care.

g. HIV screening in organ donors, tissue donors, subfertility services and prior to surgical procedures

- All above clients are referred to STD clinics for HIV screening and they should be offered HIV screening like any other STD clinic attendee.

6.3.3.2 Outreach testing

Outreach testing is provided to clients either by the STD clinic staff or by the lay providers.

a. Outreach testing by STD clinics staff

STD clinic staff conduct outreach clinics for following groups

- Key populations (KP): MSMs, Female sex workers (FSW), Trans-genders (TG), Beach boys (BB), PWID, Prison inmates
- Vulnerable groups: Youth groups, Three wheeler drivers
- Special event base testing. e.g., for world AIDS day, Medicare exhibition etc.

Outreach testing is mainly done using rapid HIV tests. Please refer to the outreach HIV testing algorithm for more details.

b. Outreach HIV testing for prison inmates

- NSACP conduct outreach HIV testing clinics in Colombo prisons once a week.
- Other STD clinics conduct outreach prison clinics at their respective districts at least once a month
- HIV test should be offered both to remanded persons as well as convicted prison inmates. All prison inmates are offered repeat HIV testing only after 6 months unless otherwise indicated.
- In addition to testing by STD clinic staff, trained prison staff also provide rapid testing for inmates.
- HIV rapid test is the test of choice for the prison inmates as the results can be provided on the same day.
- Inmates who are tested positive should be referred to nearest STD clinic immediately for further evaluation.
- All efforts need to be made to register HIV positive prison inmates to HIV care before they are released from the prison.
- It is the responsibility of the prison medical officers to link such patients to HIV care without further delay and arrange appropriate follow up as indicated by the caring consultant.

c. Mobile outreach testing

Outreach testing is also done as mobile outreach clinics where the STD clinic staff travels to various sites and conduct rapid testing.

d. Virtual outreach and testing

- Online outreach workers reach clients through social media and dating apps and encourage the clients to undergo risk assessment, online clinic booking and testing at STD clinic.
- The clients are tested using rapid tests and HIV test results are conveyed to the clients on the same day. Other test results are provided to the clients online.
- In addition to booking for HIV testing, clients could also request condoms, lubricants, HIV self-test kits and get online counselling services.

e. Outreach HIV testing and community based HIV testing by lay providers

- In addition to the STI clinic staff, lay providers who are adequately trained by NSACP, who possess the training certificate/letter, could also provide HIV rapid tests for key populations in community centres or in the community.
- The outreach workers should follow test for triage algorithm where they perform one HIV rapid test and positive client should be referred to the closest STD clinic for further testing and confirmation.
- It is the responsibility of the relevant lay provider to inform the consultant Venereologist of the nearest STD clinic about the positive client and make sure the client is linked to STD clinic.

6.3.3.3 HIV self-testing

HIV self-testing (HIV ST) allows people to take an HIV test and find out their result in their own home or other private location.

HIV self-testing is introduced to Sri Lanka in December 2020 and initial demonstration project is currently in progress. Although both saliva based and blood based self-test kits are approved by WHO and other international authorities for self-testing purposes, currently only saliva based HIVST is available in Sri Lanka.

HIV self-test kits are distributed to clients through NGO or through "know4sure" online platform. The self-testing could be done either as assisted self-testing where a provider is expected to assist the client to perform the test or unassisted where the client has to perform the test by himself by following the instructions provided.

If the HIV ST is found to be negative, he will be considered as negative unless the client is in window period. If the HIV ST is positive, they need to be referred to the nearest STD clinic for further testing. Once the clients are referred to STD clinic following positive self-test results, they need to be tested using the same three test algorithm as any other clinic attendee to confirm or exclude HIV status.

6.3.3.4 Index case testing

All newly diagnosed HIV patients need to be interviewed by the medical officer and the PHI to get the details of their sexual contacts and biological children of HIV infected females.

In addition, all HIV patients under HIV care need to be regularly evaluated about their sexual exposures and referred for contact tracing if they report unprotected sex until they are stable on ART

Once the contacts are listed and contact details are obtained from the client, the contact tracing is done either with the assistance of the client (client referral) or directly by the PHI or medical officer (provider referral). However, the contact tracing should always be done with the consent of the index patient.

Once the contact attend to STD clinic or attend to community testing site the RDT is performed to assure same day results and positive individuals are linked to treatment and care services. Negative partners who are at risk of acquiring HIV through the index partner will be referred to prevention interventions including PrEP and PEPSI.

6.3.3.5 HIV testing in private sector

a. HIV testing in private hospitals and laboratories

- HIV testing facilities are available to the clients through private laboratories and hospitals.
- It could either be client-initiated HIV testing or provider-initiated HIV testing for the client, based on risk factors or indicator conditions.

- Once the initial screening test becomes positive either the patient or a sample of blood will be sent to nearest STD clinic or to NRL for confirmation of the HIV status.
- If only the blood sample is sent for confirmation, it is the responsibility of the caring practitioner to refer the client immediately to nearest STD clinic if the client is found to be confirmed HIV positive or need further testing.
- HIV testing data need to be collected from the private labs annually in the given format and send to NSACP within the next calendar month.

b. HIV testing through general practitioners

- NSACP has started HIV testing in collaboration with selected general practitioners (GP) in some districts.
- The GPs who are willing to provide HIV testing facility to their clients should be first registered at the nearest STD clinic and they should be adequately trained on how to perform rapid test and to interpret result.
- The GPs need to request test kits from the respective STD clinic and the test kits will be provided free of charge. The GP could provide HIV testing facility to their clients either free of charge or with a nominal fee.
- The clients who are HIV rapid tests positive required to be referred to the relevant STD clinic for confirmation and it is the responsibility of the GP to make sure that the client is linked to care without any delay.
- The GP need to maintain a register of the HIV testing and provide quarterly retunes of HIV testing data including stock details to the relevant STD clinic in the given format.

c. HIV testing for inbound migrants

- All inbound migrants who are provided with resident visa are expected to undergo HIV testing before entering the country.
- The HIV testing is carried out by international organization for migration (IOM) and those who are found to be HIV positive are referred to NSACP for HIV care.
- All such clients are first registered in STD clinic and undergo retesting before registering into HIV care. However, if they provide a referral letter from the respective clinician who provided care for the client from the country of origin, mentioning the HIV status of the client, they could be directly registered into HIV care.

d. HIV testing for outbound migrants

- Outbound migrants are tested for HIV before issuing the visa if the destination country regulations request HIV testing.
- The testing is carried out by authorized laboratories selected by the destination country.
- HIV positive clients are referred to STD clinics for further investigations and care.

7 PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV AND SYPHILIS

This programme area is responsible for the prevention of mother to child transmission of HIV and syphilis in Sri Lanka with a multi-disciplinary, multi-partnered, and multi-level approach with strong links between maternal and child health services and sexually transmitted infections and HIV services in both government and private sectors. Sri Lanka has been declared as a country that eliminated mother to child transmission of HIV and syphilis by the World Health Organisation (WHO), Geneva on 13th November 2019

7.1 Strategy for PMCT of HIV and syphilis in Sri Lanka

The overall goal of the programme is to ensure the PMTCT of HIV and syphilis to a level which is no longer a public health problem. Low-cost strategies have been used effectively to reduce MTCT of HIV and syphilis in many countries. The strategy for PMTCT of HIV and syphilis in Sri Lanka was edited in 2018 aligning with the National HIV policy, UNAIDS comprehensive approach to prevent MTCT of HIV and WHO global strategy for elimination of congenital syphilis (ECS).

The approach given by the United Nations defines four key prongs, each prong plays a key role in preventing new paediatric HIV infections, improving maternal and child health and survival in the context of HIV.

Prong 1: Primary prevention of HIV among women of childbearing age
Prong 2: Prevention of unintended pregnancies among women living with HIV
Prong 3: Prevention of HIV transmission from a woman living with HIV to her infant.
Prong 4: Provision of appropriate treatment, care and support to women living with HIV and their children and families.

In 2007 WHO outlined a similar comprehensive strategy for the global elimination of congenital syphilis. The strategy consists of promoting **four pillars**.

1. Ensure advocacy and sustained political commitment
2. Increase access to, and quality of, maternal and new-born health services
3. Screen and treat pregnant woman and partners for syphilis
4. Establish surveillance, monitoring and evaluation systems

National HIV policy covers the areas such as testing, counselling, care and treatment services and prevention of HIV and STI. National HIV/AIDS policy of Sri Lanka clearly states that prevention of mother to child transmission of HIV should cover the four prongs identified by UNAIDS.

Refer “The strategy for elimination of mother to child transmission of HIV and syphilis is Sri Lanka, second edition,2018” for further details.

7.2 PMTCT unit - NSACP

7.2.1 Duties and responsibilities of PMTCT unit

- To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, protocols and standardized operational procedures (SOP) for implementation of PMTCT of HIV services in Sri Lanka.
- To collaborate with SMT and other relevant authorities in decision making and carrying out of PMTCT of HIV services.
- To prepare annual action plan related to PMTCT of HIV and syphilis services through GOSL and other international and local funding agents.
- To work with other NSACP units to develop comprehensive and coordinated plans for implementation of the National Strategic Plan and other relevant activities.
- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.
- To maintain the provision of PMTCT of HIV and syphilis services through the service delivery points of the National STD/AIDS control Programme and government health facilities in quality assured manner.

The PMTCT unit of NSACP links with several institutions at different levels. At the central level under the guidance of the Director General of Health Services (DGHS) and Deputy Director General Public Health Services (DDG PHS), the central unit responsible for maternal and child health in the country, the Family Health Bureau, works closely with National STD/AIDS Control Programme, to give leadership to the programme. At the provincial level, the Provincial Director of Health Services, Regional Directors of Health Services, community physicians and medical officer-maternal and child health guide the health care system to implement the programme in the community with the support of the district STD clinic and medical officers of health (MOH) offices. At the grass root level, the MOH staff conduct awareness programmes, collect blood for testing and STD clinic staff provide testing and treatment facilities.

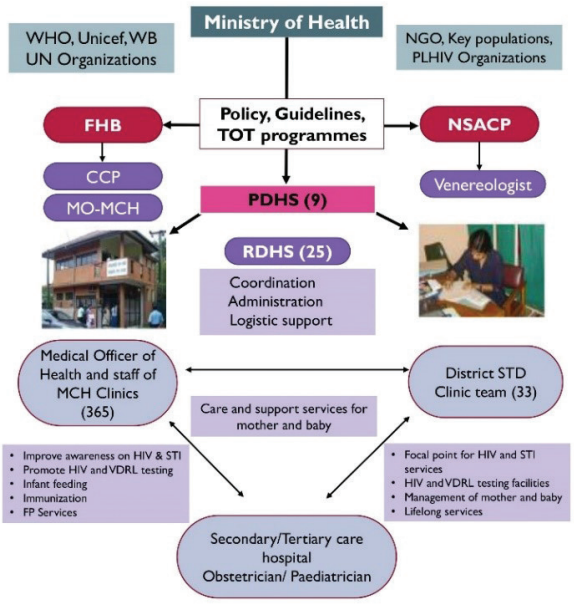


Figure 7.1: Stakeholders in EMTCT of HIV and syphilis programme

- To coordinate with and support institutions within and outside the Ministry of Health such as private hospitals, non-governmental organizations in the expansion of appropriate, high quality PMTCT of HIV services.

- To develop annual training and capacity building plan for individuals / institutions in the public, private and civil society organizations on PMTCT of HIV services, in partnership with relevant programme areas in the NSACP.

- To supervise and monitor the quality of PMTCT of HIV services in the programme and to provide expert advice to manage mothers and infants born to mothers with HIV and syphilis infection.

- To gather data and analyse using the case reporting format sent to the EMTCT unit by the respective STD clinic, and to triangulate data every quarter with the data received by the SIM unit.

7.3 Provision of PMTCT services in Sri Lanka

7.3.1 PMTCT services

All pregnant mothers are to be screened for HIV and syphilis infections before 12 weeks of gestation, preferably in the booking visit. The activities are to be carried out as out lined in Operational guidelines for HIV/STI prevention, care and support providers at sexual health clinic.

The pregnant mothers who are confirmed with HIV or syphilis infection, their partners/children and the baby should be manged by the STD clinic according to the latest national guidelines of “Management of pregnant women with syphilis” and “Guidelines for the management of pregnant women with HIV infection, Sri Lanka”.

All the pregnant women with HIV infection should be managed in collaboration with a consultant venereologist.

For any clarification and further management, the venereologist or the medical officer in charge of the STD clinic may obtain advice from the national coordinator, PMTCT services.

Accurate and timely management of data is an essential component of the PMTCT services in order to monitor and to evaluate the PMTCT of HIV and syphilis programme. The STD clinics are expected to conduct the data management according to the guidance given in the operational guidelines for HIV/STI prevention, care and support providers at sexual health clinics. Once the initial data are gathered either manually through forms and registers or EIMS system, the following documents require to be sent to the PMTCT unit.

- Once the pregnant mother who is confirmed as HIV/syphilis is registered at the STD clinic, a “Case investigation forms for pregnant women with HIV and syphilis” should be filled by the PHNS/NO/PHI under the guidance of the consultant/medical officer. There are two separate forms available for HIV and syphilis.
  (Soft copies available at the NSACP web site)

- This form cannot be completed at the time of registration, therefore the initial details available at the enrolment should be mentioned and the form should be sent to the PMTCT unit NSACP within 14 days of registering the patient at the clinic. A copy of the form should be attached to the patient’s clinic records.

- An excel data base required to be maintained at the central level of those diagnosed mothers.
- Thereafter, the form will be updated at several points e.g., at the completion of treatment, after the delivery etc. by active surveillance done by the PMTCT unit, NSACP.
- At the end of each quarter, the "Quarterly returns of STD clinics (STD/ART return)" should be filled and send to the SIM unit, NSACP, indicating
- The number of pregnant women diagnosed during the quarter
- The number of children diagnosed during the quarter
- Number of ante-natal mothers treated for HIV/syphilis during the quarter
- Number of antenatal HIV and syphilis tests done during the quarter
- Further, "Case reports" giving detailed description of children diagnosed with congenital syphilis and paediatric HIV should be prepared and sent to the PMTCT unit, NSACP.
- The EMTCT unit will then compare the data received by the PMTCT unit and SIM unit to fine tune the data further at the end of each quarter.
- In addition to the registers and records mentioned above, PMTCT register, and the Paediatric HIV case register are maintained at the central level (PMTCT unit, NSACP). These will be updated using "Case investigation forms for pregnant women with HIV and syphilis" and "Case records".
- "Data on pregnancy and STIs" should be filled at the STD clinic level and sent to the PMTCT unit quarterly. It contains numbers of ante-natal mothers registered for the management of HIV, early Syphilis, late Syphilis, GC, non-gonococcal urethritis, genital herpes,genital warts and other STIs. Data is categorized according to the MOH area where each mother belongs to.

Ref : Elimination of Mother to Child Transmission of HIV and syphilis - Validation Report Sri Lanka 2019.

7.3.2 Validation and revalidation of EMTCT of HIV and syphilis programme

According to the WHO, the term "validation" is used when a country has successfully met the criteria for EMTCT of HIV at a specific moment in time. Additionally, validation "implies that countries will also need to maintain ongoing, routine, effective programme interventions and quality surveillance systems to monitor EMTCT of HIV.

7.3.2.1 Elimination criteria, indicators and targets in validation process

Sri Lanka had to achieve the following impact indicators for one year and process indicators for two years to achieve the milestone.

Indicators and Targets for validation of EMTCT of syphilis and HIV programme

Impact indicators
New paediatric HIV infections due to MTCT of ≤50 per 100 000 live births
HIV MTCT rate of <2% (non-breastfeeding countries).
New congenital syphilis of ≤50 per 100 000 live births
Process indicators
Population-level ANC coverage (at least one visit) of ≥95%
Coverage of HIV testing of pregnant women of ≥95%
Antiretroviral therapy (ART) coverage of HIV-positive pregnant women of ≥95%
Coverage of syphilis testing of pregnant women of ≥95%
Treatment coverage of syphilis-positive pregnant women of ≥95%

7.3.2.2 Validation Process

The National Validation Committee (NVC) was formed in 2017 and chaired by the DDG PHS1. The members of the NVC consist of DDG PHS, administrators, consultants of FHB, NSACP, academic colleges of obstetricians and paediatricians, provincial consultants, representatives from NGOs, KPs and PLHIV. The NVC is expected to meet at least once every quarter or more frequently depending on the need.

Four working groups are formed under the NVC to work in four main domains of the EMTCT programme headed by two coordinators each from the NSACP and FHB, i.e., programmes and services, data management, laboratory services, and human rights. They are expected to conducted desk reviews, consultative meetings, workshops and surveys when required. The existing standard operating procedures and guidelines are to be reviewed and updated.

7.3.2.3 Maintenance of Validation

Countries that have been validated for the achievement of elimination and certified will be assessed every 2 years. The global secretariat will maintain a list of countries that have achieved validation and maintain validation criteria and standards over time.

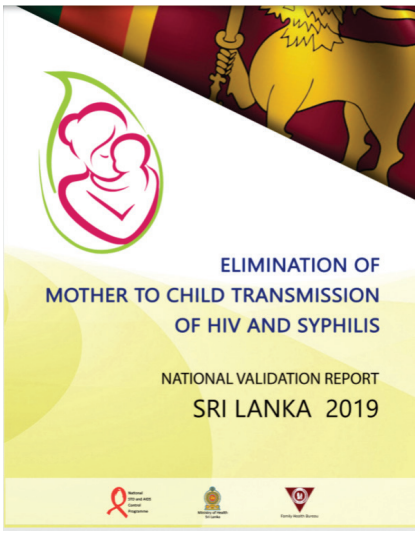


Figure 7.2: National Validation Report

Maintenance of validation reports are expected to be submitted by the country every 2 years after initial validation. This report should include updates on any programmatic data, laboratory and human rights recommendations provided by the Global Validation Committee (GVAC) at the time of validation. The maintenance of validation report should be submitted to the Regional Validation Committee (RVC), which will review the report and, if the validation criteria are still being met, will submit the report to the RVC (if applicable) and the GVAC for final review.

The report would be further assessed by the GVAC through further communication and interviews. The EMTCT levels of service coverage (process indicators) and impact criteria must remain in place to maintain validation status. Failing to maintain required EMTCT-level performance of the service and impact indicators or human, sexual or reproductive rights for women can lose validation status.

It is important to maintain the interest shown by all stakeholders to achieve satisfactory process and impact indicators and to sustain the success in the coming years.

8 SEXUAL HEALTH PROMOTION

Sexual health promotion includes promotion of healthy and safe sexual and reproductive health practices to cater the needs of the society. These services are delivered to individuals or to groups depending on the circumstances.

Sexual health promotion is carried out through IEC unit, advocacy and condom promotion unit, multi-sectoral unit, PMTCT (of HIV and Syphilis) unit and training and capacity building unit, HIV treatment, care and support unit ,STI care unit and KP unit.

8.1 Information, Education and Communication

Information, Education and Communication section of NSACP is coordinated under the IEC, Advocacy and Condom promotion unit.

This programme area is responsible for planning and implementation of IEC, Behaviour Change Communication (BCC) and promotion of means of prevention among key populations, vulnerable populations and general population in Sri Lanka.

8.1.1 Duties and responsibilities of IEC, BCC, advocacy and condom promotion unit-NSACP

- To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, and protocols for implementation of IEC, BCC and promotion of means of prevention services in Sri Lanka.
- To collaborate with SMT and other relevant authorities in decision making and carrying out of IEC, BCC and promotion of means of prevention services.
- To prepare annual action plan for IEC development, procurement, printing and dissemination through GOSL and other international and local funding agents
- To work with other programme areas to develop comprehensive and coordinated plans for implementation of the national strategic plan and other relevant IEC activities.
- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level with respect to IEC, BCC and promotion of means of prevention services.
- To maintain IEC, BCC and promotion of means of prevention services through the service delivery models of the NSACP in quality assured manner.
- To coordinate with and support institutions within and outside the ministry of health in the expansion of appropriate, high-quality IEC, BCC and promotion of means of prevention services.
- To supervise and monitor the quality of IEC, BCC material and promotion of means of prevention services in the programme.
- To carryout advocacy programmes to obtain the fullest contribution for implementation of IEC, BCC and novel means of prevention of HIV/STI.

- Provision of technical support, assistance and guidance to provinces, districts and other organizations and agencies in improving quality IEC, BCC material and promotion of means of prevention services.

- To develop training and capacity building for the relevant staff members to maintain the quality awareness programs on HIV/STIs and means of prevention for respective target populations

- To ensure regular review of IEC activities done at the national and district level based on the indicators and maintaining the standards of the IEC service in Sri Lanka

8.1.2 Services that are provided through IEC unit

1. Obtaining sufficient budgetary allocation for IEC and world AIDS day activities in advance through government of Sri Lanka (GOSL) or any other local or international funding agency.

2. Organizing and arranging NAC/ provincial AIDS committees/ district AIDS committees and IEC/Advocacy and Condom promotion subcommittee.

3. Organizing awareness programmes at various contexts in each year and on a daily basis, including community out-reach programmes, lectures, workshops, exhibitions, IEC Print material distribution, world AIDS day activities, media seminars, etc. throughout the year.

4. Organizing world AIDS day awareness programmes across the country and across organizations as well as key sectors of the society including awareness rallies, conferences and media briefings, creative competitions, and distribution of IEC material.

5. Supporting the IEC interventions carried out through the district STD clinics by providing IEC materials and capacity building at different levels, which includes providing IEC services, and training of doctors, public health nursing sisters, nursing officers and public health inspectors, attached to services to provide effective communication.

6. Development, production and distribution of appropriate IEC materials such as brochures, pamphlets, posters, leaflets, and flyers according to the programme requirements,

7. To coordinate smooth functioning of IEC services at NSACP and district STD clinics.

8.2 National Communication Strategy

The National Communication Strategy (NCS) is developed under the key strategic directions within the NSP.
The main objectives of NCS:

1. To increase awareness of HIV/STD in Sri Lanka
2. To reduce stigma and discrimination
3. To increase awareness about diagnostic, treatment and care services
4. To break negative perceptions.
5. To fill current communication gaps

The communication strategy adopts a recommendation-based approach using internal discussions, in-depth interviews and focus group discussions. The recommendations have been provided by stakeholders including medical and non-medical professionals, business professionals, media experts, key and general population, academia, clinic attendees, migrant population, armed forces and youth. The aim of NCS is to implement strategy-based activities in ending AIDS by 2030.

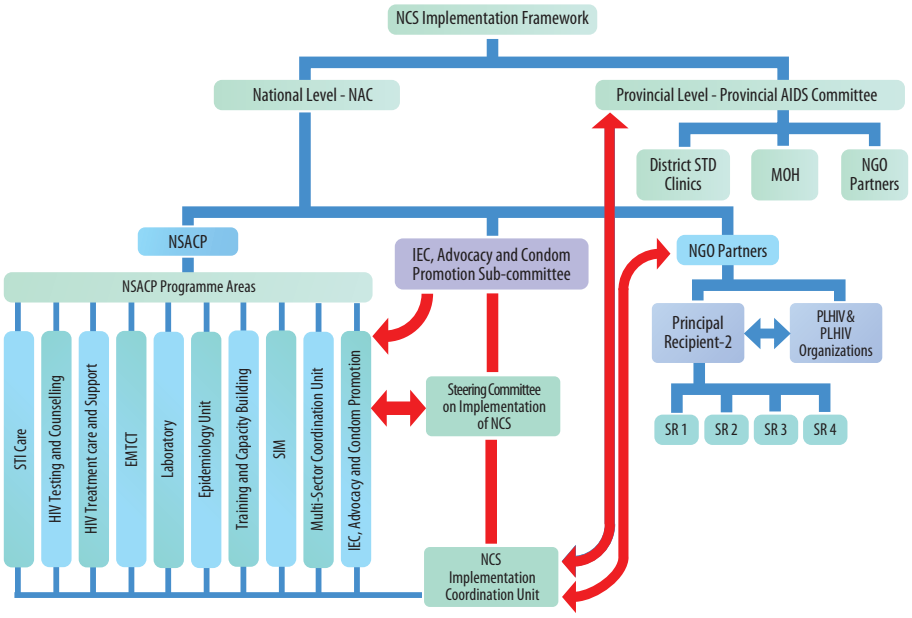


Figure 8.1: NCS implementation framework

8.2.1 Key recommendations in the communication strategy

- To develop a strong and effective communication strategy which is needed to sensitize the public on STIs and HIV/AIDS, testing facilities and services available.
- To minimize the STIs and HIV/AIDS related stigma which is perceived to be a significant barrier in providing treatment, care, control and prevention services.
- To convey positive communication messages for changing an attitude and misconceptions related to HIV/STIs.
- To communicate the clear content/messages of HIV/STIs on modes of transmission, ways of prevention, treatment, counselling and support services and the available services across the island.
- To convey the availability of verities of HIV testing approaches and ART services clearly.
- To stabilize a 24-hour call centre with operations in all three languages and available 365 days of the year at NSACP.
- To advertise the social marketing of services including STI/HIV testing and treatment, care and supportive services free of charge.

- To launch a mass media campaign and social media campaign in sensitizing the general population and communicating the messages effectively and updated on a regular basis.

- To update IEC materials/activities in a regular basis addressing the key strategic directions

8.3 Advocacy

Advocacy in health is one strategy to raise levels of familiarity with an issue and promote health and access to quality health care and public health services at the individual and community levels.
STD clinics need to advocate people, organizations and institutes to;

- Achieve changes in policy/legal framework, or to create new policies or legislations.

- Achieve a change in/obtain funding by government ministries, agencies or other donors.

- Achieve a change in a programme (objectives, criteria/standards, implementation, etc.)

- Achieve a change in degree of awareness and understanding (for example, health messages to "the public") which, it is hoped, will result in a change in attitudes and behaviour.

- Achieve a change in practice related to HIV/STD.

8.3.1 Steps to follow when carrying out an advocacy programme

- Identify advocacy 'issue' and advocacy objectives clearly with the consensus of all stake holders of the programme.

- Situation analysis by gathering credible and compelling evidence on the advocacy issue. Information gathered through key informants; research publications could be used in this process.

- Identify advocacy audience, which may include

    - Politicians
    - Decision makers – officials of the Department of Health, Health administrators
    - Donors
    - Other government organizations (health and non-health sectors)
    - Nongovernmental organizations – NGOs/ CBOs
    - Media
    - Corporations and industry
    - General public
    - Coalition and networking plan appropriate for the advocacy issue
    - Determine how each audience should be advocated
    - Establish measurable objectives for each audience
    - Define message points for each audience
    - Determine the communication activities to deliver those messages
    - Decide what resources are necessary to complete each activity
    - Establish a timeline and responsible party for each activity
    - Evaluate whether you have reached your objectives

8.4 Condom Programming

National condom programming is coordinated under the IEC, Advocacy and Condom promotion unit of the NSACP. Male condoms, female condoms and lubricants are the main items considered in this programme.

8.4.1 Main strategy for national condom programming

a. Leadership and coordination
b. Supply and commodity security
c. Support systems (programming)
d. Demand, access and utilization

8.4.2 Responsibilities of the condom promotion unit

- Coordinating the partnerships and establishing a national technical working group (Officers of the MoH, NGOs, CBOs, private sector, development partners, donors, PLHIV, officers of other government ministries and policy level officers of selected organizations)

- Advocacy to political leadership, different policy level leaders, law enforcement officers and media personnel to make supportive policies and government contribution for interventions for key populations and promotion of condom and lubricant

- Development of national policies, regulations, guidelines on national condom programming

- Mobilization of resource/funds for capacity building of service providers

- To ensure regular review of condom programme done at the national and district level based on the indicators and maintaining the standards of the service in Sri Lanka

8.4.3 Services provided through condom promotion unit

1. Effective quantification and forecasting of condoms and lubricants by using available condom distribution data and the programmatic gap table based on key population estimates.

2. Procurement of condoms and lubricants; Obtain sufficient budgetary allocation and enhance efficiency into the procurement cycle by reducing lead time.

3. Assurance of high-quality male and female condoms and lubricants based on standard checklist/ WHO/UNFPA specification for technical evaluation for condoms.

4. Ensure maintaining minimum standard of warehousing and storage at the district and national level.

5. Conduct quarterly formative supervisions from the central level in order to maintain the cold chain process in warehouse and local stores.

6. Assure a coordinated distribution from the central stores to the end users through network and conduct regular ‘on the spot’ checks to reinforce accountability, customer focus and motivation.

7. Develop pathways for better condom accessibility in difficult to reach locations.

8. Develop an information system to systematically collect and analyse information about the process of logistics management and inventory systems.

9. Define and implement a clear communication mechanism within the supply chain.

10. Develop culturally sensitive communication strategies and materials, which support effective condom promotion through appropriate media channels.

11. Strengthen the human resources and institutional capacity in public, private and commercial sectors, through relevant capacity building trainings and support recruitment of relevant condom programming personnel.

12. Develop relevant national and district level capacity building programmes for condom promotion.

13. Conduct trainings for NGOs/CBOs, private health sector, media outlets, military and other stakeholder personnel, and conduct refresher training sessions on condom programming.

14. Develop a monitoring system to facilitate the flow of information of condom programming, from the district level to the central level, at regular intervals, to enable programme managers of the NSACP to evaluate and improve the condom programme.

15. Conduct regular 'spot checks' on the monitoring system to ensure quality data management.

9 KEY POPULATION PREVENTION INTERVENTIONS

The World Health Organization (WHO) defines key populations (KP) as populations who are at higher risk for HIV irrespective of the epidemic type or local context and who face social and legal challenges that increase their vulnerability. Key Populations of interest in the NSP, Sri Lanka (2018-2022) are men having sex with men (MSM), Female sex workers (FSW), Transgender (TG), People who inject drugs (PWID), Beach boys (BB) & People in closed settings (Prison inmates). The KP prevention interventions are discussed under strategic direction 1 in the NSP (2018-2022).

There are two major categories of KP prevention interventions.

1. Health care workers provide HIV/STI prevention services directly

2. Health care workers provide services in collaboration with NGO/CBO & engaging KPs. Though, KP prevention services through health care workers are common to all district clinics, NSACP has long history of NGO/CBO collaboration in KP interventions, which is primarily funded by donors.

KP interventions engaging NGOs/CBOs & communities are selected depending on following factors:

a. KP size estimation of the district,
b. HIV & STI cases reported by STD clinic,
c. Qualitative information & value for money in operating. e.g., presence of hotels, Spas, hot spots, popular tourism market/beaches, external/ internal migration, availability of NGO/CBO and communities.

9.1 Key Population prevention intervention unit

9.1.1 Roles and responsibilities of KP Unit/ NSACP

- Technical guidance for proper implementation of the KP HIV prevention interventions in central, district clinics & by NGO/CBO.

- Support national and district level advocacy programs to cover provincial & district health administrators, other department administrators, police & community leaders to reduce KP related barriers in approaching services by creating an enabling environment.

- Monitoring and evaluation of KP programme island wide. Planning and conducting KP intervention review meetings.

- Assuring NGO/CBO & community engagement.

- Conducting initial & refresher staff training.

9.1.2 KP unit of district clinics

KP unit was evolved to facilitate KP engagement, and the unit is headed by the district consultant venereologist. The staff consists of a management assistant per each district, outreach worker per KP component and 3 peer educators per component .

9.1.3 KP prevention interventions in collaboration with NGOs/ CBOs & Communities (Peer led models)

Globally, engaging NGOs/CBOs & communities are one of the effective strategies for HIV prevention among KPs. Similar evidence has been used in Sri Lanka as "Peer led model", the intention of having NGO/CBO collaboration is to facilitate both STD staff and KP unit staff work closely. Here NGO/CBO is playing the role of a community-based structure which promote KP visibility in HIV/STI prevention programs within the districts.

Family Planning Association (FPA) being the second Principal Recipient of the Global Fund grant in two rounds consequently, primarily engages with "Peer led interventions". Eleven districts in 2013-2015 and 13 districts in 2016-2018 started KP prevention models. Since then, KP interventions were scaled up with more efficient outreach approaches. Interventions were improved after repeated program reviews & review of peer led interventions.

Year 2019 was the turning point for KP interventions, where the NSACP for the first time planned to undertake "Peer led interventions" by district STD clinics. Majority of districts are transitioned from FPA-SL. Most interventions are currently funded by the global fund while the government of Sri Lanka initiating its finance support since 2021.

There are different approaches (models) practiced in KP & HIV high burden and low burden districts separately. These approaches ensure sustainability when the donor fund comes to an end.

9.2 Service delivery models used for KP interventions

- Government STI service delivery points (STI clinics)
- Non-governmental STI service delivery points
- Private sector hospitals and clinics
- Drop-in-centre approach
- Outreach approach by a healthcare worker
- Outreach approach by a community worker
- Peer group model approach
- Social contracting approach
- Case finding team approach (case finding model)
- Hybrid model (peer group together with case finding model)
- Community based testing (CBT) models
- Escorting of key populations for services

9.3 Services provided to key population members through these service delivery models

1. Information education & communication on safe sexual practices, safe injecting practices, harm reduction services during drug use
2. Condoms & lubricants promotion and distribution

3. HIV testing, counselling & linking for services (community led testing & HIV self-testing; assisted or unassisted)
4. Referring clients for other services; STI screening, treatment, PrEP, PEPSE, Hepatitis B vaccination, community-based HCV treatment through telemedicine for people who inject drugs (PWID) and providing medication adherence support & support for mental wellbeing.
5. Applying innovative approaches in providing services; reaching the clients through online platforms & mobile applications

9.4 Monitoring & evaluation of KP activities

1. Interventions are directly monitored by the district consultants within the districts.
2. Monthly reviews are conducted collaborating with KP Unit/NSACP, KP Unit/ District clinic, & NGO/CBO
3. Indicators are monitored by SIM unit quarterly and reported annually to national & international reporting entities.

9.4.1 Monitoring Indicators

1. Percentage of MSM, TG, FSW, BB & PWID reached with HIV prevention programs

Definition of KP (MSM/FSW/TG/BB/PWUD/PWID) "Reach" for physical program

A KP (MSM/FSW/TG/BB/PWUD/PWID) is considered "Reach" when he/she is completed the following

I. registered,
II. educated on STI/HIV prevention & testing, (+/- and IEC/BCC materials)
III. provided with condoms (if needed lubricants)
IV. Refer / escort for testing

Definition of KP (MSM/FSW/TG/BB/PWUD/PWID) "Reach" for virtual program

A KP (MSM/FSW/TG/BB/PWUD/PWID) is considered "Virtually Reached" when he/she is completed the following

I. registered,
II. providing any of the following services –
   - Educated on STI/HIV prevention & testing
   - Referred to services
   - Delivered condoms, lubricants, HIV self-tests

SIM unit will monitor detail cascade of information for virtual reach

2. Percentage of MSM, TG, FSW, BB, & PWID who have received an HIV test in past 12 months and know results

Community led HIV testing is promoted; Communities are trained to do HIV testing in the field. Test for Triage algorithm will be practiced to do HIV screening. Rapid Diagnostic Tests and HIV self-test are used (A0). People with reactive results (A0+) will be linked to STD clinics for confirmations. People with non –reactive results (A0-) will be recommended to do repeat testing as needed.

10 MULTISECTORAL COLLABORATION AND PREVENTION

10.1 Multi sectoral unit - NSACP

The multisectoral unit of the NSACP is responsible for planning, monitoring, evaluation and implementation of intervention strategies; provide technical support for risk communication, advocacy, capacity building, awareness and training on behaviour change, promotion of safe sex & creating conducive environment for prevention of HIV/STI and internalization of HIV/STI related activities in multi sectoral institutions (relevant ministries/departments and the civil society organizations - NGOs, CBOs).

10.2 Key responsibilities of the multisectoral unit - NSACP

- Work with the relevant national committees and technical working groups to develop and regularly up-date national policies, strategies, guidelines, protocols, and annual action plans on evidence based for implementation of HIV/STI preventive services.
- Development of annual work plans in respect to multisectoral programmes, and monitoring, evaluation of activities to ensure implementation of effective programmes at the field level and resolution of policy related issues in the implementation process.
- Provide technical guidance to multisectoral organizations for formulation of HIV/STI prevention policies, workplace policies, guidelines, training modules and curriculum development with the perspective of gender equity, human right approach and minimizing stigma & discrimination.
- Provision and update of technical expertise relevant to national guideline packages for the service delivery points of the multi sectoral agencies (public, private and civil society organizations, NGOs) through knowledge dissemination, training and capacity building for enabling environment and behaviour change for HIV/STI prevention, treatment and care.
- Handling GFATM activities for HIV/STI prevention activities in prison sector and develop partnership with local and international agencies (UNFPA, UNAIDS, WHO, FPA)
- Work with the SIM unit to set annual targets and priorities for implementation that help to achieve the goals stipulated in the strategic plan and to monitor on regular basis. The implementation and reporting of all multi sectoral plans that are directed towards multi sectoral target groups covered under the respective sectors
- Conduct / coordinate research

Multisectoral unit conduct / coordinate research on baseline analysis and impact evaluations on HIV/STI activities related to multisectoral programme area and preparation of analytical reports in collaboration with academia, social sciences institutions, and research institutes.

10.3 Provision of services by the multisectoral unit of NSACP

10.3.1 Multisectoral collaboration for vulnerable populations and prison sector

1. Plans activities in parallel with the NSP for HIV prevention and give priority for interventions directed towards key populations and vulnerable groups through inter and intra sectoral coordination.

2. In collaboration with the department of prisons, following activities should be conducted based on “Prison HIV prevention, treatment and care policy”.

    2.1 Advocacy, awareness, training of trainers and life skill-based education programmes on HIV/STIs prevention treatment and care and enabling supportive environment for prison staff as well as for prison inmates

    2.2 Facilitate peer education programmes conduct by trained prison inmates as peer leaders on behaviour change communication for safe sex, promotion of testing and prevention of HIV/STI.

    2.3 Conduct life skill development programmes on HIV prevention for young offenders with the support from mental health unit of the ministry of health and communication specialists.

    2.4 Coordinate and conduct quarterly the “Steering committee for HIV/STI prevention in prison sector” and monitor & evaluate all activities in prisons related to HIV/ STI prevention, testing, treatments, care and welfare. Committee consists of members from the department of prisons and NSACP and chaired by the Commissioner General of prisons.

    2.5 Develop necessary IEC materials for prison inmates

3. NSACP has identified Tri-forces personal, Police personal, migrant population and tourist industry as vulnerable groups. Following activities should be carried out for relevant groups.

    3.1 Conduct advocacy for high-ranking officers in tri-forces, police, Sri Lanka bureau of foreign employment and tourist industry on prevention of HIV/STI by promotion of safe sex, enabling environment and internalization HIV/STI related activities.

    3.2 Training and capacity building to promote safe sex and prevention of HIV/STI for police & tri-forces personal, migrants who undergo training in Sri Lanka bureau of foreign employment and for relevant groups in tourist industry.

10.3.2 Multisectoral collaboration for general population

1. NSACP has identified some important groups in general population who need more attention on prevention of for HIV/STI. Those are youth council & youth corps, child protection authority, education sector, plantation sector, and vocational training authority, etc.

   Conduct advocacy, involve in development of training modules and curriculum development, capacity building, for relevant institutions/authorities.

   Conduct tailor-made training / TOT for relevant groups and internalization of programmes on behaviour change, promotion of safe sex and prevention of HIV/STIs.

   Work with other ministries, departments and directorates of ministry of health (Family Health Bureau, Youth Elderly and Disable unit) for activities related HIV/STIs. Multisectoral unit is a member of national advisory committee on young persons.

10.3.1 Assuring enabling environment

1. Coordinates and works in partnership with public & private organizations, civil society organizations, NGOs and international organizations get their support and commitment to create a conducive environment for prevention of HIV/STIs in Sri Lanka with more attention to minimize stigma and discrimination.

2. Advocacy and provision of technical support for awareness, training and capacity building on social behaviour change on safe sex and prevention of HIV/STI and internalization of HIV/STI related activities in relevant institutions / organizations.

3. Coordinate and conduct “subcommittee: prevention & multisectoral coordination” under NAC annually with all relevant stakeholders, review their activities and provide recommendation to NAC.

11 EDUCATION, TRAINING AND CAPACITY BUILDING

11.1 Strategy for training and capacity building

This programme area is responsible for the identification, need assessment, planning and implementation of strategies and activities for the human resource development in the NSACP and partner organizations. Aligning with the NSP (2018-2022) the annual training plan developed and is incorporated to annual action plan, taking into account of the activities from all sectors.

Training and capacity building unit in NSACP is responsible for the training of all categories of STD clinic staff island wide, and other medical categories, on request basis. These groups include undergraduate and post graduate trainees in the fields of medicine, trainees of other healthcare categories such as nursing officers, physiotherapists and peer educators from MSM, FSW, PWUD and BB groups.

11.2 Training and capacity building unit - NSACP

11.2.1 Duties and responsibilities of training and capacity building unit

- To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, training curricula, and materials for the implementation of training and capacity building services in Sri Lanka.
- To collaborate with SMT and other relevant authorities in decision making and carrying out training and capacity building services.
- To work with other programme areas of NSACP to develop comprehensive and coordinated plans for implementation of the NSP and other relevant activities.
- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.
- To maintain the provision of training and capacity building services to the NSACP in quality assured manner.
- To coordinate with and support institutions within and outside the ministry of health in the expansion of appropriate, high-quality training and capacity building services.
- Training and capacity building of individuals/institutions in the public, private and civil society organizations on different subject areas related to NSACP, in partnership with relevant programme area coordinators in the NSACP.
- To supervise and monitor the quality of training and capacity building services in the programme.
- Provision of technical support, assistance and guidance to provinces, districts and other organizations and agencies in improving quality, and access to training and capacity building services related to HIV/STI and sexual health.

- Need assessment and provision of technical assistance for supply and procurement of necessary items or services for training and capacity building services

11.3 Provision of training and capacity building services in Sri Lanka

11.3.1 Services that are provided through training and capacity building unit

- To work with relevant authorities to develop and regularly up-date on guidelines, training curricula for the implementation of training and capacity building.
  Training schedule consists of preservice training, in-service training, refresher training, undergraduate & postgraduate training and international training. Further, this unit provide technical guidance to develop guidelines, manuals, training modules and curricula for respective specialties in the field.

- Development of trainer manuals and curricula of undergraduate and post graduate training

- Developing trainer manuals focusing different categories of staff and other parties, which can be adopted universally

- The developed trainer manuals require to be revised frequently to assure up to date information for training.

- Curricula development for undergraduate/ post graduate training
  1. Request to develop the curriculum will be send by the authority of particular training programme.
  2. Once invitation is received, decide that particular training will lead to which type of carrier in future.
     e.g.: Public Health Inspector (PHI) curriculum – weight should give to public health aspect of HIV/STI than clinical aspect
  3. Decide the areas which should cover about HIV/STI.
  4. Relevant guidelines, curriculums, modules will be done when the need arise.
  5. Always touch the areas about stigma and discrimination in all type of curriculum development.

- Training of undergraduates & postgraduates in the medical field and other categories of healthcare workers on STI/HIV prevention.

11.3.2 Staff categories to be trained

Officer Category		Duration of training	Type of Training
Professional	Consultants	Depends on the training programme	Lectures and practical
Major staff	Medical officers attached to STD Clinics	2 months	Lectures clinical and Practical
	Matrons	2 weeks	Lectures clinical and Practical
	PHNS	2 weeks	Lectures clinical and Practical
	Nursing Officers	2 weeks	Lectures clinical and Practical
	MLT	2 weeks	Lectures and Practical
	PHLT	2 weeks	Lectures and Practical
	PHI	2 weeks	Lectures, clinical and Practical
	Pharmacist	2 weeks	Lectures, clinical and Practical
	Dispenser	2 weeks	Lectures and Practical
Minor staff	Attendant	1 week	Lectures, clinical and Practical
	Health Care Assisstant	1 week	Lectures, clinical and Practical
	Lab Orderly	1 week	Lectures and Practical
Others	NGO/CBO	1 week	Lectures and practical
Undergraduate	Medical students - University of Colombo	1 week	Lectures and clinical
	Medical students- KDU	2 weeks	Lectures and clinical
	Pharmacist	1 week	Lectures and practical
	Physiotherapy students	1 day	Lectures
	Nursing students	2weeks	Lectures, clinical and practical
	Foreign medical student (Electives)	1-2 weeks	Lectures and clinical
	Pharmacist students	1 week	Lectures and practical
	MLT students	2 weeks	Lectures and practical
	PHLT students	1 month	Lectures and practical
Postgraduate-Diploma/MSc	Child Health	1 week	Lectures
	Community Medicine	1 week	Lectures and practical
	Family Medicine	1 week	Lectures and clinical
	Microbiology	1 week	Lectures and practical
	Sport Medicine	1 week	Lectures and clinical
	Transfusion Medicine	1 week	Lectures
	Venereology	1 year	Lectures, clinical and Practical
Postgraduate-MD	Community Medicine	2 weeks	Lectures and Practical
	Dermatology	3 days	Lectures and clinical
	Medicine	2 weeks	Lectures and clinical
	Microbiology	1 week	Lectures and Practical
	Virology	1 month	Lectures and Practical
	Venereology	1 year	Lectures and clinical and practical

11.3.3 Types of training

- **Pre-service training**

  All categories of healthcare workers of STD clinics should undergo mandatory training within 6 months of enrolment to the STD clinics. It is conducted twice per year.

- **In-service training**

  This is an in-service training programme mainly on counselling for postgraduate trainees in venereology, medical officers and major staff of STD clinics island wide.
  Usually, it is conducted twice per year. Additional in-service training will be based on the upcoming needs of the programe.

- **Refresher training**

  Training is conducted to refresh the knowledge on STI and HIV of STD clinic healthcare workers to improve their attitudes, to minimize the stigma and discrimination towards clients attending to the services. This training will be conducted either in central level or at district STD clinics. It is conducted once per year.

- **Undergraduate training**

  Training includes mainly to the medical students, nursing students, MLT, pharmacist and public health laboratory technicians (PHLT) students.
  The training is conducted depend on the request and based on their curriculum by particular institute.

- **Postgraduate training**

  Postgraduate training is mainly to the postgraduate trainees attached to the Post Graduate Institute of Medicine - Colombo. The doctors of various specialties will be trained at NSACP with different curriculum and different period of time based on their course. E.g.: Post graduate Diploma/Master of Science (MSc) /Doctor of Medicine (MD).

- **International training**

  The international training is organized to the staffs of STD clinic to obtain the experience of managing STIs and HIV in different backgrounds. A marking scheme is used to short list the candidates according to following criteria.

  1. Seniority of the health care worker - One point for each year of service in the Ministry of Health is given.
  2. Each year of working experience in STD clinic carries one mark
  3. He/she should not be in transfer order for next two years. (It should not be applicable to transfers within STD clinics)

11.3.4 Training material and training methods

- **Preservice/In-service/Refresher training**

1. Decide targeted audience and the best venue.
2. Decide optimal number of training days, time slot, length of each training, and to prepare the training schedule/agenda and topics after referring the training manual/curriculum/prospectus.
3. Depend on the training schedule and topics, decide the resource person appropriate to that topic according to the seniority, availability and their interest.
4. Decide the training material/methods and language (English, Sinhala or Tamil) depend on the audience. (PowerPoint, case discussion or role play)
5. Use official method of conveying messages such as fax, letters or emails and confirm their participation as resource persons. However, informal methods such as WhatsApp or, Viber can also be used in an urgent situation.
6. Decide the training location, assess the accessibility by the trainees, comfortability, training facility and supplies on site.
7. Information for nomination and enrolment - prepare a covering letter signed by director, mention date, time and venue and send email/ post a mail to authorized person to get the name list of trainees and their details including preference of meals and accommodation.
8. If trainees are from far away clinics (E.g.: preservice training for major/minor staff) arrange accommodation, food and drink. (Accommodation is depending on the availability of rooms at Health Promotion Bureau and domestic funds).
9. Then invitation letter is sent with duty release letter via mail, post, fax or by hand to all trainees and their authority.
10. On the first day of the training, the registration of the trainees is done at the site or online.
11. Pre-test/ post-test assessment should be done physically or in a google form.(Based on curriculum/ topic/ training manuals)
12. Evaluation forms need to be filled to get the feedback from the audience, physically or in a google form.
13. Data collection form are filled for the statistical purpose, either physically or in a google form.

- **Undergraduate Training**

1. The undergraduates are appointed to the NSACP by the appointment letter from the relevant head of the institution.
2. The training is based on their learning objectives for STI/HIV in their curriculum.
3. The lectures, clinical and practical sessions at the clinic, and in the laboratory will be scheduled according to the objectives and the duration of training.
4. The clinical session is arranged after discussing with each training coordinator after their lecture hours.
    I. Registration at STD Clinic/ Registers - PHNS/PHI
    II. Clinic rooms allocation – STI Care coordinator.
    Students observe the history taking and sample collection by trained doctor
    III. Laboratory observation – Microbiologist

IV. Bleeding room observation – Nursing Officer In charge
V. Injections room observation- Nursing Officer In charge
VI. Pharmacy-Chief pharmacist

5. HIV clinic exposure should be arranged after discussing with HIV care coordinator.
6. Daily attendance should be marked before starting the first lecture.
7. Evaluation is done by giving pretest and posttest questionnaire.
8. The feedback is obtained by using evaluation form.
9. The logbook is signed by the training coordinator once they complete their training with 80% of attendance.
10. Data collection form should be filled for the statistical purpose.

- **Postgraduate training**

1. They are appointed to the Director/NSACP by the relevant authority.
2. Arrange the training according to the objectives and the duration of training mentioned in their prospectus.
3. Schedule their lectures, clinical and practical sessions at clinic to cover up their objectives.
4. Decision to be taken, either lectures with practical session or practical sessions only will vary among different postgraduate training curriculum.
5. Get their feedback about the training programme by using evaluation form.
6. Sign their logbook once they complete their training with 80% of attendance.
7. Data collection form should be filled for the statistical purpose.

- **International Training**

1. Once receive the invitation or e-mail for international training, decide the eligibility of staff category.
2. It should be sent to all coordinators and district clinic consultants with the name of the training, date and time and criteria for selection.
3. Selection should be made according to the seniority, participation of previous training in abroad etc.
4. Develop a marking scheme to select correct candidates.
5. Once the selection made, receive the details of trainees and coordinate the training until the day of training.
6. Once they return to the country, ask them to present in a continued medical education (CME) activity.

11.3.5 Other services given by the training and capacity building unit

1. Training and capacity building of NGO for implementation of HIV prevention activities.
2. Preventive services for general public
   - Conduct awareness/sensitization programmes for STI/HIV prevention
   - Support non-health sector organizations, schools, other youth organizations to conduct awareness/sensitization programmes for STI/HIV prevention
3. Preventive services for key populations
   - Support NGOs to create awareness on STI/HIV prevention and develop linkages with NSACP for screening and management of STI/HIV.
   - Support to create a safer environment.

12 MANAGEMENT OF PHARMACEUTICALS AND SURGICAL ITEMS BY CENTRAL PHARMACY/ NSACP

The central pharmacy of the NSACP, in collaboration with medical supplies division (MSD) of the Ministry of Health and State Pharmaceuticals Corporation (SPC) plays a pivotal role in order to ensure an uninterrupted supply of drugs and other medical items in adequate quantities, to cater services for the clinic attendees of the NSACP and the district STD clinics.

As NSACP provides care services for people with sexually transmitted infections including HIV and sexual health issues, drugs and medical items used in the prevention and treatment of these conditions are managed by the pharmacy of the NSACP. These include, medicines used to manage STIs, antiretroviral drugs, other drugs such as Isoniazid (INAH), cotrimoxazole, atorvastatin, antidepressants used for PLHIV, and also commodities like condoms, lubricants, surgical and non-surgical consumables.

12.1 The annual estimation of drugs, surgical and non-surgical consumables

12.1.1 Institutional annual estimate

- The management cycle of drugs and medical items begins with the preparation of annual estimates, once MSD makes an official announcement, in August each year. This is done through the Pronto system.
- The institutional drug therapeutic committee is responsible for the estimation of the annual requirement of drugs and other medical items. This committee consists of the director NSACP who is the head of the committee and relevant consultants in the programme, chief pharmacist and the pharmacist in charge of the stores
- When developing the estimate, the actual consumption and trends of each item and pipeline orders which are expected are also taken into consideration.
- The estimation of annual requirement of drugs (except antiretroviral drugs) and surgical items is prepared using the average monthly consumption of the previous year usually multiplied by 15 in order to keep an additional buffer stock for 3 months to avoid possible stock out situations.
- After getting the approval from the director the finalised annual estimate will be sent to the MSD in October each year, by the pharmacists in-charge of drugs and surgical stores, along with the laboratory estimate, by online pronto system.

12.1.2 Estimation of items received from GFATM

The institutional drug therapeutic committee headed by the director NSACP will prepare the estimation for the items procured through the GFATM and the approved estimate will be sent to the GFATM for processing.

12.1.3 Liquid N2 and Oxygen

These are directly procured through the Ceylon oxygen limited.

12.2 The procurement process, ordering of drugs and other medical items from the Medical Supply Division (MSD).

12.2.1 The annual national estimate

- At the MSD, all the institutional and regional drug estimates are consolidated to arrive at the annual national estimate.
- The national indents are developed, indicating detailed specifications for each item and the delivery schedules are planned based on storage capacity at MSD for different types of items. These order lists are then forwarded to the SPC by the MSD.

12.2.2 Procurement procedure of the SPC

- The SPC is the sole procurement agent for pharmaceuticals and surgical consumables items required by the government health institutions.
- Worldwide tenders are invited, giving approximately six weeks for suppliers to submit tenders and quotations are deposited.
- Then the quotations are submitted for technical evaluation, they will be directed to the relevant Tender Boards.
- After a tender is awarded, an indent is sent to the supplier, and a contract is signed between the supplier and the SPC. Letters of Credit are opened and items are imported or locally purchased and supplied to the MSD, from where they are distributed to government health institutions.

12.3 Stock management

12.3.1 Ordering of drugs and surgical consumables and non-consumables from the MSD

- The pharmacists in-charge of respective stores of the NSACP, order items from the MSD by online pronto system, and a reference number is generated for the order. After quoting the reference number to stock control unit of MSD, batch allocation of the particular item is carried out. Thereafter items can be collected from MSD stores. Receipt of items are to be acknowledged by online pronto system.
- On receipt of the institution stock, it is verified with the relevant documents, against the quantity, expiry date, batch number and labelling instructions etc.

12.3.2 Storage of institutional stocks of drugs and other medical items

- Proper storage of drugs and other medical items is vital to ensure efficacy, safety, quality, accountability and availability of the item up to their point of use.
- Storage areas should be of sufficient capacity, well-ventilated, well lighted, should be clean and dry and maintained within the manufacturer specified temperature limits.
- Drugs should be stored by sections, according to pharmacological groups and kept under lock and key and in the custody of the designated officer.
- Storage of drugs should be done in a manner to facilitate, first expiry/first out (FEFO) principle, where those items expiring soon should be utilized first.
- Substances presenting special risks such as pressurized gases should be stored in a demarcated area that is subjected to appropriate additional safety, and precautionary measures.
- Validity expired, sub-standard, quality suspect (withheld and or withdrawn) drugs should be stored separately in a demarcated area.
- Cold chain management - Thermolabile pharmaceuticals such as Hepatitis B vaccines, should be stored in refrigerators to maintain the temperatures specified by the manufacturer.

12.3.3 Issuing of drugs, condoms and lubricants to district STD clinics

- From district STD clinics, duly filled requests forms, signed by the consultant/MOIC, for ARV drugs and other medical items are received.
- The approval for the request is granted by the Director/NSACP.
- Requested items are issued after considering balance in hand and on FEFO basis.

12.3.4 Issuing of drugs, condoms, lubricants and surgical consumables to units of the NSACP

- Weekly requirements are entered in the order books and should be approved by consultant/MOIC of the unit.
- The order books should be sent to pharmacy on every Thursday.
- Items are issued on FEFO basis, considering previous consumption pattern and balance in hand.

12.3.5 Issuing of surgical non-consumables and inventory items to units of the NSACP

- Requests with accurate specifications are received by the pharmacy.
- Then items concerned are ordered from MSD and Biomedical Services (BES) along with the director's covering letter.
- Approval of the order request by the Director MSD or BES is granted.
- Items are collected from MSD/BES.
- Once receipt, all items are entered in main inventory book at the pharmacy.
- Then the said item/s are entered in the sub-inventory of the relevant unit (in both pharmacy copy and section copy) and issued from there.

12.3.6 Issuing of drugs to patients in Colombo clinic

- Either manual or electronic prescriptions are received at the pharmacy.
- Then drugs are issued to the patient with necessary instructions on how to use, store the drugs and their possible side effects.
- If there are any concerns about the prescribed products, the pharmacist needs to discuss with the prescriber and clarify the doubts before issuing the drugs.
- Until EIMS online system is fully established, manual registers are also to be maintained.
- Regular update of short expiry, low stocks/surplus items need to be informed to prescribers and remedial actions need to be taken.

12.3.7 Monitoring of consumption, quality and Adverse Drug Reactions (ADR).

Monitoring is an important element to ensure uninterrupted availability of drugs at NSACP and it is carried out by the institutional drug review committee. The committee also monitor the quality of drugs and adverse drug reactions (ADR).

Monitoring of quality and ADRs of drugs

- If a quality defect is confronted it should be communicated to Director/MSD and Director/NMQAL using the given format (available at the central Pharmacy/ NSACP) Quality Assurance of vaccines is done by the Medical Research Institute (MRI) and should be informed if identified.

- All adverse drug reactions encountered should be reported to the ADR monitoring centre of the Pharmacology Department / University of Colombo, in the form provided.

12.3.8 Re-distribution of excess / short-dated stocks of drugs

- Institutions should ensure that all excess/short dated stocks are informed to MSD 6 months before the expiry date for re-distribution.

- The head of the Institution should inform a list of excess / short dated stocks to director MSD for re-distribution.

12.3.9 Disposal of withdrawn, expired and spoilt drugs

Disposal of all medical supplies are done periodically. Pharmacist in charge of the stores need to submit the unserviceable items list to the head of the institution and these are to be reported to MSD quarterly. A board of survey is established by Director/ NSACP and after disposal returns to be submitted to Director/ MSD.

12.3.10 Annual stock verification.

All stocks of medical supplies available in the NSACP, including drugs, surgical equipment and laboratory items should be verified annually. A board of survey appointed by the director general of health services (DGHS) carry out this verification by online pronto system. For consumable items, the physical verification of available stocks is done.

12.4 Management cycle of ARV drugs

Forecasting and quantification of ARV needs of the country are performed under the leadership and coordination of MSD of Ministry of Health, SPC and relevant staff of the National STD AIDS control Programme.

12.4.1 Preparation of ART estimates

Forecasting ARV drug requirements is highly complex, particularly where there are frequent changes in the WHO and national guidelines on preferred drug regimens or ambitious treatment scale-up plans such as ending AIDS. This process is often based on the NSP.

The ART estimate of the country is done using HIV patient data, which is an aggregation of a clinic level data from ART dispensing STD clinics, received at the SIM unit, combined with existing stock-level data and desired levels of in-country buffer stock.

The buffer stock, is the minimum stock maintained in hand to prevent any stock outs due to undue delay in ART delivery or unexpected increase in demand of ARV. Therefore, keeping an adequate buffer stock plays a crucial role in ART estimates.

Due to the long procurement process, the adult and paediatric ART estimate needs to be done one year ahead, based on certain assumptions agreed by the ART procurement committee members.

Once the quantities have been agreed upon, the estimate along with formal order request is sent to the MSD.

From MSD, the ART estimate and the order requests will be forwarded to the government procurement agent which is the SPC. The formal procurement process is commenced with the formal request for tenders from pharmaceutical companies.

12.4.2 The evaluation and selection of suppliers

Once the pharmaceutical companies produce quotations for the specific order, the details are sent to the NSACP for evaluation. The evaluation and selection of suppliers are done based on defined criteria, such as price, performance, compliance with quality standards (e.g. prequalification by the WHO), in-country registration status at the National Medicines Regulatory Authority (NMRA) for the concerned item, shelf life etc. Only pharmaceutical manufacturers who satisfactorily meet the criteria are recommended to process with the purchase order. If the quoted companies do not fulfill the criteria mentioned above, the tender will be recalled.

12.4.3 The order placement and execution

The placement of purchase orders is done by SPC with respective manufacturers. Once the order is placed by SPC, the manufacturer accepts the order, manufacture and pack the drugs according to the tender specifications.

12.4.4 Primary transportation

Transportation of ARVs from manufacturing location to the country is governed by export regulations of the country of origin, import regulations of the recipient country and international trade practice related to transportation of goods.

Drug and quality policies and regulations:

1. Customs clearance: Upon arrival at the destination port, goods need to be cleared through customs to comply with import regulations.

2. Registration: ARV drugs are subject to import control by customs authorities and by the NMRA Sri Lanka, which follow a stringent quality control for batches of drugs purchased for the country. Product registration with NMRA in Sri Lanka is the primary requirement for import.

3. Shelf life: Most countries have minimum shelf-life requirements as part of import requirements in order to prevent an exporting country or supplier from passing-off low shelf life or near-expiry stocks. The typical restrictions on minimum shelf life are expressed as a percentage of overall product shelf life, typically between 75% and 80%.

12.4.5 In-country distribution

The importation process ends when the goods are received at MSD. Then ARVs are delivered to the central pharmacy at the NSACP and in-country distribution to ARVs to other STD clinics is done, based on requests.

12.5 Data management

Both papers based and electronic data management are performed to manage information. Entries in rough entry book is re-entered in detail accountable book. Daily, weekly and monthly data reports can be generated through EIMS once the data is entered into EIMS.

13 HIV/ STI SURVEILLANCE & EPIDEMIOLOGICAL ANALYSIS OF DATA

13.1 Strategy of HIV/STI Surveillance

The strategy for the HIV and STI surveillance is planned under Strategic direction 3 of the National Strategic Plan, Sri Lanka 2018-2022, in which the priority actions that need to be undertaken are as follows;

- Ensure regular HIV sentinel surveillance (HSS) every two years among KPs and strengthen the system, conduct integrated bio- behavioural survey(IBBS) every 5-6 years and coordinate and integrate the two systems
- Prioritize surveillance among MSM with wider coverage by location, by sub-typologies and employ innovative methods for recruitment
- Further strengthen STI surveillance and ensure data is entered electronically and reported regularly
- Strengthen mortality surveillance
- Establish drug resistance surveillance for HIV
- Establish a strong HIV case-based surveillance system
- Integrate the entire HIV case tracking system from screening to viral suppression into the new electronic database that is being developed

For further details refer National Strategic Plan, Sri Lanka 2018-202.

13.2 Epidemiology unit

This programme area is responsible for the STI/HIV surveillance to monitor trends and magnitude of the disease conditions under the purview of NSACP. In addition, annual HIV burden estimation and projection, conducting special surveys related to HIV has been entrusted to the Epidemiology and Surveillance programme area.

13.2.1 Duties and responsibilities of the Epidemiology unit, NSACP

- To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, protocols and standard operational procedures (SOP) for implementation of STD, HIV surveillance in Sri Lanka
- To collaborate with senior management team (SMT) and other relevant authorities in decision making and carrying out of STD, HIV surveillance
- To work with other NSACP units to develop comprehensive and coordinated plans for implementation of the National Strategic Plan and other relevant activities.
- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.
- To maintain the STD, HIV surveillance activities in the NSACP in quality assured manner and development of timely reporting for action

- To coordinate with and support institutions within and outside the Ministry of Health in the expansion of appropriate, high-quality STD, HIV surveillance
- Training and capacity building of individuals/institutions in the public, private and civil society organizations on STD, HIV surveillance, when and where appropriate, in partnership with relevant programme areas in the NSACP
- To supervise and monitor the quality of STD, HIV surveillance in the programme.
- Provision of technical support, assistance and guidance to provinces, districts and other organizations and agencies in improving quality of STD, HIV surveillance.
- Need assessment and provision of technical assistance for supply and procurement of necessary items or services for STD, HIV surveillance.

13.3 Services provided through epidemiology unit

The epidemiology unit carryout STI/HIV surveillance through the following.

- HIV surveillance
- Behavioural surveillance/ Integrated Bio Behavioural Surveillance(IBBS)
- People living with HIV (HIV burden) estimation and projections
- Special surveys
- STI surveillance (carried out by the SIM unit/NSACP)

13.3.1 Survey and Surveillance

Surveillance in epidemiology is the process of systematic collection, and analysis of data with prompt dissemination to those who need to know, for relevant action to be taken (WHO, 2001). The main purpose of this is to simply apply gathered data for the implementation and evaluation of public health programs. In contrast, survey in epidemiology refers to the process which is undertaken to find the root cause of a problem.

(Protocol for the Assessment of National Communicable Disease Surveillance and Response Systems WHO/CDS/CSR/ISR/2001.2)

13.3.2 HIV Surveillance:

Sri Lanka has a long history of collecting STI and HIV surveillance data. Major components of the HIV surveillance system include HIV sentinel surveillance, HIV case reporting, IBBS, behavioural surveillance surveys (BSS), and KP population size estimation. Several other routine data sources, including HIV and STI testing and case reporting data, pregnant mother, blood donor and newly diagnosed TB patient HIV, STI screening also supplement the surveillance system.

Objectives of HIV surveillance

Sri Lanka is experiencing a unique epidemic pattern. HIV and STI surveillance encompass the collation and analysis of data and that data to be used to:

I. Characterize the epidemic in terms of modes of HIV transmission
II. Detect geographic areas where HIV may be emerging
III. Provide data to prioritize the prevention response for different populations in different geographic locations
IV. Track the trajectory of the epidemic among different populations in priority locations
V. Produce data for estimating the number of people living with HIV
VI. Provide data for M&E indicators

HIV surveillance components in Sri Lanka

1. Routine monitoring

- By offering HIV screening in identified situations (as described in HIV testing chapter). Most HIV screening is done in STD clinics, private hospitals and labs, or at blood banks.
- Basic demographic information and risk profile data (e.g., sex worker, client of sex worker, men who have sex with men, drug user, prisoner) to be collected form all STD clinic patients who undergo HIV screening at STD clinics. The information is recorded in the STD Patient Form.

2. HIV case reporting

- At the moment of writing this SOP, all screening positive HIV samples from government as well as privet sector undergo confirmatory testing by Western Blot at the National Reference laboratory (NRL) in Colombo
- When requesting HIV confirmatory test, the samples are sent to NRL along with H1214 form which contains basic demographic and risk profile data. In addition, EIMS system also collect same data at the time of specimen collection for the confirmatory test. For patients who are confirmed positive, an attempt to fill in missing demographic, risk profile or mode of transmission information in the H1214 form is made by the epidemiology unit of NSACP by communicating with referring providers.
- Blood bank data for HIV, Hepatitis B/C and syphilis are available for all units tested (currently not possible to disaggregate by district).

3. Size estimation of key populations at higher risk

- Mapping is the primary method used for size estimation of key populations in Sri Lanka
- In 2018 round, Multiplier method using unique object was carried out and coupled with mapping to estimate population sizes.
- Female sex workers (FSW), men who have sex with men (MSM), beach boys, transgender women and intra venous drug users sizes were estimated.

4. HIV sentinel surveillance

- Main objective of the HIV sentinel surveillance (HSS) is to measure the seroprevalence of HIV in selected populations. It is planned to be done biannually among STD clinic attendees and female sex workers.
    - HIV surveillance among ANC mothers and TB patients are not included because of routine systematic screening.
    - Sample collecting centres are the island wide STD clinics who are requested to adhere to the HSS protocol, during survey period which will be informed by the epidemiology unit.
- The number of sentinel sites (provinces) that have HSS for FSWs has expanded over time to include all provinces. MSMs are enrolled in 4 sentinel sites and IVDUs in 2 sentinel sites. Last HSS was conducted in 2019.
- HSS protocol development and staff training prior to the survey will be accomplished in order to assure uniform survey implementation. Survey implementation is supervised through the supervisory site visits.

5. Integrated bio-behavioural survey (IBBS Survey)

IBBS survey track seroprevalence and risk behaviours at the same time in order to correlate both attributes. Surveillance strategy specifies to conduct IBBS once in 4 years. Last IBBS survey was conducted in 2018.

6. AIDS deaths Surveillance

Reporting units collect and send AIDS death information in a special form to the Epidemiology unit. Objective of AIDS death surveillance is to examine and take corrective measures from the HIV diagnosis till the death.

14 STRATEGIC INFROMATION MANAGEMENT

14.1 Strategy for information management

Strategic information management is a key component for the National STD/AIDS Control Programme as it provides the guidance to the national response for STI and HIV control and prevention.

The Strategic Information Management (SIM) Unit is the centralized location where patient related data collected from NSACP central clinic and district STD clinics reach. The SIM unit compiles all quantitative and qualitative data quarterly through data collection templates, the "quarterly returns" and publishes them in the Annual report.

According to the national strategic plan 2018-2022, the priority actions that need to be undertaken by SIM unit include:

- Provide regular feedback from the SIM Unit to ART centres regarding left to follow up and any other relevant findings after analysing quarterly ART returns and Excel databases
- Analyse programme data on regular basis
- Fast track the electronic system for data management through an integrated web-based data system
- Enhance capacity of NSACP and facilitate staff to conduct regular analysis of existing data

14.2 Strategic information management unit of NSACP

This unit is responsible for the overall monitoring and evaluation of sexual health related programmes, projects and activities in close liaison with all development sectors, partners and bi-lateral and multi-lateral donors in Sri Lanka. The unit functions across following subcomponents, relevant to the control of HIV and STIs.

Sub-Components

- Development of monitoring and evaluation frameworks
- Surveillance and research
- Handling of cross-cutting areas
- Maintenance of local area network, PIMS and the website

14.3 Duties and responsibilities of strategic information management unit-NSACP

- To work within and support the relevant NAC technical working group to develop and regularly up-date national policies, strategies, guidelines, protocols and frameworks for implementation of strategic information management services in Sri Lanka
- To collaborate with SMT and other relevant authorities in decision making and carrying out of strategic information management services
- To ensure implementation, appropriate extension and be accountable for M&E frameworks, collation, collection, analysis, interpretation and dissemination of strategic information and reports as per national level protocols.
- To work with other NSACP units to develop comprehensive and coordinated plans for implementation of the National Strategic Plan and other relevant activities.

- To coordinate and work in partnership with public, private, civil society organizations, and development partners at local, national and international level.
- To maintain the strategic information management services of the National STD/AIDS control Programme in quality assured manner
- To coordinate with and support institutions within and outside the Ministry of Health in the expansion of appropriate, high quality strategic information management services
- Training and capacity building of individuals/institutions in the public, private and civil society organizations on strategic information management, in partnership with relevant programme areas in the NSACP
- To supervise and monitor the quality of strategic information management services in the programme.
- Provision of technical support, assistance and guidance to provinces, districts and other organizations and agencies in improving quality, supply and access to strategic information services
- Need assessment and provision of technical assistance for supply and procurement of necessary items or services for strategic information management services

14.4 Provision of services through Strategic Information Management unit – NSACP

14.4.1 Data Management

Data management is a key aspect under the SIM unit, which helps to automate and simplify operations of the NSACP. EIMS and PIMS are rationalized data management mechanisms used to accommodate new initiatives leading to paperless patient data. With the current pandemic situation in the country and way forward in the coming years, it is better to collect data via EIMS and PIMS as well as using google sheets. Assuring the security of patient information and ensuring uninterrupted computer systems for clinic level end users are challenges faced by the SIM unit in data management.

14.4.2 Data analysis, interpretation, and dissemination

The data from the centres are captured using standardised formats every quarter (quarterly returns) which provide comprehensive information.

There are four types of quarterly returns through which data reaches to the SIM unit.

1. **STD Quarterly return** – Data collected from the STD clinic will be collected to 15 separate tables and will be sent to the SIM unit quarterly.
2. **ART Quarterly return** – Data collected from ART centres on people who are on antiretroviral therapy are collected and analysed. This data is compiled from HIV/STD clinic staff. This return consists of seven separate tables and will be sent to the SIM unit quarterly.
3. **Quarterly Cross-sectional data base** - From all ART centres PLHIV cross sectional data base is maintained in excel format. It should be updated and sent to the SIM unit quarterly basis.
4. **KP Quarterly return** – Data collected through the Global Fund funded projects and KP units in STD clinics.

Above returns should reach SIM unit by the 20th of the following month of the ending quarter and will be cleaned, cross checked and analysed by relevant subject staff under the guidance of the Coordinator of the SIM unit.
Other than the above four quarterly returns, data traced under the newly developed web platform know4sure.lk (who have taken up the risk assessment) are added when compilation of data.
Interpretation and dissemination of collected national and district level data are produced to various international agencies such as Global fund, UNAIDS, Global Aids Monitoring and for HIV estimations. The NSACP annual report is a key dissemination point for the above collected data which reflect the country's HIV/STI data and present status.

14.4.3 Evaluation

Successful evaluations rely on the collection of data and the use of reliable analysis methods. The quarterly returns help to evaluate and analyse the patient that aligns with stakeholder expectations, project timelines, and program objectives.

14.5 Key indicators (national level)

Key indicators segregated to each indicator type are as follows.

1. Impact/Outcome indicator

- HIV 1 : Percentage of people who inject drugs who are living with HIV
- HIV 2 : Percentage of sex workers who are living with HIV
- HIV 3 : Percentage of transgender people who are living with HIV
- HIV 4 : Percentage of men who have sex with men who are living with HIV
- HIV 5 : Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy
- EMTCT 1: MTCT rate of HIV
- EMTCT 2: Annual rate of new paediatric HIV infections per 100,000 live births
- EMTCT 3: Annual rate of congenital syphilis per 100,000 live births

2.Coverage Indicators

- KP1 : Percentage of men who have sex with men reached with HIV prevention programs - defined the package of services
- KP2 : Percentage of men who have sex with men that have received HIV test during the reporting period and know their results
- KP3 : Percentage of transgender people reached with HIV prevention programs - defined package of services
- KP4 : Percentage of transgender people that have received an HIV test during the reporting period and know their results
- KP5 : Percentage of sex workers reached with HIV prevention programs - defined the package of services
- KP6 : Percentage of sex workers that have received an HIV test during the reporting period and know their results
- KP7 : Percentage of people who inject drugs reached with HIV prevention programs - defined the package of services
- KP8 : Percentage of people who inject drugs that have received an HIV test during the reporting period and know their results
- KP9 : Percentage of other vulnerable populations reached with HIV prevention programs - defined the package of services
- KP10 : Percentage of other vulnerable populations that have received an HIV test

during the reporting period and know their results

- KP11 : Percentage of people in prisons and other closed settings that have received an HIV test during the reporting period and know their results
- TCS1 : Percentage of people living with HIV currently receiving antiretroviral therapy
- TCS-2 : Percentage of people living with HIV that initiated ART with a CD4 count of < 200 cells/mm^3
- TCS-3 : Percentage of people living with HIV and on ART, who have a suppressed viral load at 12 months (< 1000 copies/ml)
- EIMS-1 : Percentage coverage of HIV testing among pregnant women
- EIMS-2 : Percentage coverage of syphilis testing among pregnant women
- EIMS-3 : Percentage coverage of ART among HIV positive pregnant women
- EIMS-4 : Percentage coverage of syphilis treatment among syphilis positive pregnant women
- EIMS-5 : Percentage antenatal care coverage

These indicators are captured using the above mentioned four quarterly returns which are then reported and disseminated to various relevant parties.

14.6 EIMS/PIMS

14.6.1 Electronic Information Management System (EIMS)

The National STD/AIDS control programme established an EIMS with the financial support of the Global Fund with the intention of improving clinical care of clients who attend seeking care for STD and HIV related services. The development of the system commenced in 2017 and is coordinated by the SIM unit of the NSACP. By early 2021, many clinics are using EIMS for management of client information. EIMS data is saved in a local server as well as in a cloud server and is said to be a system with many modules to track all patient related information.

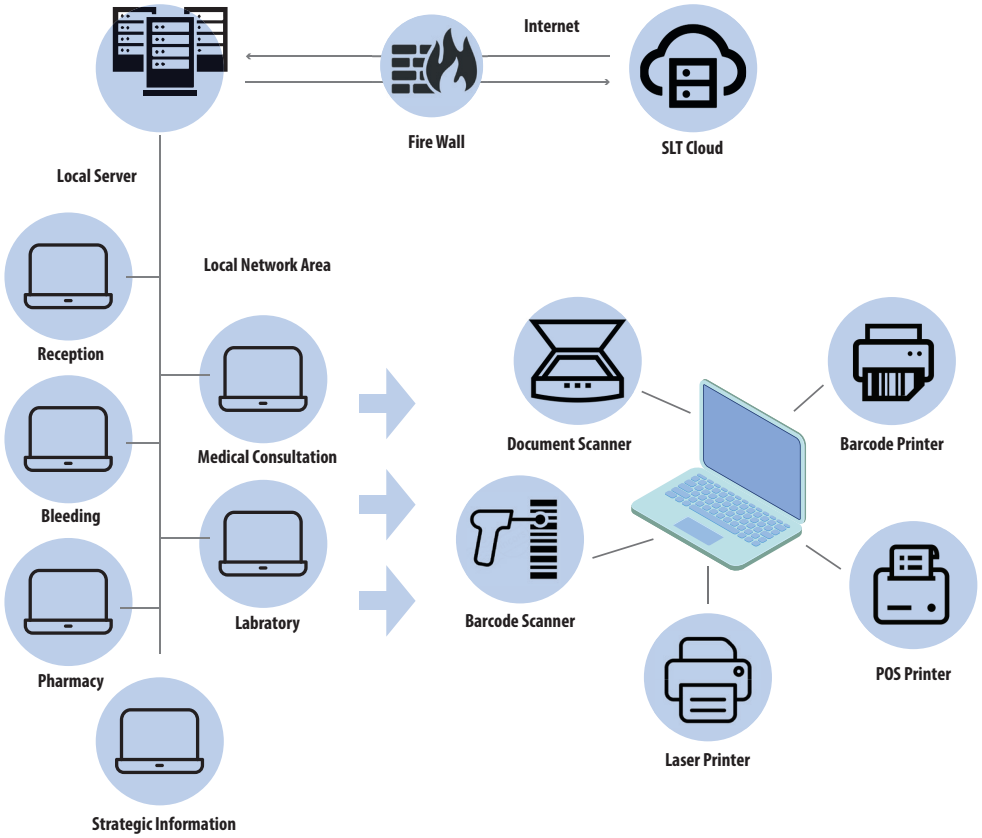


Figure 15.1: EIMS Diagram of equipment and modules

Domain name is eims.aidscontrol.health.gov.lk to access the system.

EIMS comprises of several modules from patient-registration to report-generation which requires a wide variety of users of the system ranging from venereologists, medical officers, nursing officers, public health staff, laboratory staff, and pharmacy staff. During 2019, NSACP developed an E-Learning System (ELS) for the EIMS to ensure sustainability of training on EIMS.

This ELS is accessible through http://eims.nsacp.headstartcloud.com/During registration all clinic patients are issued a unique clinic number called PHN number in EIMS. PHN number is used to identify the patient's electronic records in EIMS in subsequent visits. EIMS provide categorization of patients based on the services that are provided to patients I the clinic. Patients' records can be kept as PDF in EIMS. Unless there is a very special reason, it is not necessary to keep the hard copies of clinic records. Once the EIMS is fully established the necessary data could be generated from EIMS without maintaining separate hard copy registers.

14.6.2 Prevention Information Management System (PIMS)

The purpose of the PIMS software is to provide an electronic system for monitoring of KP related HIV prevention programmes conducted by the central and district STD clinics. It is currently under developmental stage. Once the system is fully established, it will replace the paper-based monitoring and evaluation of key vulnerable population programme, and provide efficient, accurate real time data monitoring and reporting.

Upon registering in EIMS and PIMS, a UIC will be generated for each key population member, which help to track of the KP member across variety of continuum of care services as a unique individual.

14.7 Research

To have a better understanding about HIV and STI epidemics and its dynamics in addition to routinely collected data, it is important to conduct special research studies. Such studies will provide in depth information on areas where there is knowledge gap.
The following are some suggestions to improve the number and the quality of research by the NSACP and district STD Clinics.

- Create an environment that supports research involving relevant research organisations and universities and revitalise the research sub-committee of National AIDS Committee.
- Plan special studies and surveys to answer key questions.
- Engage KPs, and CBOs in research studies and surveys when appropriate.

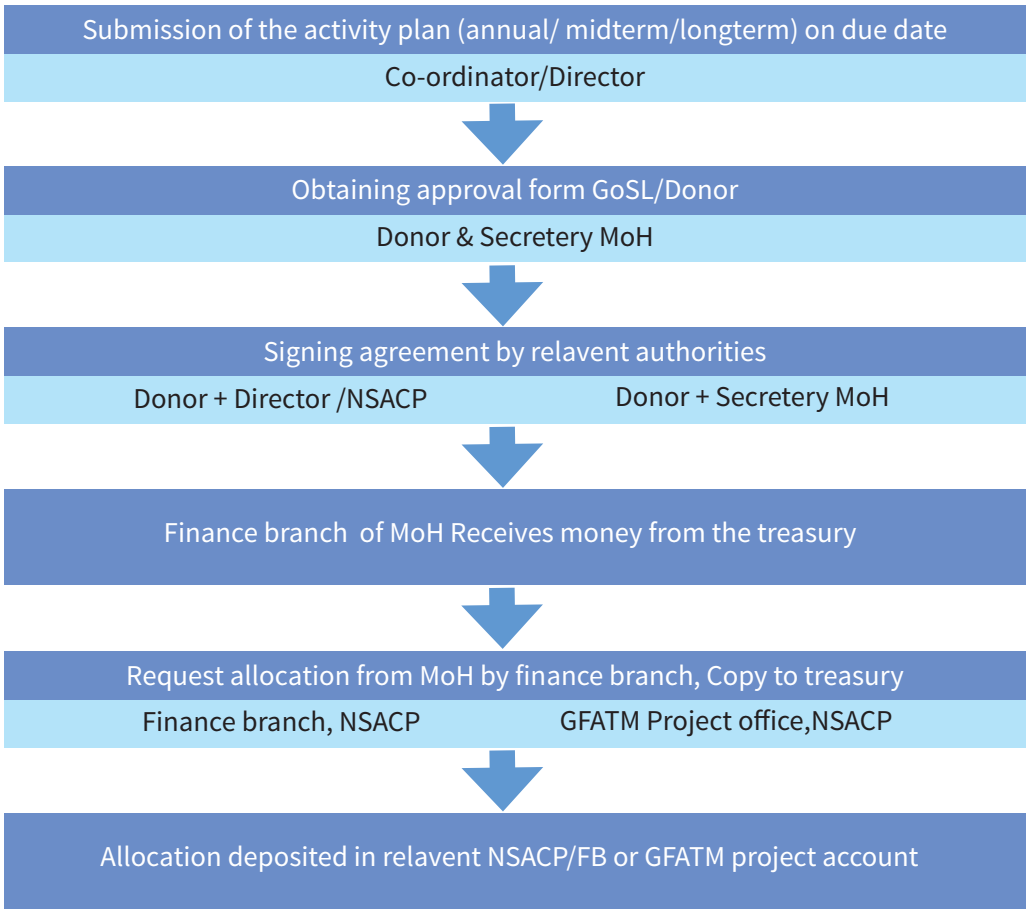
15 FINANCIAL MANAGEMENT

The National STD/AIDS Control Programme is a government organization, under Ministry of Health, Sri Lanka, which receives allocations from the following sources for the annual activity plan:

1. Government of Sri Lanka (GoSL)
2. International donors (GFATM, WHO, UNICEF, UNFPA)
3. Local doners

15.1 Process of Financial Management

15.1.1 Request and obtain allocations



15.2 Implementation

15.2.1 Procurement of goods and services

1. Goods and services need to be procured directly according to procurement guideline 2006, work and goods issued by the ministry of finance and in accordance to financial regulations.
2. Proposals should be written according to the specific formats provided by the specific donor agencies for foreign funded activities. For GoSL funds, no proposals are required for the activities included in the annual action plan of the given year. However, even for GoSL funds if an activity is not in the annual action plan, a detailed proposal needs to be written and approval needs to be granted from the authorizing officer before utilizing funds.
3. When submitting the proposal to get an approval from the authorizing officer, it should be submitted with the signature of relevant coordinator and the Director.
4. The officer/coordinator should follow up the proposal approval process until the approval is granted.
5. The officer/coordinator should handover a purchase request to the procurement officer with the Director's approval for procurement activities.
6. Regional Procurement Committee (RPC) should consist of Director, Accountant and Ministry officer appointed by the Secretary of MoH. RPC limit is Rs. 25 million.
7. A Technical Evaluation Committee (TEC) should consist of a technical expert/s, administrative expert and other relevant officers. If there is a major financial evaluation, finance expert should be included in the TEC.
8. TEC prepares the specifications and procurement officer make the bidding documents for procurement.
9. Once the procurement method is selected, the bidders are invited to bid for the relevant goods or services as described in the Procurement Guideline 2006.
10. Director of NSACP appoints a bid opening committee and open the quotations/ tenders in front of the bid opening committee and record details of bids in the bid opening minutes.
11. All the bids that are received are handed over to the TEC and the TEC provide recommendations which are then forwarded to the RPC.
12. Then RPC take the decision on procurement considering the recommendations of the TEC and any other relevant information.
13. After procurement process is completed, the goods are ordered and once the order is received the goods are handed over to the stores and entered in the inventory registers. Payment vouchers are submitted to the finance unit for payment.

15.2.2 Approval limits of the GOSL programmes for the year 2021

- Director up to Rs. 100,000
- DDG (PHS1) up to Rs. 200,000
- Additional Secretary (Public Health) up to Rs. 500,000
- Secretary Health over Rs. 500,000

15.2.3 Approved procurement Limits

- For up to Rs. 5,000, quotations are not required.
- Up to Rs. 50,000, quotations need to be called from minimum of five suppliers. The director can give approval for the suitable bidder without RPC. When procuring technical items (e.g. laboratory equipment) recommendation of TEC is required.
- For procurements above Rs. 50,000, quotations need to be called from minimum of five suppliers and selection of supplier is done by TEC & RPC.
- Under shopping method goods could be purchased up to Rs.15, 000.00 per day after obtaining quotations with the approval of the Director. This method is limited to maximum of Rs.60,000.00 per month for the institute.
- If the amount exceeds Rs.1, 000,000 need to prepare bidding documents and advertise in three newspapers in three languages and in government official websites.

15.3 Conducting Programmes

1. The programmes funded by foreign funding agencies should be done in accordance with General Circular No. 1822 and dated 15.03.1994 and 1822/1 and dated 05.01.2015. In addition, government financial regulations and circulars issued by the government time to time will also apply.
2. After the approval is taken as described above, the coordinator can request for advance funds, 4 days before conducting the programme.
3. Maximum of Rs.100, 000.00 can be given to an officer as an advance in accordance to 22.1 of the Delegation of Financial Authority – year 2021 issued by the Secretary of MoH.
4. If more than Rs.100, 000.00 is required the coordinator can request Rs. 100,000.00 and balance can be request under other officer/ officers' names.
5. Responsibility of the settlement of advance is with the advance requesting officer (Coordinator). Advance should be settled within 10 days after the programme or work completed.

15.3.1 Advance Request Procedure

Advance for programmes

1. Coordinator of the programme must submit General 35 voucher to the Director for approval of the advance payment with the copies of the approved proposal and budget.
2. After approval has been given by the Director, it should be submitted to the finance branch four (04) days before the programme for payment.
3. Finance division will release the money two days before implementing the programme.

Advance for any other work

1. An officer should submit a letter to the Director explaining the requirement of the advance with the budget to get the approval.
2. After getting the approval, General 35 voucher is prepared and the approval letter and other relevant documents need to be attached and send to get the approval for the payment.
3. Then approved General 35 voucher is submitted to the finance branch for payment.
4. After obtaining cash from the bank finance branch inform the relevant officer/ Coordinator.

Settlement of Advance

1. Soon after completion of the relevant work, the balance money needs to be handed over if any, to the finance branch with a filled pay in voucher. Then finance branch issue an official receipt confirming the receipt of the money.
2. Then settling the money, a voucher should be submitted to the Director to get approval with following documents.
    a. Expenditure statement mentioning the budgeted and actual expenditure for settlement of programme advances.
    b. Relevant bills and documents and TEC & RPC decisions to confirm the expenditure. (With director's approval whenever necessary)
    c. Other documents such as quotations, quotation calling letters.
    d. Official receipt of the balance money deposited.
    e. If there was an additional cost incurred should get Director's approval for reimbursement.
3. After approval has been given by the Director, settlement voucher is submitted to the finance branch.

Petty cash payments

1. Petty cash is handled by administrative branch of the office. Small expenses can be incurred from the petty cash up to maximum of Rs. 5,000.00 per bill.
2. Any expense can be paid from petty cash except voucher payments. Overtime, travelling and other expenses requests from the voucher also could not be paid from the petty cash.

Procedure of petty cash payments

1. If any officer needs to buy an item below Rs. 5,000.00 from the petty cash, a letter should be submitted explaining the requirement and the approval need to be taken from the director. After approval has been given the document need to be submitted to the petty cash handling officer at admin branch. Then the petty cash handling officer purchase and supply the item.
2. If any officer incurred expense for official matter, written approval needs to be taken from the Director and it should be submitted to petty cash handling officer for reimbursement.

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