SRI LANKA

SKPA-2 Baseline Assessment Report

March 2023

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AFAO	Australian Federation of AIDS Organisations
APCOM	Asia Pacific Coalition on Male Sexual Health
ART	Antiretroviral Therapy
CEDAW	The Committee for the Elimination of All Forms of Discrimination Against Women
CLM	Community-Led Monitoring
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DIC	Drop-in Center
EMIS	The Electronic Management Information System
FSW	Female Sex Workers
GDP	Gross Domestic Product
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GoSL	Government of Sri Lanka
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
IPPF	International Planned Parenthood Federation
KP	Key Populations
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MSM	Men who have sex with men
M&E	Monitoring and Evaluation
NSACP	The National STD/AIDS Control Program
NGOS	Non-governmental organizations
N/A	Not Applicable
PIMS	The Prevention Information Management System
PLHIV	People Living with HIV
PrEP	Pre-exposure Prophylaxis
PWID	People who inject drugs
SKPA	Sustainability of HIV Services for Key Populations in South-East Asia
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
S&D	Stigma and Discrimination
TB	Tuberculosis
TG	Transgender People
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
U=U	Undetectable=Untransmittable
WHO	World Health Organization

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EXECUTIVE SUMMARY

Sustainability of HIV Services for Key Populations in South-East Asia (SKPA)-2 is a three-year (1 July 2022 to 30 June 2025) multi-country program funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). The program aims to improve the sustainability of evidence-informed, prioritized HIV services for key populations in Bhutan, Mongolia, the Philippines and Sri Lanka. There are four program objectives:

1. Accelerate financial sustainability
2. Improve strategic information availability and use
3. Promote programmatic sustainability
4. Remove human rights- and gender-related barriers to services

Between July and December 2022, SKPA-2 conducted a rapid baseline assessment in each of the four countries, to better understand the financial landscape, strategic information needs, policy and regulatory barriers, human rights and gender situation and country readiness for the sustainability of services for key populations. The assessments included a desk review and key informant interviews with government, civil society and key population stakeholders.

The following summarizes key findings for each of the SKPA-2 objectives and key issues and recommendations (in bold) from the baseline assessment in Sri Lanka. Detailed findings, issues and recommendations are included in the main report.

Key findings

Objective 1: **Accelerate financial sustainability**

- In Sri Lanka, 70% of the National STD/AIDS Control Program (NSACP) budget is provided by external donors. The Global Fund provides all financing for HIV self-testing and PrEP, outreach in national grant districts, and virtual interventions to create demand for those services. The current economic crisis and future transition from Global Fund support have serious implications for the financial sustainability of HIV services for key populations.
- There are no laws or policies governing social contracting but national procurement guidelines permit direct contracting from community-based organizations for goods, services and consultancies. The government is already engaged in social contracting of civil society organizations for prevention outreach and testing activities financed by the Global Fund.
- There are concerns about whether government mechanisms and processes will ensure that adequate domestic resources are allocated for civil society organizations to sustain the HIV response for key populations. Lessons could be learned from other countries with experience of social contracting of HIV services, including about approaches to costing of service delivery and to management of contracting of civil society organizations.
- Support for civil society organizations to secure funding from new sources and develop business enterprises will be critical to reduce dependence on government and the Global Fund

and ensure they remain viable. Capacity building may be required for smaller organizations to enable them to comply with procurement requirements.

Objective 2: Improve strategic information availability and use

- HIV surveillance shows that Sri Lanka has a low-level epidemic concentrated among key populations in Colombo. The national HIV epidemiology dataset is comprehensive, with HIV prevalence estimates, population size estimates and data on risk behaviors available for all key population groups. However, prevalence estimates for key populations are not up to date and there are gaps in HIV cascade data for key populations.
- Service coverage data are available but there are key gaps. For example, there are no program data on PrEP or HIV self-testing and there is no recent data on on the extent to which people avoid seeking health care due to stigma and discrimination.
- Available data show that coverage with HIV prevention interventions is low for key populations, highlighting the need for more specific data, for example, local population size estimates, to inform targeting of interventions.
- There is scope to strengthen the comprehensiveness, analysis and usefulness of information systems including through integrating community data with the facility data captured by the Electronic Management Information System (EMIS), adapting data collection tools used in outreach settings to collect data on linkage to care as well as data on HIV prevention and testing, and using the Unique Identifier Code system in program monitoring.
- There is demand for a system that allows key populations to provide feedback on the quality of HIV services, but there are concerns about the NSACP feedback system and there is currently no common understanding of, or coherent approach to, community-led monitoring in Sri Lanka.

Objective 3: Promote programmatic sustainability

- The 2019 National HIV Testing Guidelines 2019 include innovative testing approaches such as lay provider testing, HIV self-testing, community-based testing, and social network-based testing approaches. However, the current approach to confirmatory testing is a barrier to more widespread adoption of rapid testing. HIV self-testing shows promise, but is only available in Global Fund-supported districts. Awareness of self-testing is low in other districts.
- The foundations are in place for scale up of PrEP, but additional key steps are required including expanding eligibility to female sex workers increasing awareness and demand among key populations and providing training for healthcare providers.
- Physical and virtual outreach services, which are essential to increase coverage, need to be strengthened. Key population organizations have insufficient outreach workers, and many outreach workers are inadequately trained. Some organizations are using virtual interventions to compensate for limited physical outreach coverage. The main focus of outreach work is increasing HIV testing and less attention is given to follow up.
- Shortages of commodities due to the economic crisis in Sri Lanka are undermining delivery of essential HIV services. Shortages are

restricting access to resupply of ART and to PrEP medications. There are also limited supplies of self-test kits, although anticipated government approval for import of self-test kits and for kits to be made available through retail pharmacies is expected to help address this.

Objective 4: Remove human rights- and gender-related barriers to services

- Sri Lanka has measures in place that, in principle, protect the rights of key populations and people living with HIV. While sex work is not criminalized, same-sex relations and drug use are, and punishments are harsh. In addition, existing laws are commonly used by the police to harass and arrest sex workers, transgender people and people who use drugs. There are no specific laws related to discrimination or violence against key populations or people living with HIV, or to guarantee their rights or protect their access to services.
- Stigma and discrimination towards key populations and people living with HIV in wider society and in healthcare settings is a significant barrier to accessing health services. Informants report poor attitudes and ill treatment by health providers, denial of services, and practices that threaten confidentiality. Key populations and people living with HIV also face stigma and discrimination in the workplace and difficulties in securing employment. Women with HIV face additional gender-related stigma, and economic dependence on male partners limits their access to information and services. Gender-based violence is pervasive in Sri Lanka.
- Although the Human Rights Commission of Sri Lanka is mandated to investigate complaints and the Legal Aid Commission can provide legal aid to redress complaints, these mechanisms do not function optimally and are not user friendly. Although some health facilities have introduced complaints systems these are reported to be ineffective and inefficient. Outside health services, there appear to be few systems to register complaints and sex workers highlight lack of police responsiveness when they report crimes against them.
- More than half (54%) of all stakeholders surveyed, and 75% of key population respondents, in the sustainability pulse check survey believe key populations are not well represented in planning and decision-making forums.

Key issues and recommendations

The need for a sustainable financing model for priority HIV services and a sustainable supply chain for key drugs and commodities – Increased domestic financing in the medium- to long-term, social contracting and alternative resource mobilization strategies for civil society organizations are all required to ensure sustainability of HIV service delivery for key populations in light of the expected decrease in external funding. Current shortages of ART, PrEP medications, condoms and other critical commodities pose a threat to HIV prevention and treatment services. Shortages, combined with other factors, such as the high cost of baseline liver or kidney function tests, present barriers to accessing services that could undermine progress towards national targets.

- Strengthen the social contracting system already being used by the NSACP through formalizing processes and systems, identifying what services will be covered and at what cost, and how contracting will be managed.
- Provide support to build the capacity of civil society organizations to meet the conditions required for accreditation and eligibility to deliver contracted services, including the capacity to manage funds, deliver quality services and collect quality data.
- Explore additional funding opportunities for civil society organizations, including from public and private sector donors and through income-generating initiatives.
- Assess and strengthen procurement and supply chain management systems for ART, PrEP and other critical commodities and reagents.

The need to address information system weaknesses and data gaps – HIV surveillance data is outdated, there are gaps in cascade data for key populations, data are insufficiently granular to guide the HIV response at the local level, and information systems are not adequately monitoring key population progress across the cascade. Sri Lanka is planning another round of HIV prevalence and risk behaviour surveillance among key populations in 2023 and this will be critical to determine epidemic trends and to address data gaps.

- Use the 2023 surveillance round to address gaps in data for cascade indicators for each key population group and to generate updated risk profiles and coverage and size estimates.
- Strengthen information systems to better monitor key population progress across the cascade, including through expanded collection of linkage and follow up data by civil society organizations and integrating community and outreach data with facility data.

The need to scale up innovative interventions – Although Sri Lanka has made good progress in implementing innovative HIV testing approaches such as self-testing and in expanding access to PrEP for men who have sex with men, a number of regulatory and programmatic issues need to be addressed – actions required include advocacy, demand creation, developing accurate estimations and targets – before these services can be scaled up to reach all who need them.

- Scale up access to HIV testing, including through expanding the role of lay counsellors and expanding access to HIV self-testing; the latter requires inclusion of self-test kits in the national procurement system and consideration of service delivery models involving distribution through the private sector.
- Scale up equitable access to PrEP, with access expanded to include female sex workers and transgender women; shortages of PrEP medications need to be addressed and, as with self-testing kits, consideration should be given to service delivery models that involve the private sector.
- Develop and implement training and standard operating procedures for healthcare providers.

The need to ensure meaningful engagement of civil society organizations and key populations in national HIV program decision making – Existing engagement needs to be strengthened to enable civil society organizations to participate effectively in planning and budgeting of HIV services for key populations and people living with HIV, so that their experience informs planning and their comparative advantage is used in service delivery. If well designed and properly resourced, community-led monitoring could also provide opportunities to improve HIV services in Sri Lanka.

- The national HIV program should review its engagement with civil society organizations, including taking steps to engage key population networks and organizations, identifying opportunities for involvement, for example in the annual budget preparation process, and building capacity for participation.
- Take steps to implement community-led monitoring, including defining the scope, finalising tools and developing an action plan.

The need to address human rights- and gender-related barriers to accessing HIV services – Key issues include criminalization of the LGBTQI community and people who use or inject drugs, use of the law to harass and arrest key populations, gaps in legal protections for key populations and people living with HIV, stigma and discrimination in society, healthcare settings and the workplace, gender-specific factors that increase the vulnerability of women, and lack of access to adequate mechanisms to seek redress.

- Support civil society organizations and key population-led organizations to advocate for changes in laws and policies that increase vulnerability and adversely affect access to HIV services.
- Implement measures to build legal literacy among key populations and people living with HIV and to provide access to legal support and establish safe and effective mechanisms for reporting and redress for incidents of discrimination, rights violations, and violence.
- Take steps to eliminate stigma and discrimination in healthcare settings, including through anti-stigma and anti-discrimination training for healthcare providers in pre-service and in-service training, developing guidance and protocols for facilities, and establishing an effective and accountable complaints mechanism that is integrated into the national health system.
- Develop and implement anti-discrimination training for the police.

1. Introduction and country context

SK PA·2

BASELINE ASSESSMENT OBJECTIVES AND METHODOLOGY

At the start of the program cycle in Quarter 1 and 2 of Year 1 (July to December 2022), SKPA-2 commissioned a team of independent regional and national consultants to conduct a rapid baseline assessment in each of the four countries, to understand the extent to which these countries are able and ready to provide domestic financial support for HIV service delivery for key populations. The assessment was designed to help host country governments and partners, SKPA-2 implementers and the SKPA-2 Regional Steering Committee better understand the financial landscape, strategic information needs, operational policy and regulatory barriers, and the human rights and gender situation. The assessment also examined the extent to which each country is prepared for the financial sustainability of services for key populations.

The specific objectives of the baseline assessment were to:

1. Establish regional and country-specific baselines against which progress can be measured (during an end-of-program evaluation in Year 3) with respect to increased domestic financing of programs and services for key populations.
2. Assist countries in planning for and implementing comprehensive, sustainable, rights-based policies, programs and services for key populations.
3. Fine tune the SKPA-2 Theory of Change and develop more nuanced, country-specific pathways to sustainability.
4. Examine the extent to which key populations and people living with HIV are meaningfully engaged in their country's national HIV responses.
5. Identity opportunities and approaches where political, bureaucratic and community interests most closely align and can be mobilized through the SKPA-2 program.
6. Determine ongoing technical assistance needs for the principal recipient and subrecipients, particularly regarding financial sustainability, human rights and gender[1].

The consultant team developed the assessment methodology and data collection tools, which were circulated to all stakeholders for comment and revised accordingly[2].

The baseline assessment consisted of four phases of work: 1) inception planning; 2) data collection; 3) data analysis; and 4) production and dissemination of the reports.

Phase 1: Inception planning

- **Assessment team recruited:** A team of 13 external independent consultants were recruited. This included a Regional Team Leader and a Human Rights and Gender Specialist, together with national consultants with expertise in the areas of the four program objectives.
- **Working group established:** An internal SKPA-2 working group was established to oversee the process and ensure coordination with country activities.
- **Desk review:** Subrecipients, consultants and the working group sourced and reviewed a range of relevant documents to help formulate the assessment questions and data collection needs.

[1] AFAO has earmarked funding to be programmed at the end of the baseline to support technical assistance and additional activities under Objectives 1 and 4.
[2] More detailed information about the baseline assessment questions and data collection tools can be found in the annexes to the overarching report for the baseline assessment.

- **Data collection tools developed:** Data collection tools, including structured key informant interview guides, were developed for each of the SKPA-2 objectives, and reviewed by the consultants and regional technical assistance providers.
- **Stakeholder identification:** SKPA-2 subrecipients and national consultants identified local stakeholders to be interviewed.

Phase 2: Data collection

- **Key informant interviews and focus group discussions:** The national consultant team in Sri Lanka met with a range of government stakeholders, non-governmental organisations, and key population-led organisations, and conducted interviews with 38 key informants during 17-21 October 2022. Information generated by these interviews provided a primary source of data to inform the baseline situation in the country for each SKPA-2 objective.
- **Sustainability Pulse Check Survey:** Using Google Forms, a sustainability pulse check survey was conducted online, engaging a cross-section of key stakeholders from the four countries and responses have been received from 60 stakeholders. The survey was designed to support both baseline and end of project needs, and indicators can be disaggregated by country, objective and stakeholder group (governments, civil society organizations, key populations, and multilateral organisations).

Phase 3: Data analysis

- **Data analysis:** Data collected was analyzed iteratively throughout the process, with fact-checking and verification occurring where required. Survey results were analyzed using R and Power BI for dashboard development. Dashboard results can be accessed online. https://www.afao.org.au/our-work/international-program/dashboard/
- **Revision of SKPA-2 Theory of Change:** As part of the data analysis, the baseline assessment team tested the assumptions in the SKPA-2 Theory of Change and constructed more detailed causal pathways and milestones for each country.

Phase 4: Report production and dissemination

- **Country presentation of preliminary findings:** During each country assessment visit, preliminary findings were presented to local stakeholders to verify the data and to discuss the key findings. This meeting took place in Sri Lanka on 21 October 2022. Further feedback meetings to review the draft reports were organized in February 2023.
- **Dissemination:** The four country reports and overarching baseline report were presented to the Regional Steering Committee at its meeting on 31 January 2023. Following this, the reports were circulated widely to stakeholders for comment and review. This process allowed for verification of key findings and recommendations. The reports were finalised by the end of February 2023.

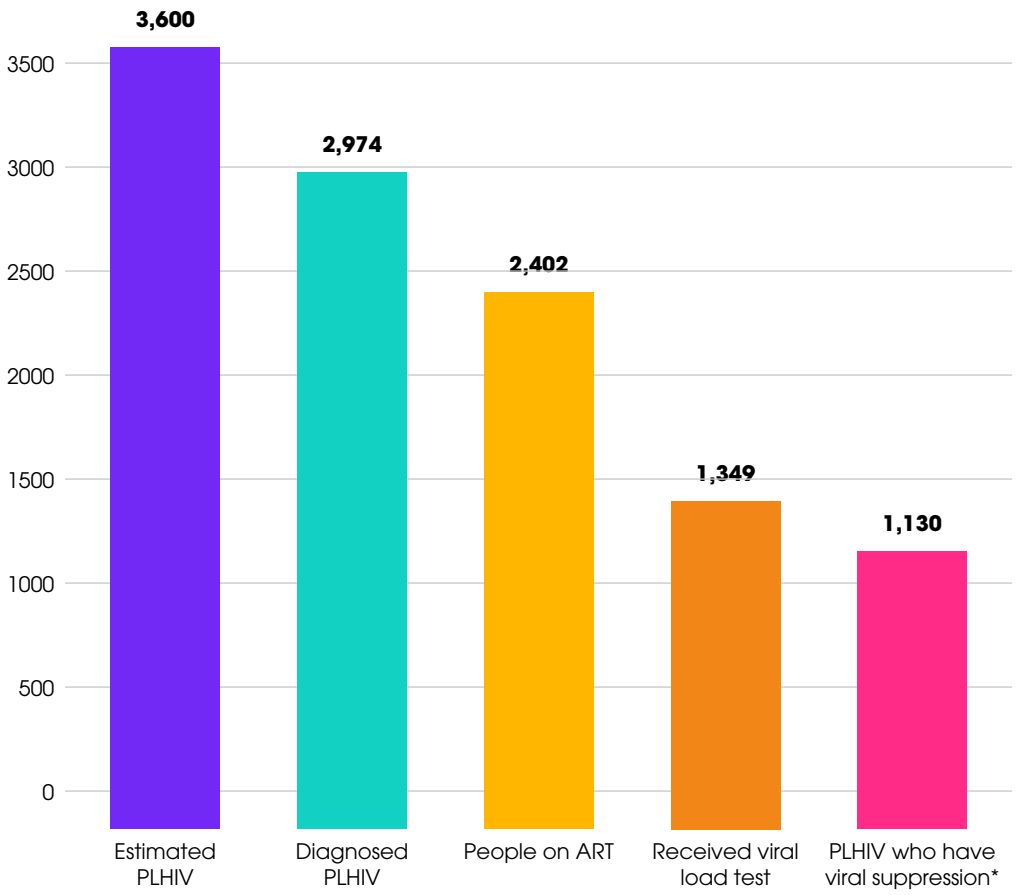
The limitations of the baseline assessment fall into two categories: limitations related to the data collection process and limitations related to the data itself. The short timeframe for field visits and data collection and analysis was a key challenge and, while many of the program's partners are working at subnational level, the scope of work was limited to collecting baseline data at national level due to practical considerations. Much of the quantitative data gathered by the baseline assessment is from the year 2021, although some of the data used is from previous years. Some of the baseline data collected were sourced from the published literature, compiled by governments and development partners, and thus reflect their indicators and timelines. The situation in each country also changes quickly, and some of the findings and recommendations in the baseline assessment may be out of date or already in the process of being addressed.

This report is based on information gathered during a field visit to Sri Lanka in October 2022 and during follow-up meetings and discussions. The audience for the baseline assessment includes national policymakers, healthcare workers, key populations, people living with HIV and communities most affected by HIV, regional and country technical partners, the Country Coordinating Committee, other local and international organizations implementing HIV programs, multilateral and bilateral donors, and the Global Fund. The baseline assessment team hopes that the findings will contribute to existing knowledge and enhance understanding of the opportunities and challenges facing Sri Lanka. Readers are encouraged to read this report in conjunction with the overarching report for the baseline assessment, and may also be interested in the challenges faced and recommendations made in the other SKPA-2 program countries, which are reflected in the corresponding reports for those countries.

HIV IN SRI LANKA

Sri Lanka is a lower-middle-income country with a Gross Domestic Product (GDP) per capita of US $3,815 in 2021 and a population of around 22 million. Sri Lanka's first case of HIV was detected in 1987 and the epidemic has remained at a low level since, with HIV prevalence among the general population estimated at less than 0.1%. In 2021 and 2020 there were estimated to be fewer than 100 deaths due to HIV and AIDS, a decrease from the estimated 200 or so deaths in 2019. In 2021 there were an estimated 3,600 people living with HIV in Sri Lanka. As of Quarter 2 of 2022, the cumulative number of diagnosed cases of HIV was 4,686, with approximately 72% of all cases among males[3].

Figure 1: Cumulative cross-sectional cascade for HIV treatment and care, Sri Lanka 2021



* Number of patients on ART who received a viral load test in the past 12 months and have VL of <1000 copies/mi

[3] NSACP (2022). Quarterly data. http://www.aidscontrol.gov.lk/mages/HIV_2ndQ_2022.pdf. Accessed December 16, 2022

The epidemic in Sri Lanka is concentrated among key populations, with around half of new HIV cases attributed to male-to-male sex, and about 40% to heterosexual sex. There are gaps in the HIV cascade (see Figure 1 above), and increased efforts are needed to accelerate the response in order to reach the 2030 targets. The number of cases diagnosed represents about 82.6% of the estimated total number of people living with HIV. Of the 2,974 total HIV cases diagnosed, 2,402 are estimated to be currently on ART. Slightly over half of these people living with HIV have received a viral load test (56%), and 84% of these have achieved viral load suppression (AIDS DataHub). Cohort analyses undertaken by the National STD/AIDS Control Program (NSACP) indicate over 80% retention on treatment after 1, 2 and 3 years.

The cascade analysis highlights key gaps in reaching all the 95-95-95 targets in Sri Lanka. In particular, there is room for improvement in the first 95 for key populations. For example, only 40% of men who have sex with men have tested for HIV in the past year, and the proportions for sex workers, transgender people and people who inject drugs are 30%, 37% and 8% respectively. The low figure for viral load suppression appears to be linked to a lack of access to timely viral load testing, as only 1,349 received a viral load test.

Sri Lanka collects and analyzes data on HIV prevalence and related indicators among key populations through its HIV surveillance system. Population size estimates generated in 2018 and still used today show that men who have sex with men are the most numerous key population (40,000), followed by female sex workers (30,000). The size of other key populations is estimated to be lower, including 4,500 tourism service providers, 2,200 transgender people and 900 people who inject drugs.

HIV sentinel surveillance was conducted among the key populations in 2019. The highest prevalence was found among the men who have sex with men (1.5%), followed by transgender women (1.4%). Prevalence was low among female sex workers (0.1%), clients of sex workers (0.1%) and people who inject drugs (0%)[4] . Prevalence among men who have sex with men in 2019 was higher than that found in previous rounds of surveillance, for example the 2014 Integrated Bio-Behavioral Survey, which found a prevalence of 0.9%. In 2019, HIV prevalence estimates for all key populations tended to be higher for Colombo district than national figures.

Although HIV prevalence estimates indicate that Sri Lanka has a relatively stable, low-level epidemic and modelling predicts fewer than 200 new infections a year, 410 new HIV infections were detected through counseling and testing in 2021 and 282 in the first half of 2022[5]. Prior to 2018, fewer than 300 cases were detected in any year. While new infections due to heterosexual transmission are thought to have remained relatively stable between 2016 and 2020, new HIV infections among men who have sex with men increased from around 100 a year in 2016 to almost 200 a year in 2019 and 2020.

A number of factors suggest that there is high potential for sexual transmission of HIV, both through male-to-male sex and linked to sex work. These factors include a high number of sex partners among MSM in Colombo (mean of 17 in the last six months, 2018) and female sex workers in Colombo (26 in the last month, 2018), and low levels of comprehensive knowledge on HIV. Among men who have sex with men, risk behavior is exacerbated by chemsex[6]. Discussions with men who have sex with men and transgender people in Colombo and Gampaha districts suggest that use of amphetamine type stimulants

[4] Alagiyawanna et al. 2020).HIV Sentinel Surveillance Survey 2019. DOI: http://doi.org/10.4038/joshhm.v6i0.99
[5] NSACP (2022). Quarterly data. http://www.aidscontrol.gov.lk/images/HIV_2ndQ_2022.pdf. Accessed December 16, 2022
[6] T. Munasinghe (2021). Preliminary Report on the STI/HIV Risks associated with Sexualized Drug Use. Produced by the SKPA-1 program.

is becoming more common among these communities, and that sexualized drug use could become a significant factor driving HIV transmission among certain key populations in Sri Lanka.

At the same time, the World Bank reports that the economic crisis in Sri Lanka doubled the poverty rate from 13.1% to 25.6% between 2021 and 2022, and increased the number of poor people by 2.7 million[7]. Key informants interviewed for the baseline assessment suggested this could have implications for HIV, for example, if more vulnerable young women turn to sex work, and if sex workers are forced to reduce what they charge their clients, resulting in the need to increase the number of clients. Other potential effects include increases in the costs associated with HIV treatment and accessing health care. In addition, the economic crisis and Covid-19 have already had a detrimental effect on access to HIV services for key populations.

While Sri Lanka's response is appropriately targeted on key populations through its National HIV Strategic Plan (2018-2022) and its Global Fund national grant (2022-2024), ensuring that the next National HIV Strategic Plan reflects surveillance findings and responds to the impact of the economic crisis will be critical.

HEALTH AND HIV FINANCING ENVIRONMENT

Following decades of war, compounded by political instability and Covid-19, Sri Lanka is experiencing an unsustainable debt and severe balance of payments crisis, with adverse consequences for growth and poverty.

According to the latest South Asia Economic Focus and the Sri Lanka Development Update, the country's real GDP is expected to fall by 9.2% in 2022 and by a further 4.2% in 2023. This is likely to further exacerbate the already poor outlook for health financing. In 2021, the Government of Sri Lanka's contribution to health expenditure was 2.3% of GDP[8]. In 2022 it is estimated at around 1.5% of GDP[9], a very low figure by international standards.

Since the 1930s the Sri Lankan government has provided universal, free health services, with no user fees charged by health facilities. Around 90% of in-patient care, all preventive care, and 50% of out-patient care are provided by the government health sector. Private health services mostly provide out-patient curative care and some in-patient care, mostly in urban areas[10]. According to UNICEF[11], Sri Lanka has outperformed regional peers for most health outcomes, including child and maternal mortality, and life expectancy. There has been considerable progress in eliminating communicable diseases such as malaria, tuberculosis and measles. Nonetheless, challenges remain including regional disparities in health outcomes, a rise in non-communicable diseases associated with an ageing population, and increasing child malnutrition due to the ongoing economic instability.

[7] World Bank (2022). Protecting the poor and vulnerable in a time of crisis: Sri Lanka Development update
[8] Central Bank of Sri Lanka, Annual report, 2021; Key social indicators.
[9] Institute of Policy Studies of Sri Lanka, 2021. Sri Lanka's Health Financing challenge.
[10] DAST/Global Fund Advocates Network Asia Pacific, 2022. "Towards 95-95-95 in Sri Lanka": 17
[11] https://www.unicef.org/srilanka/media/1706/file/BUDGET%20BRIEF:%20HEALTH%20SECTOR.pdf

Public sector health services are financed through pooled tax-based government funding. Sri Lanka's recent difficulties, including a collapse in tourism income, changes in regulations which led to tax revenues falling drastically, accompanied by shortages and spiralling prices of basic commodities including fuel and medicines. At 8.4% in 2020, Sri Lanka's tax to GDP ratio is among the lowest in the world[12]. The impact of this on a tax-funded national health system is enormous, and Sri Lanka is seeking to reduce its budget deficit by minimizing government expenditure, including for health[13].

Until recently, Sri Lanka's economic prospects were positive. In mid-2019, the World Bank reclassified Sri Lanka from the lower-middle income to the upper-middle income country category. In light of the economic crisis, Sri Lanka has since been reclassified to the lower-middle income category.

FUNDING THE HIV RESPONSE

Free HIV services are provided by the NSACP, as stipulated by the National AIDS Policy 2011 and five-yearly National Strategic Plans. Central government governs HIV expenditure through the Ministry of Health and the nine Provincial Councils. Regional Health Services administer HIV and sexually transmitted infection services, which are delivered through 41 sexually transmitted diseases clinics ("STD centres") across the country. Antiretroviral therapy for HIV is provided by 29 of the 41 STD centres. In-patient care for HIV and sexually transmitted infections is available in all secondary and tertiary hospitals. The National Institute of Infection Diseases of Sri Lanka provides specialised in-patient care for people living with HIV. The NSACP provides policy and technical guidance to the Regional Health Services and STD centres. The government provides around 75% of funding for tests, clinical services and, via provincial budgets, administration of STD centres. The NSACP also procures and distributes pharmaceuticals and commodities. General supplies, recurrent and capital expenses are provided by the Regional Health Services under provincial budgets.

Currently key population interventions including PrEP and purchasing HIV services from civil society organizations are budgeted under the Global Fund budget and not under the national program budget. However, the Government provides funding for all tests, clinical aspects, administration of all STD clinics to which funds flow from the provincial budget for salaries, infrastructures, transport etc.

Due to the financial and other challenges Sri Lanka is enduring, it is difficult to present accurate current financial figures for the HIV program. The 2022 HIV budget is 0.3% of total health expenditure[14], which would be an increase from 0.14% in 2020 and 0.24% in 2020. The prospect of lower overall health expenditure due to the economic crisis could mean that even if this higher target of 0.3% of the health budget is met, the total budget available for HIV is still reduced. **Table 1** and **Figure 2** give a breakdown of total HIV investments in Sri Lanka and the breakdown by donor agency from 2017 to 2021. As Table 1 and Figure 2 show, in 2022, the Ministry of Health provided an estimated 31% of the NSACP budget, while the Global Fund provided 68.7% and other donors (WHO, UNPFA and UNICEF) contributed 0.3%.

[12] Ibid., 18.
[13] Ministry of Finance - Sri Lanka (treasury.gov.lk)
[14] DAST/Global Fund Advocates Network Asia Pacific, 2022

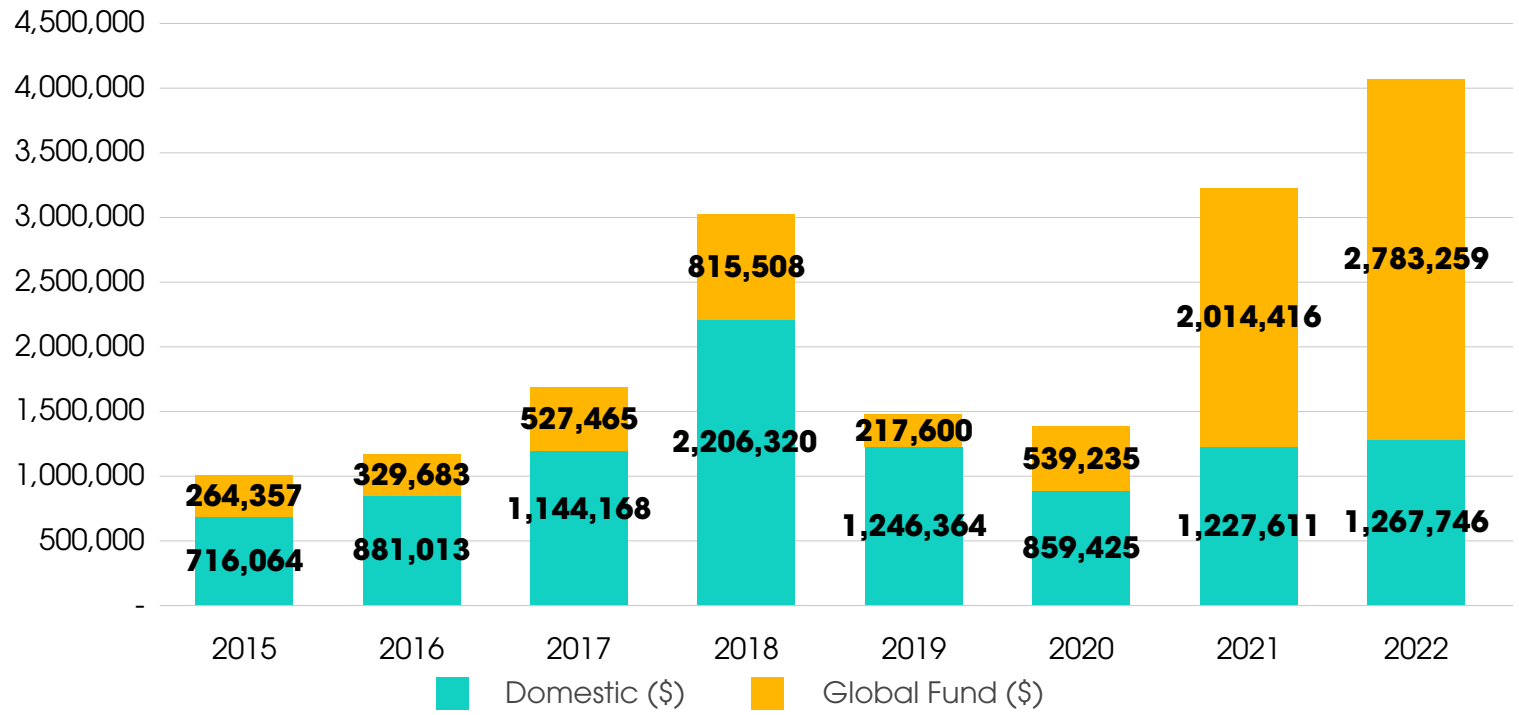
Table 1: Funding of the HIV response in Sri Lanka, by funding source

Agency	2017	2018	2019	2020	2021	2022
Total Budget (USD)[15]	1,671,633	3,021,828	1,463,964	1,398,660	3,242,027	4,051,005
MoH contribution (USD)	1,144,168	2,206,320	1,246,364	859,425	1,227,611	1,267,746
MoH contribution (%)	53%	63%	82%	36%	38%	31%
UNFPA/WHO/UNICEF (%)	1%	0.1%	0.2%	0.25%	0.3%*	0.3%*[16]
Global Fund contribution (%)	46%	37%	17.5%	63%	62%	68.7%

This 31% contribution in 2022 represents a dramatic reduction in the proportion of the HIV response funded by the government since a high of 82% 2019, and indicates that the relative importance of external funding, especially from the Global Fund, has increased. Although there has been a decline in the proportion of the HIV budget funded by domestic resources, in real terms there has been a relatively stable contribution from the MoH in three of the last four years (between USD$1.2-$1.3m), while funds available from the Global Fund really ramped up in 2021 and 2022.

[15] Annual budget for MoH excludes provincial budgets, as this data is not available
[16] estimate

Figure 2: Domestic and Global Fund contributions to Sri Lanka annual HIV Budget, USD



Source: Annual Reports, NSACP[17]. USD figures may be inexact as converted from Sri Lankan rupees at Dec 2022 rate (but this slide demonstrates key trends).

Figure 2 depicts clearly how the shrinking proportion of the total HIV budget funded domestically is not due to lower domestic financial commitments, but rather the acceleration of funding from the Global Fund in the last two years. As this acceleration is occurring against the backdrop of relatively stable domestic investments, and now the economic crisis, there may be a risk to sustaining new activities funded by the Global Fund and implemented in the last two years. However Figure 2 also shows that in 2018 the Sri Lankan government made a significantly higher investment (~$2.2m), meaning the government does have a precedent of making larger funding commitments that what has been witnessed over the last four years. The Global Fund has also agreed to provide emergency funding for provision of ART to 2024, with the possibility of extension.

[17] See http://www.aidscontrol.gov.lk/images/publications/annual_reports/Annual_Report-2020.pdf, and other reports by year.

Table 2 below shows the difference between the budget allocation and expenditure by key population. Across all key populations, but especially for transgender people and men who have sex with men, expenditure has been far below budget.

Table 2: 2021 HIV budget vs expenditure, by key population (USD)

Key population	Budget	Expenditure	Difference $	Difference (%)
Transgender people	$28,584	$14,885	-$13,699	-48%
Sex worker	$66,701	$63,216	-$3,485	-5%
Men who have sex with men	$34,6963	$237,016	-$109,947	-32%
People who inject drugs	$35,596	$32,542	-$3,054	-9%
Prisoners	$39,769	$32,223	-$7,546	-19%

Source: Global Fund key population budget and actual expenditure

Although Sri Lanka had been increasing the share of the HIV program it funds domestically, it is much more reliant on external funding than it was in two years ago (table 1). Global Fund support remains crucial, especially for key populations.

HIV BUDGETING AND PLANNING

The Ministry of Health has authority over policy-making and strategic planning, financial management, health sector monitoring and evaluation and is responsible for regulating both public and private provision of health care. The Provincial Councils and local government entities are entrusted with delivery of preventative and primary curative services and a significant share of secondary health services.

At all levels of government, Treasury is the main channel for both domestic and foreign financing.

Sri Lanka's budget follows an annual cycle, comprising national and sub-national budgets. In last two quarters of the year, the budget is finalized and approved by the Parliament. The key steps in the budget cycle are summarized in **Table 3** below.

Table 3: Main steps in the budget cycle

Period	Main steps in the budget cycle
First quarter	Ministry of Finance issues the Budget Circular.
First quarter	Ministry of Health with the help of its departments and agencies prepares estimates of revenue and expenditure.
Second quarter	Finance Commission recommends allocations to the Provincial Councils and submits them to the President. These are considered by the Treasury.
Second/third quarter	Ministry of Finance negotiates with Ministries to make estimates that conform to government policy and priorities. Estimates are submitted to cabinet for their study and approval.
Fourth Quarter (Early October and December)	Minister of Finance presents the Appropriation Bill, which includes the above estimates, to Parliament, in the first reading of the Budget.
1st of January, the following year	Budget comes into force after passage through Parliament

The HIV budget is prepared based on the National Strategic Plan for HIV and STI, and the National Health Policy. Information to inform budget preparation is gathered from many sources including progress updates, financial progress reports, programmatic and financial gap analyses, epidemic and surveillance reports, key population size estimates and from the Strategic Management Information Unit. The budgeting process involves discussions with the advisory committees and stakeholder meetings in which key population and civil society organizations participate.

The committees are:

- National AIDS Committee and Sub-Committees (quarterly)
- Formation and HIV Testing Steering Committee (quarterly)
- Provincial & District AIDS Committees (quarterly)
- Prison Sector Advocacy & Sensitization: Prison Steering Committee (quarterly)
- TB/HIV Advisory Committee (annual)
- Sub-Committee: Prevention & Multi Sectoral Coordination (annual).

The government Budget mainly focuses on services for the general population, covering expenses such as salaries, utilities, maintenance, clinical services, testing, and until recently, antiretroviral medicines.

INVOLVEMENT AND FUNDING OF THE KEY POPULATION-LED CIVIL SOCIETY SECTOR

Civil society and key population-led organizations are included in the development of HIV program budgets. They are included in the membership of several of the committees and sub-committees mentioned above, which are consulted in the formation of national and regional HIV budgets. They also participate in the development of the National Strategic Plan, and through the Country Coordinating Mechanism in the Global Fund's country dialogue, which provides opportunities for their concerns and needs to be reflected in plans and budgets.

While this is valuable, the situation is more nuanced. With regard to national policy and decision-making processes, key informants reported that civil society organizations that enjoy a close relationship with government are invited to participate, while those with divergent views tend to be excluded. Community representatives report that Country Coordinating Mechanism deliberations are dominated by the government, that community voices are not heard, and that community recommendations do not make headway. In addition, the shift in Global Fund-supported services from civil society service providers to government facilities has reduced the accessibility and quality of services for key populations.

A key challenge to effective engagement is the fragmented nature of the civil society sector. There is currently no platform where civil society and community organizations can jointly strategize, although a key population organizations network is being established. Another challenge is the capacity of some of these organizations. Many smaller civil society organizations and members of key populations have little agency, due to low levels of literacy and imperfect understanding of how "the system" works, including the timing and process of key deliberations. There is a clear need to build networks and capacity, including advocacy skills, so that they can engage meaningfully in national and local committees and processes[18].

The Global Fund program supports 23 key population-led organizations to deliver services for female sex workers, tourism service providers, men who have sex with men, people who inject drugs, transgender people and people living with HIV. Services provided include behavior change communications, condoms and lubricant, HIV pre-exposure prophylaxis (PrEP), HIV self-test kits, and virtual interventions that guide people toward information, testing and treatment. There is a need for clear, transparent accreditation standards for these organizations, both with respect to service delivery and to enable them to have a strong voice in strategic decision-making processes.

[18] DAST and Global Fund Advocates Network (Asia Pacific): Towards 95-95-95. 2022: 40

2.

Key findings by objective

SK PA·2

OBJECTIVE 1: ACCELERATE FINANCIAL SUSTAINABILITY

Key challenges for sustainability

The economic crisis and eventual transition from Global Fund support mean that the financial sustainability of Sri Lanka's HIV services for key populations is precarious. The NSACP is the principal recipient of the Global Fund national HIV grant. Global Fund-financed programs have complemented services delivered by the national program by providing essential HIV services for key populations. Crucially, all finance for HIV self-testing and PrEP, for outreach in national grant districts, and for virtual interventions to create demand for those services, is provided by the Global Fund. If Sri Lanka transitions from Global Fund support, these interventions would need to be integrated into the government budget. This will be a challenge in the current economic context.

In the current economic crisis, the importance of the Global Fund grant has escalated in importance to represent over 80% of all HIV expenditure in 2022 (Table 1). When Sri Lankan stakeholders were asked in the sustainability pulse check survey about the possible timeframe for government to co-finance HIV services and scale them up with domestic resources, only 15% of respondents felt that government will be able to accomplish this in the next 3 years. Around half of the respondents (46%) felt this would take 5 years or more.

Social contracting and procurement of HIV services

Purchase of HIV services from civil society organizations is not specifically addressed by any law or policy, but national procurement guidelines, which cover procurement by all government institutions, permit direct contracting from community-based organizations for goods, services and consultancies. Such procurement is common and is coordinated by the relevant government unit. The government unit develops a procurement plan, which specifies which officers are responsible for managing the procurement, the details of procurement to be carried out, the conditions that must be met, both in terms of the capacity of the successful bidder and the format of tender documents, scoring of financial and technical bids, and a work plan which specifies timeframes for the procurement process. Civil society organizations may bid in a competitive process to supply goods, services and consultancies. To do so they must comply with the terms of reference in the selection criteria. This information is published through government circulars and guidelines for procurement of services.

The Government of Sri Lanka is already engaged in social contracting of civil society organizations as part of the HIV response, for activities financed by the Global Fund. The NSACP and the Ministry of Health carry out goods and reagents procurements through the Medical Supplies Division. The NSACP has arrangements in place with 23 civil society organizations and one non-government organization to procure essential HIV services for key populations. Through these arrangements, organizations have been contracted to provide HIV, sexual health and harm reduction services for female sex workers, men who have sex with men, transgender people, people who inject drugs and people living with HIV. These services tend to be limited to HIV prevention outreach and testing. In addition to one-off service procurement, the NSACP has a Memorandum of Understanding with the Family Planning Association of Sri Lanka for HIV prevention services and support groups for people living with HIV to support activities financed by the Global Fund.

However, there are concerns about whether government systems are sufficiently robust to sustain the response for key populations, in particular systems to ensure that civil society organizations receive domestic funding to maintain services. According to the Global Fund Advocacy Network and Diversity and Solidarity Trust (DAST), an advocacy group:

> *"The government does not have the required commitment, resources, mechanisms, and processes to allocate domestic resources for civil society organizations and community-led organizations to maintain and expand key population interventions to address social, legal and policy barriers and prevention interventions"*[19]

There are also barriers to civil society organizations bidding for government contracts, including their ability to meet eligibility criteria. This can be a particular challenge for smaller organizations and those with capacity limitations. If a civil society organization lacks the skills and training to comply with accreditation or procurement requirements, there are several ways to build capacity. Training in health service provision is available from the National Institute of Health Sciences and, for capacity building in financial management and compliance with procurement regulations, options include the Sri Lanka Institute of Development Administration and private organizations which provide training at commercial rates.

Although it is unlikely that Sri Lanka will adopt the national health insurance model of social contracting that is being used successfully in other countries in the region, such as the Philippines and Thailand, it would be strategic of the government to expand the use of civil society organizations to fill the gaps in the HIV response. Worldwide, key populations have been far more ready to seek HIV services from civil society and community organizations than from government service providers. There are several reasons for this. Firstly, key population members often feel more comfortable talking about sensitive issues to their peers. Secondly, some may engage in activities that are illegal and this is a deterrent to seeking health care from government services. Thirdly, key populations often have concerns about stigma and discrimination and how they will be treated by healthcare providers in government facilities, as well as about confidentiality. In addition, there is evidence that civil society organizations can provide HIV services more efficiently and more effectively than government services[20,21,22,23,24,25].

Several social contracting models are used in the region. In the Philippines and Thailand, HIV services are reimbursed under the national health insurance program. Although Sri Lanka directly funds health services from the national budget, there may be valuable lessons from these programs. For example, Philippines

[19] Global Fund Advocacy Network and DAST, 2022. Towards 95-95-95 in Sri Lanka: investment analysis of the HIV response for universal health coverage for key populations by 2030 in Sri Lanka.
[20] Mills S., et al., "Fast tracking the end of HIV in the Asia-Pacific region: domestic funding of key population-led and civil society organisations". The Lancet HIV, Volume 7, Issue 5, May 2020
[21] Nareenrut Pudpong et al., "Public contracting with civil society organisations for HIV aids service provision a key strategy for ending aids in Thailand". Journal of HIV AIDS and Social Sciences, 20 September 2021
[22] van Griensven, F., et al., ". Uptake of primary care services and HIV and syphilis infection among transgender women attending the tangerine community health clinic Bangkok Thailand 2016 to 2019. Journal of the international AIDS Society June 2021
[23] Wongkanya, R., et al., "HIV rapid diagnostic testing by late providers in a key population lead service programme in Thailand". Journal of virus eradication" January 2018
[24] Nittaya Phanuphak et al., "Princess PrEP programme: the first key population-led model to deliver pre exposure prophylaxis to key populations by key populations in Thailand". Sexual Health, 2018, 15, 542-555.
[25] USAID, "Improving social contracting to end HIV in Thailand: experiences from selected countries and implications for the national response". USAID, PEPFAR, FHI360 October 2019.

and Thailand have developed costed units of service delivery for reimbursement. Costing HIV services to be delivered outside government has additional considerations. To be sustainable, it is important that the organization that delivers a service is reimbursed at a rate that covers the commodities and consumables used as well as the cost of delivering the services, including staff, rent, utilities, fuel and so on. Another model used, in Malaysia, is the creation by the Ministry of Health of a "government organized non-government organization" that manages all contracting work with CSOs, gathers and shares strategic information.

Sri Lanka could adopt one of two approaches to social contracting (see **Annex 1**).

- Develop contracts directly with civil society organizations, as the NSACP does now in its capacity as principal recipient of the Global Fund grant. It could do this by building a dedicated unit within the NSACP to replace the Program Management Unit.
- Use the approach already taken of using a well-established non-government organization to be a hub for social contracting. The organization would receive and manage an overall contract and manage sub-contracts, awarded competitively, to civil society organizations. The benefit of this would be that the NSACP would not need to manage multiple contracts but would retain strategic and financial control, shaping engagement through the overarching contract.

Building entrepreneurial capacity and resilience among civil society organizations

It will take some time for the Sri Lankan economy to recover and for the government to take forward social contracting. In the meantime, civil society organizations that provide essential HIV services for key populations need support to ensure that they remain viable. Two approaches are proposed.

Business enterprise development: In the short term to ensure survival, and in the longer term to complement social contracting activities, civil society organizations could consider developing business enterprises. The Family Planning Association of Sri Lanka is one potential resource. On behalf of its regional network, International Planned Parenthood Federation (IPPF), the Family Planning Association houses a Social Enterprise Hub[26] which has developed high quality business enterprise development programs and social marketing models and can provide support and tools for income generation ideas and efforts.

New funding sources: Secondly, civil society organizations could seek new funding sources to reduce dependency on government and the Global Fund. The proposed SKPA-2 Sustainability Financial Advisor could help organizations to identify and research novel funding opportunities and to prepare professional funding proposals.

[26] https://ra.seippf.org/.

OBJECTIVE 2: IMPROVE STRATEGIC INFORMATION AVAILABILITY AND USE

HIV surveillance data show a low-level epidemic concentrated among key populations in Colombo but needs to be updated and has some key gaps

The NSACP leads on strategic information related to the national HIV response, which includes HIV prevention, testing and treatment services. The national HIV epidemiology dataset is comprehensive, with HIV prevalence estimates, population size estimates and data on risk behaviors available for all key population groups from an Integrated Bio-Behavioural Survey conducted in 2018 (a follow up is planned in 2023).

As **Table 4** below shows, prevalence estimates for key populations are not up to date and there are also gaps in data for each stage of the HIV cascade for key populations, which mean it is not possible to assess progress towards the 95-95-95 targets for these populations.

Table 4. HIV prevalence, population size estimates and 95-95-95 targets by key population[27]

Indicators and groups		HIV prevalence (year)	Number of new infections (year)	95: People living with HIV (in each sub-population group) who know their HIV status (%, all ages) (year)	95: People living with HIV (in each sub-population) who know their HIV status and are on treatment (%, all ages) (year)	95: People living with HIV (in each sub-population) who are on treatment and have achieved viral load suppression (%, all ages) (year)	Population size estimate
1	All adults	0.02% (2021)[28]	<200 (2022)	83% (2,974/3,600) (2021)	81% (2,402/2,974) (2021)	47% (1,130/2,402) (2021) 91% in 2020	16.8 million
2	Men who have sex with men	1.5% (2019)	172	N/A	N/A	N/A	40,000
3	Female sex workers	0.1% (2019)	N/A	N/A	N/A	N/A	30,000
4	People who inject drugs	0% (2018)	N/A	N/A	N/A	N/A	900
5	Transgender people	1.4% (2018)	N/A	N/A	N/A	N/A	2,200

[27] Tourism service providers were not included in the IBBS
[28] Country Snapshot from AIDS DATA HUB https://www.aidsdatahub.org/sites/default/files/resource/lka-snapshot-2022.pdf

Some service coverage data are available, but there are also gaps in key program data

To collect and report routine data the NSACP uses standard data collection forms which are regularly revised and updated. Digitalization of the strategic information system is evolving. The Electronic Management Information System (EMIS) was introduced in 2018, and the Prevention Information Management System (PIMS) was launched in 2021. The EMIS reports patient information and is managed by the NSACP and the STD clinics located across the country. Regularly, the NSACP reviews interventions for key populations, with the participation of all relevant stakeholders including civil society. The NSACP also conducts an annual comprehensive progress review of HIV service delivery.

The NSACP is working with the Family Planning Association of Sri Lanka to develop a prevention-related strategic information system for key populations. The system is both paper based and electronic and uses information from a range of paper-based data collection forms, the most comprehensive being the Quarterly Return submitted by all STD clinics. There is also an Excel-based HIV patient database. Data collection from clinics is both electronic and paper based, as electronic systems are not functional at some clinics.

Table 5 below shows the coverage of key populations with HIV prevention, testing and PrEP interventions. There are large gaps in this dataset, including no program data for PrEP or HIV self-testing. There is also no recent data on the extent to which people avoid seeking health care due to stigma and discrimination, as the last time data were collected for the Stigma Index was in 2010.

Available data show that coverage with HIV prevention interventions is low for key populations, in particular men who have sex with men, transgender women and sex workers – only 7%, 13% and 21% of these sub-populations respectively were reached by prevention services delivered by key-population led organizations in 2020. The proportion who received HIV testing in the last year was also very low – only 10% for men who have sex with men, 12% for sex workers, and 13% for transgender women. The national grant currently plans to scale up HIV prevention coverage to reach 44% of priority men who have sex with men by 2024 and 80% of priority female sex workers with peer led interventions. Table 5 shows much higher proportions of people who use/inject drugs accessing these services, however this may be misleading given large uncertainty around the actual number of this key population (the denominator).

Table 5: Coverage of key populations with HIV prevention, testing and PrEP interventions

Indicators and groups		HIV prevention coverage[29]	Number of people on PrEP (received any time in last 12 mths)	% of key populations reached with prevention interventions provided by key population led organizations	Number of people who received HIV testing in last year (HIV testing coverage)	Number of people who received HIV self-testing in last year	Avoidance of health care due to S&D
1	Men who have sex with men	5,189 (13%)	0	2,937 (7.3%)	4,108 (10%)	0	N/A
2	Sex workers	6,331 (21%)	0	6,331 (21%)	3,515 (12%)	0	N/A
3	People who use drugs/inject drugs	463 (51%)	0	463 (51%)	964 (>100%)	Not reported	N/A
4	Transgender women	284 (13%)	0	284 (13%)	280 (13%)	Not reported	N/A

Source: NSACP annual report 2020

With HIV prevalence studies indicating a higher prevalence in Colombo than in other districts, improving coverage of services for key populations in and around Colombo and in other urban areas is a priority. Coverage gaps can be addressed using strategies such as micro-planning, as discussed below.

[29] Prevention coverage is measured as the percentage of people in a key population who report having received a combined set of HIV prevention interventions in the past three months (at least two out of three services): (1) given condoms and lubricant; (2) received counselling on condom use and safe sex; (3) tested for STIs (for transgender people, sex workers and gay men and other men who have sex with men) or received sterile needles or syringes (for people who inject drugs).

Lack of updated granular data on key population size and location

The mobility of key populations was cited by informants for the assessment as the main reason for not generating local maps and size estimates. However, the current population size estimates of 40,000 men who have sex with men and 30,000 female sex workers need to be disaggregated into local estimates to inform effective planning and targeted implementation of interventions. Local hotspot maps with the estimated number of key populations accessible at each venue provide an operational denominator for outreach efforts, including planning outreach worker to key population ratios.

Current data collection by outreach service providers does not support effective client follow up

Data collection tools used in outreach settings reflect the limited role key population service providers have in the HIV cascade, i.e., they focus primarily on HIV prevention and testing. When a client tests positive, confidentiality protocols effectively break the link between the outreach worker and the client, as the latter moves on to receive care, support and treatment from a health facility. Key population-led service providers under the national grant, such as Heart 2 Heart, have appointed the team leader as being responsible for ensuring linkages to treatment, and providing follow-up case management where needed, but there is no data collection tool to record this. The ability to receive follow-up case management support from peers was an important need identified during discussions with key population service providers. In addition, these organizations need to be able to report on linkage to treatment and to understand whether index testing opportunities have been maximized for newly-diagnosed people living with HIV.

Information systems are evolving towards better management and analysis of individual-level data

The current lack of interoperability between the EMIS and the PIMS is a barrier to linking community- and facility-based efforts across the HIV cascade.

The ability to understand the effectiveness of key population-led services will be enhanced through an activity of the national grant that seeks to integrate community data with the EMIS in a phased manner. There are also plans in 2023 to integrate the PIMS into the EMIS.

Sri Lanka has a unique identifier code (UIC) system in place for outreach to key populations. However, it is not clear whether or how this is being used in program monitoring. A monitoring system that uses UICs to monitor and report coverage through a program database can provide better data on service coverage indicators, determine patterns of coverage, and improve linkage to services.

Current program targets effectively skew outreach to prioritize recruiting and testing as many new individuals from key populations as possible, to address the gap in the first 95 target. This means that less attention is given to repeat testing or follow up of people who were recruited but did not take an HIV test. Individual-level data can support a case management approach, helping outreach workers identify clients who were not tested previously, who are due for another HIV test, or who may need condoms and lubricant.

Other data-related limitations also need to be addressed

The baseline assessment identified several factors that undermine data quality and programming. These include:

- **Timeliness of reporting:** Some data relating to individual patient management, such as quarterly viral load test results and contact tracing follow-up information, are not entered into the EMIS on a timely basis. This can result in incomplete analysis, which provides an inaccurate picture of trends.
- **Lack of feedback loops:** The end users (the Regional STD centres) do not receive summary feedback on the data they submit, which limits their strategic response to changes in the local epidemic.
- **Inconsistencies in strategic information between the Global Fund and government HIV programs:** Standard core indicators, disaggregated by key population, are reported to the Global Fund, but these data are not comprehensively reported in the NSACP annual report. This may undermine the move towards one national-level M&E system.
- **Community-based PrEP data are not reported to the EMIS:** Currently, only clinic-based PrEP data are included in the EMIS for individuals on PrEP. Community PrEP data are not included in the EIMS or the PIMS and are reported via a paper-based form. Civil society service providers will be able to enter this data and data on other prevention services into the PIMS in 2023.
- **Data on HIV self-testing is limited:** The ability to monitor usage by key populations is limited. HIV self-test kits are given on demand and anonymously. No information about the sub-population or age or sex of users is collected or monitored.

New opportunities for scale up of community-led monitoring

Community-led monitoring is not understood in a consistent way by stakeholders in Sri Lanka. Some view it as third party monitoring of the HIV response in the form of a survey to be carried out every 3-5 years. Others define it as assessment of HIV services provided by all government and civil society service providers. Others suggest that its role is limited to community review of HIV services provided by the NSACP and its regional clinics. This confusion is compounded by the use of different community-led monitoring tools on different platforms administered by different service providers.

There is, however, emerging demand for a system that allows key populations to provide feedback on the quality of HIV services. The NSACP has developed a 'know for sure' online reservation system that has the potential to provide a cost-effective means of obtaining feedback through automatic forms sent to service recipients after they have received a service. There are two areas of concern relating to this system. Firstly, concerns about sustainability, including reliance on a Global Fund contract with FHI 360 to program important changes to the platform through an information technology firm in Bangkok. Secondly, key populations have significant concerns about storage of their unique identifiers in the system, and the implications for the confidentiality and anonymity of feedback.

OBJECTIVE 3: PROMOTE PROGRAMMATIC SUSTAINABILITY

Roll-out of rapid testing and new HIV testing modalities

The WHO Testing Guidelines 2019 were adapted to suit the local context and released as the Sri Lanka National HIV Testing Guidelines 2019. Innovative testing approaches in the new guidelines include lay provider testing, HIV self-testing, community-based testing, and social network-based and testing for triage approaches.

Lay provider testing is used to carry out blood-based rapid tests in the community in Global Fund-supported districts. Confirmation of HIV diagnosis using rapid tests, as recommended by WHO, is not carried out by lay providers, as laboratory-based tests (western blot) are still used for confirmatory testing throughout Sri Lanka.

Sri Lanka is yet to validate the three-test algorithm and so not all the recommended rapid tests are being procured. A research proposal for carrying out the validation study is complete and ethical clearance has been obtained. WHO will fund the rapid tests and the reagents required for the study. In addition to delays in conducting the validation study, some stakeholders interviewed suggested that the investment made for conducting ELISA tests and confirmatory Western Blot tests at the NSACP laboratory is a barrier to adopting a new rapid test based algorithm. However, recognition that reliance on laboratory confirmation can delay initiation of treatment has led to a change in practice and treatment is now initiated as soon as a case is reported as reactive using rapid tests.

HIV self-testing was piloted under SKPA-1 in 2021 and is currently available to clients via civil society organizations in the Global Fund-supported districts, through the online platform Know4Sure for online ordering and delivery, and at NSACP's central clinic and selected STD centres. The self-test, which is saliva based, is provided as 'assisted self-testing', where a peer educator assists with the HIV self-testing process. For those who request anonymity, test kits are delivered by courier in an unlabelled package, which includes a self-test kit, a video on how to use it and a provider feedback form. Who the kit is sent to – whether a member of a key population or not – is not recorded.

Civil society organizations report that there is low awareness of HIV self-testing in districts that are not supported by the Global Fund, among sister organizations and private sector providers. This reflects the fact that the supply of self-test kits is limited – kits are not manufactured in Sri Lanka and have to be imported – and kits are not yet available in the private sector. However, the registration process to enable saliva-based and blood-based self-tests to be available in the private sector through retail pharmacies is ongoing. Two private sector firms have already submitted documentation for clearance to import these two types of self-test kits, and approval is expected shortly.

Contact tracing from an index case

Feedback from stakeholders also suggests that systems for contact tracing of an index case are not sufficiently comprehensive or robust.

Key steps are required to ensure Pre-exposure Prophylaxis (PrEP) scale up and equitable access

Following a pilot under SKPA-1, PrEP is now being scaled up in 15 districts through STD centres and civil society organisations

with Global Fund support. PrEP is expected to be included in the next National HIV Strategic Plan (2022-2030). There are no regulatory barriers, as PrEP medications are WHO approved, but it will need to be registered for import. This may pave the way for PrEP being available in the private sector.

There is no technical committee for PrEP or HIV testing and currently no plan for scale up of PrEP, although this may be included in the new National Strategic Plan under development. National guidelines for PrEP and a new national PrEP training curriculum are being drafted. The NSACP has identified the need to include PrEP guidance in annual refresher training for health workers, and to update training materials and job aids.

Demand generation activities for PrEP have been limited, and will need to be scaled up and intensified to reach all key populations who need it.

Civil society stakeholders interviewed for this assessment reinforced this, noting that PrEP scale up may be held back by inadequate knowledge and skills, and judgemental attitudes, of health workers. These stakeholders highlighted the need to make PrEP available to a wider range of vulnerable populations – currently PrEP is only available to men who have sex with men and transgender people, but sex workers and other at-risk populations also require it. They also suggested that making PrEP available through private pharmacies and at a subsidized cost through civil society organizations such as the Family Planning Association will be important to ensure widespread and equitable access.

According to respondents in the sustainability pulse check survey, access to PrEP and HIV self-testing is mixed. 61% reported that key populations cannot readily access PrEP, while 31% felt the same way about HIV self-testing.

Physical and virtual outreach need to be strengthened

Two intervention models are being used, (supported by Global Fund), to provide comprehensive prevention services to key populations through the principal recipient, NSACP/ Ministry of Health. The Family Planning Association of Sri Lanka (as the sub recipient) manages programs for men who have sex with men and female sex workers in Colombo and Galle districts while NSACP directly contracts civil society organizations in other high risk districts. The first, a "peer-led" model through social media platforms and dating apps, involves reaching out to new and unreached key populations. This is implemented through a comprehensive online platform called Know4sure which links people to services and tracks clients for follow up services. The second, known as the "case finder" model, is more intensive and is focused on increasing HIV testing among key populations.

Virtual interventions have been implemented in Sri Lanka since 2020 to reach hidden and hard to reach populations. The online platform, Know4Sure provides comprehensive HIV-related services for key populations and encourages HIV self-testing. The virtual strategy was formalized in 2021 through NSACP's plan to integrate virtual education, clinical and health promotion services for HIV and STIs. The Covid-19 pandemic has increased reliance on virtual interventions like Know4Sure which have been used more than anticipated and new applications have been

introduced. The current National HIV Strategic Plan refers to virtual interventions and the plan for 2022 to 2030 is expected to include virtual interventions as an important strategy.

The NSACP believes that virtual outreach services are already helping to expand access to HIV testing. The assessment team visited civil society organizations that provide outreach services for men who have sex with men and female sex workers. The Heart 2 Heart centre, which provides services for men who have sex with men, has added a twice-monthly PrEP clinic and assisted self-testing to its service package and expanded its team to include two virtual outreach workers. Organizations such as Heart 2 Heart are doing their best, but there is a real risk of further HIV transmission occurring among men who have sex with men due to the inadequate coverage of priority services and limitations of current outreach services. Outreach services supported by the national grant are limited in scope with only six men who have sex with men outreach workers for the whole district of Colombo, resulting in an unrealistically high key population to outreach worker ratio. Outreach workers report receiving limited formal training – many have only been trained on sexually transmitted infections and monkey pox – however there are no up-to-date standard operation procedures for the case finder model, and the materials they distribute are focused on information and education rather than on behavior change. One civil society organization providing key population services interviewed seemed unaware of the standard operating procedures to guide how virtual services are to be delivered in practice, and lacked clarity on how condoms or testing are to be provided through online outreach or how virtual clients can be connected to physical outreach workers and to facility-based services. Sri Lanka was one of the pioneers in having virtual interventions SOPs and reporting indicators, so this may reflect incomplete knowledge of the guidelines.

Further, as discussed under Objective 2, due to legitimate concerns around privacy and confidentiality, follow up to ensure that individuals who test positive for HIV are linked to treatment and care is a challenge. The baseline assessment found that there is very little focus on ensuring that the U=U message is understood or promoted in outreach and other settings. Other issues identified include the need to improve the quality of virtual messages.

The Community Strength Development Foundation, which provides services for female sex workers, faces many of the same challenges and constraints as Heart 2 Heart. The economic crisis has had a profound effect on the sex industry in Sri Lanka. There are estimated to be around 8,000 female sex workers in Colombo district and increasing numbers of women are turning to sex work. The Foundation's outreach workers report that they are seeing younger, as well as better educated, women working as sex workers in spas and lodges. Like Heart 2 Heart, the Foundation has expanded outreach into the virtual space, with three virtual outreach workers joining the five doing outreach in person. Online outreach has reached 2,800 sex workers this year so far. Those who have been tested for HIV have either visited a clinic or opted for assisted self-testing via the Family Planning Association of Sri Lanka mobile service.

A sex worker is considered as "reached" when they have received the service package of HIV information, a condom demonstration and an information sheet. As with outreach services for men who have sex with men, the focus of outreach

work targeting sex workers is on increasing HIV testing, especially among those who have not previously been tested, and less attention is given to follow up. Sex workers who visit clinics for HIV testing are not consistently screened for other sexually transmitted infections. Outreach workers are being overwhelmed by the number and increase in the number of sex workers and changing needs – for example, young women living at home may not be able to keep an adequate supply of condoms, so outreach workers need to have contact with them more often to provide condoms. Other challenges include coverage, condom availability and materials. Physical or offline outreach workers report that they are missing some sub-groups, for example, sex workers who are based in nightclubs. The NSACP provides 30 condoms per month per sex worker, and this is not always enough. Outreach workers often provide condoms wrapped in newspaper, and this is not acceptable to some sex workers. The Foundation also commented that the materials they are provided with to distribute during outreach are not as well targeted or of the same quality as those used for men who have sex with men.

Outside Colombo, outreach workers are trained by medical doctors, who also manage outreach activities. Civil society stakeholders view this as a flawed approach, as medical officers and other health staff working in STD clinics do not have the same inside knowledge of the community and trusted relationships, and therefore may not be best placed to provide some training or supervise and guide peer educators.

Civil society organizations that provide services on behalf of NSACP participate in key population service reviews with NSACP every month. They report that the reviews are primarily focused on sharing of numbers, with limited discussion. They would like more training and standard operating procedures to guide provision of better quality services, including training to manage and support clients with positive diagnoses, and more involvement in monitoring the quality of outreach services.

Build on success to further improve linkage to treatment and other aspects of case management

There have been several positive developments. The key population clinic established at the NSACP, which is staffed by a key population outreach worker, is viewed as a major achievement. Delays in initiating treatment have been significantly reduced as a result of the widespread use of rapid tests.

However, there are concerns about linkage to treatment. In addition to the different responsibilities of civil society organizations and health facilities, and the lack of systems to ensure effective follow up of referrals, there are no protocols for accompanying clients to HIV or health services. This is exacerbated by the lack of standard data collection tools for linkage to testing and treatment from outreach services and for follow up, as discussed earlier in this report.

Civil society organizations also highlighted other issues that might undermine successful linkage to treatment at government facilities, including the generation gap between clients and healthcare providers and the lack of space for confidential counseling, and other support services at clinics for those who have tested positive.

Commodity shortages are undermining delivery of priority HIV services

Despite the sustained effort of the government and Global Fund-financed programs, there are serious commodity shortages and other challenges linked to the economic crisis in Sri Lanka. Feedback from the Country Coordinating Mechanism indicated that currently 100 essential medicines are either out of stock or in extremely short supply. Shortages are restricting access to ART, especially for key populations who live outside Colombo, with some clients having to make do with one or two weeks resupply. Other people who have yet to start treatment face significant increases in the cost of baseline liver and kidney function tests and this is a real barrier to initiating treatment. There are also shortages of PrEP medications and, as a result, clients have had to move from ongoing to event driven access. The Community Strength Development Foundation did not receive any self-test kits in November 2022.

OBJECTIVE 4: REMOVE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO SERVICES

Sri Lanka has several important measures in place that protect the rights of its citizens, and these apply to key populations and people living with HIV as well. Article 12 of the Constitution of Sri Lanka guarantees all citizens equal protection under the law and prohibits discrimination on the grounds of race, religion, language, caste or sex. Sexual orientation and gender identity is not included in the fundamental rights chapter of the constitution but this addition has been recommended by human rights groups during the constitutional reform process. Sex work is not criminalized in Sri Lanka. In 2016, the Ministry of Health issued a circular on the issuance of a gender recognition certificate to enable transgender people to formally change their sex in their personal identity documents. Transgender people can present their gender recognition certificate to relevant state institutions to request amendment of critical identity documents such as their National Identity card, passport and school certificates. However, in practice many officials are not aware of this circular, and the process the obtain the certificate is complex. In addition to this the assessment identified several human rights- and gender-related issues that adversely affect access to HIV services for key populations and people living with HIV.

The LGBTQI community and people who use or inject drugs are criminalised

Sections 365 and 365A of Sri Lanka's Penal Code criminalize same sex relations. Punishments are harsh, including fines and imprisonment for up to 10 years. Section 54A of the Poisons, Opium, Dangerous Drugs Ordinance of 1984 criminalizes possession, trafficking, import and export of illicit drugs and is routinely used by the police to arrest people who have small quantities of drugs in their possession. Arrest under Section 54A is a non-bailable offence, and people charged under this section are usually incarcerated until the conclusion of their trial as bail can be obtained only at the high court. Besides imprisonment, people arrested for drug offenses may be sent for mandatory drug rehabilitation at state drug rehabilitation centers, some of which are operated by the military.

The law is commonly used to target, harass and arrest members of key populations

The assessment found that police regularly use a colonial-era law – the Vagrants Ordinance of 1841 – to arbitrarily arrest and detain members of key populations such as people who use drugs, as well as those who are not criminalized, such as sex workers and transgender people. The Vagrants Ordinance grants police the power to arrest, without warrant, "every common prostitute wandering in the public street or highway, or in any place of public resort, and behaving in a riotous or indecent manner". Section 7(1)(a) prohibits public soliciting "for any act of illicit sexual intercourse or indecency," and those arrested can receive a punishment of 6 months imprisonment or a fine of Rs.100 or both. Section 9 makes it a crime to live off the earnings of prostitution and Section 11 penalizes "every person, having the custody, charge or care of a girl, who causes or encourages the seduction or prostitution or unlawful carnal knowledge of the said girl". The Brothels Ordinance of 1889 stipulates that anyone who "keeps or manages or acts or assists in the management of a brothel" is guilty of an offense and punishable with a fine of Rs.500

or 6 months imprisonment or both. Section 399 of the Penal Code makes it an offense to cheat the public by impersonation, and this has been used to specifically target and arrest transgender people. In one study of sex workers and transgender people, nearly 50% of respondents reported that they had been either arrested or detained by the police for engaging in sex work, cross-dressing, and "loitering" on the roads at night.[7]

There are gaps in protections for key populations and people living with HIV

Other than the equality clause in the Constitution, there are no specific laws related to discrimination or violence against key populations or people living with HIV, nor are there any laws to guarantee their rights or protect their access to services. In addition, even when protective laws are in place, mechanisms for implementation or enforcement are often lacking. For example, transgender people who wish to change their sex designation on their official identity documents "face a bewildering array of bureaucratic obstacles. Government officials handle such applications in an ad-hoc manner".[1]

Stigma and discrimination are common in wider society and in healthcare settings

External studies highlight the high levels of societal stigma and discrimination in Sri Lanka, especially towards the LGBTQI community. For example, in a recent study of views on sexuality, 44.4% of respondents said it would be shameful to have a LGBTQI child.[2]

Our review found that this widespread stigma and discrimination directly affects key populations' health and ability to access services. For example, key informants reported that the discontinuation of a transport allowance to help transgender people come to services by private vehicle reduced access to services, as transgender people were unwilling to use public transport to travel to a clinic due to "humiliation" they suffer when they take public transportation.

Key informants widely reported stigma and discrimination in healthcare settings, from both medical practitioners and administrative staff. Specific examples cited include:

Poor attitudes and ill-treatment by healthcare providers: Although some health workers at government health facilities treat key populations with respect, there were multiple reports of ill-treatment at the hands of medical professionals and of a lack of willingness to recognize and address this. For example, one key informant reported the case of a sex worker whose doctor gave her a pelvic examination. When the doctor inserted a swab into her vagina and she winced in pain, the doctor said *"she can put everything else in her vagina but something this small is painful"*. A study conducted by Human Rights watch also identified instances of abuse in healthcare settings, including people being subjected to forced physical examinations in an attempt to find proof of homosexual conduct.[3]

Some key informants reported that senior doctors tended to be better aware of the needs of key populations and people living with HIV than their younger, less experienced counterparts. Younger doctors were reported to ask questions such as "why

are you like this, why can't you be normal, why don't you behave normally, get married, settle down?" There was also a consensus that stigma and discrimination in healthcare settings is more common in rural areas than in urban areas. Consequently, key populations and people living with HIV in rural areas report that they try to travel to Colombo for services or else avoid services altogether.

There were also reports of poor treatment of key population clients by administrative staff, for example, staff refusing to accept transgender people's gender recognition certificate on "moral grounds".

Denial of services: Key informants reported that hospital staff working in non-HIV areas sometimes deny services to people living with HIV. This has happened, for example, to people who have been referred from HIV services to other departments for further testing. People living with HIV reported that "The staff make excuses by saying the test isn't available on the day or the machine is not working, and they send the patient away".

Discriminatory systems and lack of confidentiality: A number of systems in healthcare settings increase the risk of discrimination and threaten confidentiality, undermining the willingness of people living with HIV and key populations to access services. Examples cited include health facilities using different colored files for people living with HIV, writing "HIV" visibly on referral forms for further testing, and hospital staff calling people by their HIV status instead of by their name or file number.

Key informants also cited practises that deter key populations from accessing PrEP and HIV self-testing. For example, some reported being asked intrusive screening questions at PrEP appointments, which made them reluctant to proceed. Another informant reported being sent an HIV self-test kit that arrived in a box with HIV written on it.

Reluctance to attend services: Reluctance or refusal to attend health services, as a result of stigma and discrimination in healthcare settings, was commonly reported by key informants. People who use drugs and sex workers said that they were afraid to access health services as they thought they would be turned away. Women living with HIV reported that gender-specific stigma made them reluctant to access HIV testing services. Transgender people said that they were uncomfortable attending government HIV testing services due to concerns about confidentiality. Many members of key populations and people living with HIV reported that they would travel long distances to attend clinics that were far from their home, because of fear that local clinics would breach confidentiality in their own communities.

Key populations and people living with HIV face stigma and discrimination in the workplace and economic vulnerability

The assessment findings highlight the impact of stigma and discrimination on key populations in the workplace. In a recent survey of LGBTQI employees, for example, 38% reported that they did not enjoy a supportive and non-discriminatory work environment.[4]
Key informants reported that transgender people are especially affected and many find it difficult to obtain employment at all.

Lack of income, together with stigma and discrimination, exacerbate barriers to accessing services. For example, people living with HIV reported that, due to stigma and discrimination in government facilities, they preferred to attend private clinics, but that the high cost of private care was prohibitive. Some reported that viral load testing was only available in private facilities, which they were unable to afford. For some, economic hardship was so severe that they were unable to afford condoms.

Gender-related factors increase women's vulnerability and limit their access to services

Women with HIV face additional gender-related stigma, being labeled as promiscuous and being blamed for bringing HIV into the family. Women also reported that they need their husband's permission to go to a health facility when they are sick or they need healthcare services and those who do not have an income are also dependent on their husband to pay for the costs of seeking health care including transport.

Gender-based violence is pervasive in Sri Lanka. A recent study found that one in five (20.4%) ever-partnered women have experienced physical and/or sexual violence from an intimate partner in their lifetime. Almost half of the women who had experienced sexual violence perpetuated by a partner did not seek formal help citing "shame, embarrassment and fear of being blamed or not being believed, and/or thinking the violence was normal or not serious enough to seek help" as reasons.[5] A study of lesbian, bisexual and transgender women found that more than half had experienced physical and sexual violence, and all had experienced some form of emotional violence, including gender norm enforcement, restrictions on socialization, physical and emotional neglect, family ostracism, and constant pressure to enter into (heterosexual) marriage.[6]

There is a lack of access to mechanisms for redress of rights violations

The Human Rights Commission of Sri Lanka is mandated to register and investigate complaints while the Legal Aid Commission can provide pro-bono legal aid to redress complaints, however key informants reported that these mechanisms do not function optimally and are not user friendly. Some reported that they were subjected to degrading treatment and discrimination when they tried to lodge complaints with these organizations. Sex workers who attempted to register complaints with the Human Rights Commission said that the staff treated them disrespectfully, there was no way to register a complaint and maintain confidentiality, and that they were unable to complete the requisite paperwork because they lacked a permanent address. Key populations also reported that they were reluctant to lodge complaints about health service providers, due to fear of reprisals and future denial of health services.

The assessment team found that most hospitals and clinics lack anti-stigma and anti-discrimination policies. As a result, when members of key populations have raised issues, there have been no repercussions for offenders and, in some cases, the result has been further discrimination against the person who raised the compliant.

There are some examples of efforts to establish complaints mechanisms. Some clinics have introduced complaints systems, but there is no mechanism to monitor their functionality and no assessment has been conducted to measure client satisfaction with these systems. At some clinics where complaints have been registered, the responses have been so delayed that the person who registered the complaint gave up waiting for a response. A complaints mechanism was set up under a FHI 360 program, but it lacked a third party monitoring system and did not continue beyond the life of the program.

Outside health services, there appear to be few systems to register complaints. Key populations reported that, when they have complained to the police about crimes committed against them, the police refused to take any action. Transgender sex workers in particular noted the lack of police responsiveness to their complaints and the absence of pro-bono legal services, except for the legal Aid Commission, to deal with these issues.

The majority of respondents to the sustainability pulse check survey (54%) felt that referral mechanisms in cases of violations of patient's rights or experiences of violence are not functioning, while a further 23% felt these mechanisms are unclear. A similar proportion felt that key populations are not well represented in national planning and decision-making forums (54%), which rose to 75% among key population respondents.

(1) "All Five Fingers Are Not the Same" - Human Rights Watch, 2016. https://www.hrw.org/report/2016/08/16/all-five-fingers-are-not-same/discrimination-grounds-gender-identity-and-sexual
(2) Survey Report: Sri Lankan Society's Views about Sexuality and LGBT People's Experiences in Sri Lanka. https://www.wfd.org/what-we-do/resources/sri-lankan-societys-views-about-sexuality-and-lgbt-peoples-experiences-sri
(3) https://www.hrw.org/news/2020/10/20/sri-lanka-forced-anal-exams-homosexuality-prosecutions
(4) Chowdhury, S.A. (2021), A study on workplace discrimination: Challenges faced by LGBTIQ employees and the perspectives of employers in Sri Lanka, Equal Ground, Sri Lanka. https://www.equal-ground.org/wp-content/uploads/DAP-REPORT-FINAL.pdf
(5) Women's Wellbeing Survey - 2019 Findings from Sri Lanka's first dedicated National Survey on Violence against Women and Girls - Department of Census and Statistics, Sri Lanka and UNFPA; https://asiapacific.unfpa.org/sites/default/files/pub-pdf/srilanka_wws_2019_final_report.pdf
(6) Presented to the 66th Session of the Committee for the Elimination of All Forms of Discrimination Against Women (CEDAW) - 2017, Women and Media Collective. https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT_CEDAW_NGO_LKA_26252_E.pdf
(7) Rapid Situation Assessment of Transgender Persons in Sri Lanka - National STD/AIDS Control Programme, 2016

3.

Recommendations

SK PA·2

Recommendations in this report are grouped under issues that reflect the key findings above. They are not all activities which the modestly funded SKPA-2 program has the scope to address, but rather are intended to help the national program, and stakeholders, consider and address priorities for the Sri Lankan HIV response.

Issue 1: Lack of a sustainable financing model for priority HIV services for key populations

It is recognized that Sri Lanka is in the midst of an economic crisis and that increasing domestic financing for the HIV response will be challenging in the short term. However, in the expectation that this will pass, and that Sri Lanka will be able to resume its trajectory of increased investments in health and other social sectors, it will be important to plan carefully for future investment in HIV. This is particularly important given the impact of the current situation on delivery of essential HIV services to key populations, which has increased the risk of a growth in HIV infections, and the expected decrease in external support, especially from the Global Fund, for the HIV response for key populations. In the short term to ensure survival, and in the longer term to complement social contracting activities, civil society organizations could consider developing business enterprises.

Recommendation 1: Strengthen the social contracting system which is already being used by NSACP, by taking deliberate steps to plan and formalise the process, determine the type of services to be covered, the scale of coverage and projected costs, and make the system as easy to use as possible.

Recommendation 1.1: Fast track current SKPA-2 activity `develop a roadmap for social contracting' in coordination with NSACP. With regional support from ACHIEVE, and national Financial Sustainability Advisor or independent consultant, on specific activity including:

- Assess the current model, reviewing and adapting processes in other countries, determine the focus of essential HIV interventions for key populations and the interventions to be including in social contracting and the volume and costs of services to be procured.
- Prepare the required legal and policy framework to enable purchase of HIV services from civil society organizations that includes financing for human resource and overheads such as office running costs, and ensure that government circulars advertising procurement opportunities automatically include civil society organizations as invited bidders.
- Decide whether to procure services based on a contract with payment in advance that requires a certain number of services to be provided within a specific timeframe, in a determined location, among a particular key population, and at an agreed quality – or to refund organizations for services after they have been delivered, on a performance basis.

Issue 2: Insufficiently broad engagement of civil society organizations in national HIV program planning and budgeting

The baseline assessment found that, while there is government engagement with civil society, more can be done to ensure meaningful involvement of civil society in national program planning and budgeting, especially as it affects key populations. There is also a need to capacitate civil society organizations to maximize their participation and contribution to the national response.

Recommendation 2: The national HIV program should review its engagement with civil society to ensure that civil society organizations are meaningfully engaged in planning and budgeting key population-related HIV services, that their strengths are used in delivery of services, that communities needs and wants are being heard, and where needed, that their capacity is strengthened to ensure effective financial management, technical capacity, strategic information and advocacy. Specifically:

Recommendation 2.1: The NSACP should develop and publish an internal timeline for the annual budget preparation process, providing opportunities to civil society organizations to contribute to budget development.

Recommendation 2.2: Improve understanding of the real costs of delivering the HIV program by capturing provincial expenditure in NSACP annual reports to improve understanding of total government HIV spending, and by developing units cost for service delivery by civil society organizations.

Recommendation 2.3: Systematically assess the cost and cost-effectiveness of services implemented by the existing pool of civil society and key population organizations and consider which of them would be most appropriate to deliver essential services to their communities.

Recommendation 2.4: Expand the range of key population organizations which are consulted in planning and budgeting, by working in partnership with the soon to be formed key population network, and support these organizations to establish a functional platform that will allow them to jointly strategize.

Recommendation 2.5: Set up clear mechanism for key population-led organizations to engage in national policy and decision-making processes and then build the capacity of key population-led organizations to effectively participate.

Recommendation 2.6: Map and assess the capacity needs of civil society organizations to deliver confidential good quality services, manage funds, manage strategic information, and engage in national planning and budgeting. Work with organizations such as the National Institute of Health Sciences to develop an accreditation and licensing system so the NSACP can ascertain the ability of a civil society organization to provide the agreed services, and fund and deliver capacity development training to meet the needs identified.

Recommendation 2.7: Explore additional funding opportunities for civil society organizations. Discussions should also be held with other existing multilateral and bilateral donors and with the private sector and high net worth individuals in Sri Lanka. There may also be opportunities for public-private partnerships, particularly with

respect to health service delivery, marketing and distribution. Civil society organizations could consider developing business enterprises. The Family Planning Association of Sri Lanka is one potential resource with its Social Enterprise Hub which can provide support and tools for income generation.

Recommendation 2.8: To meet the complex needs of issue 1 and 2 recommendations, engage an appropriately senior independent consultant to work with NSACP, FPA SL and other stakeholders to as a financial sustainability advisor. This individual will need to be able to facilitate detailed consultations in support of financial sustainability of key population HIV services, including high level engagement and advocacy with government, and supporting the development of strong plans and other documents. Stakeholder feedback suggested this individual is best placed within a government office, in a position able to connect effectively with other ministry of health programs, the ministry of finance, the social service ministry, district divisional secretariat etc.

Issue 3: HIV surveillance data is outdated, there are gaps in cascade indicators for key populations, data are insufficiently granular to guide the HIV response at the local level, and information systems are not adequately monitoring key population progress across the cascade

Sri Lanka is planning another round of HIV prevalence and risk behaviour surveillance among key populations in 2023. This will be critical given the increase in HIV prevalence among men who have sex with men since 2018 and the increasing number of new infections detected in HIV counselling and testing settings over the last three years. Several other gaps were mentioned in the text around the ability of information systems to understand the key population situation and monitor service coverage and quality.

Recommendation 3.1: Use the 2023 survey to address data gaps, including for cascade indicators for each key population group, and to generate updated risk profiles, and coverage and size estimates. With appropriate ethical provisions in place, surveillance can also be used to increase HIV case detection and to identify new key population members willing to receive HIV prevention interventions such as PrEP.

Recommendation 3.2: Strengthen information systems to better monitor key population progress across the cascade. Specifically:

Recommendation 3.2.1: Upgrade individual-level tracking through improved collection and recording of data in outreach settings. The use of unique identifier codes should enable anonymous tracking of individuals who are yet to be tested, or not linked to treatment or at risk of defaulting.

Recommendation 3.2.2: Add indicators on linkage to treatment, care and support and follow-up of individuals needing HIV services in civil society organization data collection tools and NSACP reports. This should help to `digitise the client journey', thereby strengthening the link between community and health facility activities, ensuring that outreach workers or team leaders have a stronger role in connecting key populations to services, and limiting lost to follow up.

Recommendation 3.2.3: Roll-out the PIMS and integrate it with the EIMS. The inclusion of PrEP and other interventions delivered in community settings will strengthen overall data quality and accuracy. The Strategic Information Management unit will need technical assistance to ensure the two systems are fully integrated and operational for all users, with appropriate security measures. The unit should also provide capacity building for civil society service providers on accurate recording and reporting of data.

Recommendation 3.2.4: Establish a feedback mechanism from the NSACP to civil society organizations for disaggregated data by key population and area, and from clinics to outreach organizations for clients needing follow up. If unique identifier codes are harmonized between health facilities and community service providers, there is potential for the latter to do more in terms of client follow up if a client misses PrEP or ART initiation or refill. This would have to be done in close consultation with key populations in order to protect their privacy and confidentiality.

Recommendation 3.2.5: Build the capacity of Strategic Information Management unit to collect and maintain good quality data. The unit would benefit from: task analysis with a view to integrating data quality assurance responsibilities across the team; and putting in place monthly data reviews in addition to the overall annual reviews, to improve the quality of data and promote a culture of evidence-based programming at NSACP.

Issue 4: Positive enabling environment to implement community-led monitoring

Sri Lanka is in a good position to implement community-led monitoring with pilots already having taken place and a strong Technical Working Group that includes representatives from most key populations as well as from NSACP and the Family Planning Association of Sri Lanka. The roll-out of community-led monitoring, if it is well designed and adequately resourced, will provide opportunities for improving HIV services.

Recommendation 4: Support roll-out and implementation of community-led monitoring. Specifically:

Recommendation 4.1: Fast track pilot testing, adaptation and roll-out of community-led monitoring tools as per the SKPA-2 workplan.

Recommendation 4.2: A clear agreement is needed between NSACP and civil society on the definition and scope of community-led monitoring based on its potential contribution to improving program efficiency and outcomes. Regular meetings of the Technical Working Group will be needed to design, test and finalise a community-led monitoring system for Sri Lanka based on the Availability, Accessibility, Acceptability and Quality-focused toolkit developed under SKPA-2. Design considerations to be resolved include:

- How will data be collected (tablets have been successfully used in the Family Planning Association system)?
- Where will the data collection take place (at some or all NSACP HIV clinics, or only civil society organization centres?) Will it

cover only organizations providing comprehensive services including treatment, or also those providing outreach and testing services?

- Who will be the focal point for following up problems and concerns among key populations? Who will this focal point liaise with at NSACP?
- What resources are needed to program a custom data collection app and dashboard for the results?
- How can community-led monitoring be promoted among key population service recipients to ensure a high uptake?

Recommendation 4.3: Establish a mechanism for dealing with serious issues such as stigma and discrimination at both regional and national levels. This may involve stakeholders from other Ministry of Health departments or a quality assurance team within the Ministry or the law society of Sri Lanka. Activities here should include establishing a review system, with individuals assigned responsibility for clinic/service level feedback, and a referral system with standard operating procedures to complementary services where needed.

Recommendation 4.4: Analyze community-led monitoring data and present the data in charts and graphs using an interactive dashboard. The NSACP and the Technical Working Group should allocate time and resources to review the findings of the analysis and identify implications or action items for quality improvement of services.

Issue 5: Implementation of HIV testing and PrEP needs to be scaled up

Sri Lanka has made good progress in implementing innovative HIV testing approaches such as self-testing and in expanding access to PrEP for men who have sex with men. However, a number of regulatory, planning and programmatic bottlenecks need to be addressed before these services can be accessed by key populations who need them.

Recommendation 5: Scale up HIV testing and PrEP including advocating for PrEP and self-testing targets based on key population size estimates and updating the targets each year to reach 2030 national targets.

Recommendation 5.1: Scale up HIV testing access. Testing access can be scaled up through strategies including: 1) validating and rolling out the three-test algorithm; 2) expanding the role of lay counselors to include use of the three-test algorithm; 3) expanding access to HIV self-testing, which requires adding self-test kits to the national procurement system and building capacity for estimation of test kits and reagents at the national level, and strengthening monitoring of self-testing; 4) working with HIV testing and treatment centers to implement comprehensive contact tracing for each newly detected case; and 5) making provisions for the private sector to contribute to self-test access and utilization.

Recommendation 5.2: Scale up equitable PrEP access. Access should be expanded to include female sex workers and transgender women. Conduct an assessment of community preferences and attitudes towards PrEP, including willingness to pay, and other options available, such as introduction of long

acting injectables. As with HIV self-testing, there is a need for capacity building on the estimation of drugs and reagents at the national level, and for consideration of service delivery models that involve the private sector.

Recommendation 5.3: Sensitization of health service providers combined with scale up training and accreditation to support both HIV self-testing and PrEP, including: 1) developing standard operating procedures and training modules for each of the different testing options for key populations and 2) providing training and capacity building for health service providers through the use of an accredited training manual on use of both PrEP and self-testing.

Recommendation 5.4: Budget for procurement of commodities and implementation of all testing approaches and PrEP, and for demand creation for these services including virtual interventions. These commodities and activities need to be integrated in the national program to ensure that they receive domestic funding in future and that innovative approaches to testing and access to PrEP are also scaled up in districts that are not funded by the Global Fund. Demand creation strategies need to be tailored to each target audience/key population.

Issue 6: Strategic behavioral communication and case management approaches are not integrated, which limits the effectiveness of outreach efforts

Given the importance of outreach in reaching new key populations and achieving high levels of testing and access to other services among those at risk, there is a need to refresh the overall approach and the tools used.

Recommendation 6: Improve the effectiveness of outreach efforts by integrating strategic behavioral communication and case management approaches with a focus on the following:

Recommendation 6.1: Commission an independent technical review of outreach approaches and messaging, conducted by an expert in HIV prevention for key populations and strategic behavioral communication. A study tour in South Asia to review good quality behavior communication materials and peer-led approaches is also recommended. The review and/or study tour should inform revised standard operating procedures for conducting cost-effective physical and virtual outreach that includes U=U messaging and peer navigation to confirmatory testing and treatment services, and capacity building in interpersonal communication skills and online outreach for outreach workers. Data collection tools and targets should be updated for outreach workers. Procedures that may benefit from standardization include: the high intensity approach to physical outreach, virtual outreach, assisted self-testing, linkage to treatment and follow up, and partner tracing/index testing. Some of these procedures may require additional budgetary allocations to cover the costs associated with, for example, escorting key populations to confirmatory testing or for treatment initiation.

Recommendation 6.2: Expand and scale up virtual Interventions adding additional features or new interventions including: 1) ability

to order PrEP/ART refills on the online platform and other telehealth services; 2) access to chat box and hotline services; 3) expanding the target audience for virtual interventions to cover younger key population members and other key population groups; 4) expanding aspects related to community-led monitoring and demand creation; 5) using more attractive interfaces and 'hooks' to engage key populations; and 6) including the private sector on the same platform to increase access to services.

Recommendation 6.3: Mobilize additional peer educators or outreach workers to adequately service eacher key population. Start by building the capacity of civil society organizations to map local key population hotspots and client numbers, and to use the data this generates for local (micro) planning, including ensuring there is an appropriate ratio of key population community members to outreach workers or peer educators and that they are deployed where the needs are greatest.

Issue 7: Shortages of ART, PrEP and other critical commodities and reagents pose a threat to HIV prevention and treatment targets

Access to and availability of ART, PrEP and condoms varies across the country. Shortages, combined with other factors, such as the high cost of baseline liver or kidney function tests, present barriers to accessing services that could undermine progress towards national targets.

Recommendation 7: Assess and strengthen procurement and supply chain management systems for ART, PrEP and other critical commodities and reagents. A procurement and supply chain management assessment could help to understand whether any additional provisions or new procedures are needed in planning or procurement.

Issue 8: A range of human rights and gender barriers limit access to and use of essential HIV services by key populations

The review of human rights and gender barriers identified a number of key issues, including: criminalization of the LGBTQI community and people who use or inject drugs; use of the law to target, harass and arrest members of key populations; legal gaps in protections for key populations and people living with HIV; societal stigma and discrimination; stigma and discrimination in healthcare settings and in the workplace; gender-specific factors that increase the vulnerability of women; and lack of access to adequate mechanisms to seek redress.

Recommendation 8.1: Support key populations to address legal and policy barrier. Specifically:

Recommendation 8.1.1.: Support civil society organizations, including organizations that consist of and represent key populations, to raise awareness of the adverse impact of criminalization on the LGBTQI community and on people who use and inject drugs and to advocate for legal provisions to adhere to international human rights standards and against the misuse of legal measures – notably the Vagrants Ordinance – to detain and arrest transgender people and sex workers.

Recommendation 8.1.2: Expand pro-bono legal services considering the right to legal aid as a fundamental human right, and build legal literacy among key populations and support access to pro- bono legal services to enable them to seek redress for human rights violations, including violence perpetuated by the police.

Recommendation 8.2: Take steps to eliminate stigma and discrimination in healthcare settings, including facilities in rural areas. Specifically:

Recommendation 8.2.1: Provide anti-stigma and anti-discrimination training for healthcare providers in pre-service and in-service training.

Recommendation 8.2.2: Develop good practice guidance and protocols for facilities to prevent and address stigma and discrimination by healthcare providers. Examples could include a patients' bill of rights, instructions on how to keep data confidential, and establishing a safe and effective reporting and redress system.

Recommendation 8.2.3: Establish an effective and accountable complaints mechanism that is integrated into the national health system.

Recommendation 8.3: Take steps to reduce and eliminate violence against key populations and people living with HIV, and hold perpetrators accountable. Specifically:

Recommendation 8.3.1: Establish a complaints mechanism that is accessible and accountable, and linked to the appropriate institution (Human Rights Commission or other).

Recommendation 8.3.2: Develop and implement anti-discrimination training for the police on key populations, and ensuring there is no impunity for human rights violations against key populations. Training modules developed in other countries could be adapted for use in Sri Lanka. These could be complemented by advocacy materials to sensitize the police on sexual orientation, gender identity and expression, and sex characteristics.

Recommendation 8.4 : Engage a Human Rights and Gender Advisor to help prioritise and support the implementation of recommendations 8.1 to 8.3.

ANNEX 1: PATHWAY TO FINANCIAL SUSTAINABILITY OF KEY POPULATION HIV SERVICES

Sri Lanka's pathway to financial sustainability of key population HIV Services

Sustainable financing mechanism: Government of Sri Lanka procures priority key population HIV services from KP organizations

Assumptions/Rationale: GoSL already contracts out outreach to key population-led CSOs through the Global Fund national grant. There are existing accreditation and registration systems in place to facilitate key population led organisations receiving funding.

What might sustainable financing look like under social contracting?

Option 1: Through existing funding mechanisms
(HIV program budget)

GoSL contractsg CSOs to provide key population services

Mechanism: Direct contracting or overarching contract with NGO

Assumptions/Rationale: Some KP led services are cost-effective & GoSL has precedent for funding KP-led CSOs through GF. Potential timing for this stage impacted by economic crisis.

AND

AND

Option 2: Through new funding mechanisms
(Income generation, new philanthropic partners)

CSOs generate income and/or attract private and philanthropic sector funds

Assumptions/Rationale: New funding sources needed that do not depend on GF or government. CSO leaders are already engaging in resource development activities at an individual and organisational level: encourage this.

Support from SKPA-2 Financial Sustainability Advisor

What are the key processes and activities?

CSOs adopt effective business models

Assumptions/Rationale: At the network and organisational level, key population led CSOs need to navigate the registration and accreditation process of the GoSL and set up effective systems to manage funding. Leaders need to actively engage in organisational development

Cost and modelling data used to inform cost effective role for CSOs

Assumptions/Rationale: Service level costs are being collected through SKPA-2 ongoing activities, and strengthening the evidence base for a package of key population led HIV services within the continuum of HIV prevention and care.

What is the baseline situation & bottlenecks that need to be addressed?

GoSL already contracts CSOs to provide key population services

Assumptions/Rationale: The basic funding mechanism is in place through the national grant, as well as independent of the national grant, following an accreditation and registration process.

Economic crisis of 2022 will have a lasting impact

Assumptions/Rationale: The severity of the economic crisis means the country could take years to recover economically

CSOs are already entrepreneurial

Assumptions/Rationale: Interruptions to funding are common for KP led CSOs and their sustainability can feel constantly under threat. There are examples of great resilience and openness to new opportunities among the CSO leaders

ANNEX 2. KEY INFORMANTS INTERVIEWED IN SRI LANKA

Sri Lanka: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Dr. Rasanjanjalee Hettiarachi	Director	National STD & AIDS Control Program (NSACP)	1,2
Niluka Perera	Independent/ Optima consultant	Global Fund Advocates Networks	1,2,3
Dr. Janaki Vidanapathirana	Director	Policy Analysis and Development, Ministry of Health	1
Dr.Sathya Herath	National KP Coordinator	National STD & AIDS Control Program (NSACP)	1,2,3
Dr. Kumari Navarathne	Public Health Specialist, Independent Consultant	Consultant, Asian Development Bank (ADB)	1
Dr. Ariyaratne K.A. Manathunge	Coordinator of Strategic Information	National STD & AIDS Control Program (NSACP)	2
Amal Bandara	Assistant Director M&E	Family Planning Association	2
Dr. Sujatha Samarakoon	LFA-GFATM	National AIDS Council	2,3
Dr. Geethani Samaraweera	HIV Care Coordinator and Training Coordinator	National STD/AIDS Control Program (NSACP)	2

Sri Lanka: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Nadika Fernandopulle	HIV/AIDS Project Officer	Family Planning Association	2
Dr. Nimali Jayasooriya	National Testing coordinator	National STD & AIDS Control Program (NSACP)	3
Mahesh Chandana Nissanka	Civil Society Organization/Team Leader	Alcohol Drug Information Centre	3
Palitha Wijebandara	Civil Society Organization, Program Coordinator	Positive Hopes Alliance	3
Niroshan Senadheera	Civil Society Organization, President	Lanka Plus	3
Madhu Dissanayake	Assistant Representative	UNFPA	3
Thusahara Agus	Executive Director	Family Planning Association	3
Damith	CSO/Team Leader High impact model	SARD	3
Kanthi Abyekoon	CSO/activist	Community Strength Development Foundation	3
Dr. Geethani Samaraweera	HIV Care Coordinator and Training Coordinator	National STD & AIDS Control Program (NSACP)	3

Sri Lanka: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Justice, Rohini Marasinghe	Retired as a supreme court judge. Chair Person	Human Rights Commission, Sri Lanka	4
Ms. Princy Mangalika	CSO/Activist	Positive Women's Network	4
Mr. Chalana Wijesuriya	CSO/Psychologist	MHPSS, Western Province	4
Ms. Sakuni Mayadunne	CSO/Activist	Trans Equality Trust, Western Province	4
Ms. Imasha Perera	CSO/Activist	National Transgender Network, Western Province	4
Ms. Bhoomi Harendran	Transgender Activist	Independent	4
Shevandra Wijemanne	Program Assistant	UN, Sri Lanka	4
Ms. Angel Queentus	Transgender Activist/Founder	Jaffna Transgender Network	4
Ms. Sutha S.	Officer	STD Clinic, Jaffna	4
Dr. Rajaharan	Medical Doctor	Jaffna, Hospital	4

Sri Lanka: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Kanti Abeykoon	Project Coordinator and Admin coordinator	Community Strength Development Foundation	4
Dr Thiloma Munasinghe	Gender Specialist and Community Physician	Independent	4
Ms. Manju Hemal	CSO/Activist	Heart 2 Heart	4
Mr. Thushara Manoj	CSO/Activist	Equite Sri Lanka,	4
Ashiq Rose	Anihcam Board member	Anicham Group	4
Ms. Paba Deshapriya	CSO/Activist	Grassrooted Trust	4
Sarala Emmanuel	CSO/Activist	Suriya Women's Development Centre	4
Mr. Janarthan	CSO	Anicham Group	4
Mr. Roshan de Zilva	LGBTIQ Activist	Diversity and Solidarity Trust	4

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