# Sri Lanka College of Venereologists

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8th June, 2016.

Dr D A B Dangalla,
Director/ Policy Analysis & Development &
Acting Senior Assistant Secretary (Medical Services)
Ministry of Health
Colombo 10.

Dear Sir,

**Re: Health Strategic Master Plan 2016-2025**

With reference to your letter numbered PA&D/03/2016 dated on 25.05.16 I am herewith submitting the Proposal of Sri Lanka College of Venereologists for the Health Strategic Master Plan 2016 - 2025 for your kind perusal.

Thank you,

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Dr Ajith Karawita
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**(Sexual Health and HIV Medicine)**

# Proposal by the Sri Lanka College of Venereologists
## For the next Health Strategic Master Plan 2016-2025

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| Programme title | Sri Lanka College of Venereologists (SLCV) |
| Focal point | President, Sri Lanka College of Venereologists and Director, National STD/AIDS Control Programme (implementing entity). |
| Background/ situation analysis* (Problem analysis) | **Epidemic status:**<br>**HIV:** Low prevalent country, estimated HIV prevalence among adults (15-49 years) less than 0.1% and among most at risk populations < 1%. Sex ratio 2.8:1 (2015), Cumulative total of HIV cases were 2308. Approximately 4.5 new cases are reported per week. Probable modes of transmission in 2015; male-female 49%, male-male 37%, mother-child 3%, IDU 1%, and no data 10%. Estimates for 2015 shows that number of PLHIV was 4200, incidence 550 cases/year.<br>**Other STIs:** Overall, about 10,000-14,000 STD cases per year are reported to the NSACP. The number reported in the year 2015 was 13,852. The most common STDs reported to the NSACP in 2015 were Genital herpes (21%), Non-gonococcal inflammations (16%), Genital warts (14%), Syphilis (8%), and Gonorrhoea (3%).<br><br>**Epidemic focus**: the HIV epidemic is kept under surveillance from behavioural factors to reporting of AIDS cases. Although the epidemic status of any risk populations has not reached concentrated epidemic level (5%), the current focus is on FSWs and the MSM that have the greatest epidemic potential. Other people with multiple sexual partners (OPWMP) also need to be focused.<br><br>**Risk and vulnerabilities: Push factors**<br>Clandestine but flourishing sex industry, low level of condom use, concurrent and multiple sexual relationships among key population. Presence of legal barriers, Significant level of stigma and discrimination by healthcare and other settings for people living with HIV and for key populations, the presence of a large youth population and internal and external migration are risk factors.<br><br>**Risk and vulnerabilities: Pull factors**<br>Low partner exchange rate, Low level of sexually transmitted infections (STI), availability and accessibility to free health services from the state sector, high literacy rate, and a low level of drug injectors are protective factors. |
| GAP ANALYSIS by using UHC tool | **Equitable distribution of services to all patients of the country:** this is very variable due to distance issues and not having STD clinics in some districts.<br>**Accessibility to all health services by all patients of the country**: accessibility is affected by the distance as well as due to stigma and discrimination.<br>**Quality of service offered to all patients of the country**: quality of service is variable based on the facilities available.<br>**Financial protection of all patients of the country**: free government health service but service access is low due to stigma and discrimination attached to these type of clinics. |
| Target area & Beneficiaries | **1) Prevention of transmission of sexually transmitted infections; Beneficiaries:** include all the key populations, which include most-at-risk populations (FSW, MSM, BB, DU, STI clinic attendees, Clients of sex workers), vulnerable populations (migrants, prisoners, tourist industry workers), people living with HIV and general population groups. This also includes prevention of |

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| | possible transfusion transmitted infections through donor screening. Screening of antenatal mothers for syphilis and HIV<br>**2) Diagnosis, treatment and care; Beneficiaries:** Adults, adolescents and children with STI including HIV. Prophylaxis treatments for different exposure situations such as occupational and non occupational exposures, and victims of sexual abuse.<br>**3) Promotion of sexual health; Beneficiaries:** General population groups, school children, youths out of school, people with mental and physical disabilities, people with chronic illnesses, prisoners, refugees, and illegal immigrants<br>**4) Strategic information management; Beneficiaries:** Programme planners, implementers, researchers, stakeholders, law and policy makers<br>**5) Health system strengthening; Beneficiaries:** Key populations and general population.<br>**6) Supportive environment; Beneficiaries:** Most at risk populations, vulnerable populations and people living with HIV. |
| Justification | • To achieve universal health coverage (UHC), indicators of MDGs and sustainable development goals (SDG), it is necessary to prevent and control the sexually transmitted infections and to promote sexual health.<br>• Currently Sri Lanka is experiencing an increasing number of new HIV cases and new HIV infections while having low level of fluctuating bacterial infections and slightly increasing viral STDs.<br>• Provision of ART to people living with HIV has shown to reduce their viral load and hence infectivity. Therefore. provision of ART to all eligible people infected with HIV is an essential requirement to maintain their health as well as to prevent further transmission.<br>• Untreated STDs are facilitating transmission and acquisition of HIV and STI related complications. Therefore it is important to provide STD treatment facilities to all the needy populations.<br>• Prevention of mother to child transmission of HIV and syphilis can be achieved by screening and treating all infected women during pregnancy. This will save lots of money and other resources needed to treat infected children subsequently. |
| Important Assumptions/ Risks conditions | **Assumptions**<br>• Current vulnerabilities and risk situation remain for the period of the health master plan.<br>• Population continue to rely on government health service<br>• Community, faith based and civil society individuals and organizations will not oppose the implementation of the plan.<br>**Risk conditions**<br>• Proliferation of vulnerabilities and risk increasing more new HIV and STI cases such as<br>  ○ Influx of foreign migrant workers infected with HIV and HIV care tourism (Medical tourism), internal and external migration<br>  ○ The presence of a large youth population<br>  ○ Clandestine but flourishing sex industry<br>  ○ Low level of condom use<br>  ○ Concurrent sexual relationships among key populations<br>• Financial crisis in procurement of ART for HIV patients and issues related to ART supply chain management.<br>• Community, faith based and civil society individuals and organizations can |

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| | oppose the implementation of the plan. | |
| **Vision** | Quality sexual health services for a healthier nation | |
| **Mission** | Contributing to healthier nation through sexual health promotion, emphasizing prevention, control and provision of quality services for sexually transmitted infection including HIV | |
| **Goal** | **Goal 1**: Prevention and control of sexually transmitted infections including HIV<br>**Goal 2**: Provision of treatment, care and support services for infected and affected individuals<br>**Goal 3**: Promotion of sexual health | |
| Programme Objective | Indicators | Means of Verification |
| **Prevention and control of sexually transmitted infections including HIV** | Percentage of key populations, FSW, MSM, PWID living with HIV<br>(impact indicator) | Programmatic data, NSACP<br>Integrated bio-behavioural surveillance (IBBS) |
| | Percentage of key populations reached with HIV prevention programmes<br>(outcome indicator) | Programmatic data, NSACP<br>IBBS |
| | Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of condoms during their last intercourse<br>(outcome indicator) | Programmatic data, NSACP<br>IBBS |
| | Percentage of antenatal care attendees positive for syphilis<br>(outcome indicator) | Programmatic data, NSACP<br>Sero-surveillance, NSACP |
| **Provision of diagnosis, treatment and care for infected and affected people** | Percentage of eligible adults and children currently receiving antiretroviral therapy | Programmatic data, NSACP<br>(Cohort analysis) |
| | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (outcome indicator) | Programmatic data, NSACP<br>(Cohort analysis) |
| **Promotion of sexual health** | The proportion of the population that has ever received counselling on sexual health or sexuality | Special surveys |
| **Provision of strategic information management service** | Availability and accessibility to complete information on indicators listed in the strategic plan document<br>(outcome indicator) | |
| **Strengthening of Health systems** | Number and Percentage of designated government sectors that have implemented HIV/AIDS activities<br>(outcome indicator) | Programmatic data, NSACP<br>(Multisectoral unit) |
| **Creating a supportive and enabling environment** | People living with HIV stigma index<br>(outcome indicator) | PLHIV stigma Index |
| Output | Indicators | Means of Verifications |

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| **Prevention and control of sexually transmitted infections including HIV** | 1. Number of samples screened for STI (HIV, Syphilis)<br>2. Number of IEC programmes conducted and population groups covered<br>3. Percentage of MARP (FSW, MSM, DU, BB) who received a prevention programme<br>4. Percentage of MARPs and prisoners who received HIV counselling and testing<br>5. Percentage of HIV infected mothers who received ART for PMTCT<br>6. Percentage of MARPs who received an HIV test<br>7. Number of condom distributed | Programmatic data, NSACP<br>IBBS<br>Sero-surveillance data of the NSACP |
| **Provision of diagnosis, treatment and care for infected and affected people** | 8. Number of patients registered<br>9. Number of STI cases reported and managed<br>10. Number and percentage of PLHIV on treatment from the estimates<br>11. Percentage of eligible adults and children currently receiving ART<br>12. Percentage of adults and children with HIV known to be on treatment at 12, 24, and 60 months after initiation of ART<br>13. Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded<br>14. Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV | Progress performance indicators of the NG-PR of the GFATM<br>NSACP ART cohort analysis |
| **Promotion of sexual health** | 15. Number of people who received counselling on sexual health or sexuality<br>16. Number of health education programmes in which sexual health or sexuality was discussed<br>17. Availability of national sexual health strategies and plans | Programmatic data, NSACP |
| **Provision of strategic information management service** | 18. Availability of updated Multisectoral M&E plan and activity plan<br>19. Publication of annual report<br>20. Annual web updates of STI data<br>21. Availability of annual update on research gaps and research agenda<br>22. Routine sero surveillance and behavioural surveys conducted as planned<br>23. Preparation and availability of international data reporting for national indicators (GARPR, SAARC reports etc) | Programmatic data, NSACP |
| **Strengthening of Health systems** | 24. Number of new STD clinics established<br>25. Number of newly identified cadre by category of staff<br>26. Proportion of cadre positions filled by adequately skilled persons<br>27. Number of induction and in-service training programmes conducted<br>28. Proportion of STD clinics filled by a consultant<br>29. Proportion of STD clinics with different services available such as Microscopy, on site HIV testing, on site CD4 counts, Viral load, ART facility<br>30. Availability of updated national standard operational procedures. | Programmatic data, NSACP<br>Facility surveys |

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| **Creating a supportive and enabling environment** | 31. Number of health education programmes where a discussion of STI stigma and discrimination included for different groups including PLHIV, healthcare workers<br>32. Number of advocacy programmes conducted for law and policy makers and law enforcement agencies<br>33. Number of PLHIV and civil society organizations supported | Programmatic data, NSACP |
| Strategies/Major Activities | Main strategic directions (SD)<br><br>SD 1: **Prevention**<br>SD 2: **Diagnosis, treatment and care**<br>SD 3: **Promotion of sexual health**<br>SD 4: **Strategic information management**<br>SD 5: **Health system strengthening**<br>SD 6: **Supportive environment**<br><br>Guiding principles for the national STI and HIV strategic plan<br><br>1. Implementation of evidence based strategies<br>2. Rights based approach<br>3. Gender equality and equity<br>4. Stakeholder involvement<br>5. Multi-level and multi-sectoral approach<br>6. Partnership<br>7. Universal health coverage (UHC) in terms of equity, accessibility, quality and financial protection<br><br>**SD 1: Prevention**<br><br>**Strategy 1.1: Prevention of transmission of HIV among key affected populations**<br><br>Comprehensive interventions for female sex workers (FSW), men who have sex with men (MSM), people who use drugs (PWUD) /people who inject drugs (PWID) and beach boys (BB), people living with HIV (PLHIV)<br>• Improve access to HIV testing services through various approaches (outreach programmes, community testing, and testing at non-health setting etc)<br>• Comprehensive Condom Programming (CCP) for most-at-risk populations<br>• Behaviour change modification through outreach and peer education models<br>• STI prevention and diagnosis: testing, and treatment<br>• Targeted and group specific IEC and BCC through suitable channels of communication<br>• Community involvement and implementing a comprehensive prevention programs<br><br>**Strategy 1.2: Prevention of transmission of HIV among vulnerable groups** | |

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| | Vulnerable populations: Migrant populations, prisoners, armed forces and police personnel and tourist industry workers<br><br>• Population specific IEC and BCC programmes on improving awareness among vulnerable populations<br>• Ensure diagnostic, treatment and care services for vulnerable populations<br>• Provision of continuity for HIV treatment for prisoners, HIV related policy for prisoners<br>• Implement a range of STI and HIV preventive services for vulnerable populations<br><br>**Strategy 1.3: Prevention of transmission of STI and HIV among general population including young people**<br><br>• STI/HIV awareness programmes among general population using various channels of communication especially mass media<br>• Ministry of Education to expand life-skills education in schools, and include STI/HIV and sexual health in the curriculum<br>• Expand STI/HIV diagnosis and treatment services with social marketing of services<br>• Stigma reduction interventions for healthcare workers and communities<br>• Condom promotion programmes and condom social marketing<br>• Improving access to HIV testing services (HTS) and introduction of HIV testing at non-health settings<br><br>**Strategy 1.4. : Elimination of mother to child transmission of HIV (EMTCT) and congenital syphilis**<br><br>• Primary prevention of HIV transmission among women in childbearing age<br>• Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices<br>• Ensure high level commitment and advocacy to eliminate the incidence of congenital Syphilis<br>• Increase access to and quality of syphilis and HIV services at maternal and child health services<br>• Prevention of HIV transmission from women living with HIV to their children by promotion and integration/linkage of EMTCT with related services<br>• Strengthen surveillance, monitoring and evaluation systems<br><br>**Strategy 1.5: Prevention of transmission through infected blood**<br><br>• Support and maintain efficient screening of donated blood, its rational use and assure quality to prevent transmission of infections (HIV, hepatitis viruses, and other infectious agents).<br>• Introduction of new testing technologies for blood screening to reduce window period donors<br>• Strengthen the post-exposure prophylaxis for occupational exposure to |

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| | HIV among health care workers.<br><br>**Strategy 1.6 Maintain quality and coverage of STI services**<br><br>• Upgrade all STD clinics to provide comprehensive STI care for MARPS as well as general population.<br>• Continue training programmes for government and private sector providers in delivering quality STI care<br>• Provincial Health administration to support maintaining comprehensive STI care at provincial STD clinics.<br>• Strengthening the monitoring and provide technical support to provincial STD clinics.<br><br>**SD 2: Diagnosis, treatment and care**<br><br>• Review existing HIV testing policies and update guidelines for HIV Testing Services (HTS).<br>• Promote and provide HTS in clinical and non-clinical settings with human resources and infrastructure facilities.<br>• Uninterrupted supply chain management of antiretrovirals (ARVs) for adults, adolescents and children and pregnant mothers living with HIV.<br>• Maintain the model of continuum of care for PLHIV linking between the care facilities, community, home and other services<br>• Strengthen prophylaxis, diagnosis and treatment for co-infections and co-morbidities in all treatment and care programmes<br>• Ensure HBV vaccinations availability to all persons at risk.<br>• Scale up geographic coverage, through identifying and starting new HIV clinics with human resources and infrastructure<br>• Planning and implementation of induction training and in-services training for health staff on good practises and right based approaches in STI/HIV care settings.<br>• Strengthen the mechanisms for collaboration between HIV and TB activities<br><br>**SD 3: Promotion of sexual health**<br><br>• Integrate sexual health into public health programmes<br>• Develop and promote consensus in the definition and classification of sexuality and sexual problems<br>• Develop specific national sexual health strategies and plans<br>• Involvement of mass media in introducing the issues of responsible sexual behaviours<br>• Implementation of parent education programmes as agents in promoting sexually responsible behaviour<br>• Promote the understanding of the spectrum of female and male identities<br>• Decrease homophobia both among individuals of all sexual orientations<br>• Promotion of culture of reporting sexual violence and health seeking behaviour for victims of sexual violence<br>• Promote and provide age appropriate sexuality education |

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| | • Integrate sexuality education into the general curriculum of education<br>• Provide sexuality education to special populations such as persons with mental and physical disabilities, prisoners, illegal immigrants, refugees etc<br>• Promotion of basic sexual health education for health professionals specializing in STI and HIV/AIDS prevention and control programmes<br>• Promote sexual health research and evaluation<br><br>**SD 4: Strategic Information Management Systems**<br><br>• Implement the National Strategic Information Management Plan (National M&E plan)<br>• Improving the mechanisms of monitoring HIV related data from all sectors including civil society organizations.<br>• Strengthen HIV surveillance, second generation HIV and STI surveillance<br>• Mode of HIV transmission studies to be systematized and regularized.<br>• Integrated biological and behavioural data among key populations in the country to be scaled up, systematized and conducted<br>• Conduction of periodic national population-based surveys (e.g. demographic and health surveys)<br>• Develop and implement research agenda particularly in areas where vulnerabilities are known but risks and prevalence are lesser known e.g. prisoners, military personnel, young people, etc.<br>• Build research capacity and culture within Sri Lanka<br>• Regular mapping exercises for key populations.<br>• Strengthen drug resistance monitoring<br><br>**SD 5: Health Systems Strengthening**<br><br>• Capacity building of existing health infrastructure to cater to all needs of STI and HIV services<br>• Capacity building of laboratory service in the STI and HIV managements, decentralize laboratory facilities for CD4 count and viral load testing, include biochemical test in identified centres<br>• Identify and create cadre for STI clinics including laboratory services and fill cadre positions with adequately skilled personnel<br>• Training and capacity building of human resource by conducting induction training and in-service training or on the job training<br>• Establish an STI virology laboratory in the country with HIV drug resistance surveillance<br>• Build capacities of civil societies (NGO and community based organizations) working for STI and HIV prevention<br>• Establish quality management systems to address clinical care, laboratory testing and workplace improvement whether in government or in private sector facilities.<br>• Develop or update national standard operational procedures for STI and HIV healthcare<br>• Review, development, implementation and adaptation of strategic policy frameworks, policies, legislation/regulations that create the environment for an effective response to HIV, and partnerships that contribute to a |

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| | better response.<br><br>**SD 6: Supportive environment**<br><br>• Development and implementation of culturally sound and evidence-based campaigns that combat stigma and discrimination against PLHIV and promote positive examples of living positive<br>• Advocacy and capacity building of healthcare workers and social service providers to enhance access of services for PLHIV and marginalized groups like sex workers, men who have sex with men, drug users, migrant workers, etc.<br>• Support relevant ministries to develop supportive sectoral policies on the basis of the national AIDS law and national AIDS policy, for example the ministries of health, education, labour and social welfare<br>• Provide organizational and technical support to community-based organizations of marginalized groups and young people, so that they can contribute to the national response and advocate for their needs<br>• Reviewing, and where necessary, revising policies and programmes to reduce gender-based inequities, and ensuring human rights protection for key populations<br>• Leverage broad participation and collaboration of stakeholders through building coalitions and partnerships with a range of stakeholders which are essential for scaling up efforts towards universal access<br>• Strengthen collaboration between HIV and other health programmes to facilitate programme coordination and to align programme targets, guidelines, services and resources<br>• Advocate with local governments to ensure adequate funding for HIV programme at provincial and district levels under the decentralized health system<br>• Implement and monitor the programmes supported by internal and external funding sources for the maximum use of resources<br>• Social protection interventions targeted for PLHIV<br>• Strengthen policy to create an enabling environment for the national response to HIV and AIDS<br>• Involvement of police and other law enforcing agencies to create enabling environment for carrying out interventions for high risk and vulnerable populations |
| Monitoring and Evaluation | There is an M&E organizational structure establish under the national STD/AIDS control programme filled with adequately competent individuals to meet M&E needs of the NSACP. Strategic Information Management Unit and the Epidemiology Unit are the two main units established to monitor the programme activities and objectives.<br><br>M&E is guided by the national level HIV multi-sectoral M&E plan developed in align with the National Strategic Plan of the NSACP. In addition, non-governmental entities have their own M&E plans and linked to the national M&E plan.<br><br>Data for the M&E indicators are generated through various means such as HIV |

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| | sentinel surveillance, behavioral surveillance and STI surveillance, Routine programme data, Mapping and size estimation of most at risk populations, special surveys. |
| (*) Reference to Research | 1. National STD/AIDS Control Programme. Annual Report 2014/15 Colombo: National STD/AIDS Control Programme, Ministry of Health; 2015.<br>2. National STD/AIDS Control Program. Integrated Biological and Behavioural Surveillance (IBBS) Survey among Key Populations at Higher Risk of HIV in Sri Lanka. Colombo: Ministry of Health, National STD/AIDS Control Programme; 2014.<br>3. National STD/AIDS Control Programme. National HIV Monitoring and Evaluation Plan - Sri Lanka 2013-2017. Colombo: Ministry of Health, National STD/AIDS Control Programme; 2013.<br>4. National STD/AIDS Control Programme. National size estimation of most-at-risk populations (MARPs) for HIV in Sri Lanka. Colombo: Ministry of Health, National STD/AIDS Control Programme; November 2013.<br>5. National HIV Monitoring & Evaluation Plan 2013-2017 - Sri Lanka Colombo: National STD/AIDS Control Programme; February 2013. |

**Name of officials who documented the profile**

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