REPORT

Technical support to design, implement and monitor HIV prevention programmes among Female Sex Workers, Men who have Sex with Men and Transgenders in Sri Lanka

NATIONAL STD/AIDS CONTROL PROGRAMME

WORLD BANK

Centre for Global Public Health
University of Manitoba

UNFPA

UNAIDS

Technical support to design, implement and monitor HIV prevention programmes among Female Sex Workers, Men who have Sex with Men and Transgenders in Sri Lanka

A Report

December 2011

Year of Publication	:	2012
Copyright	:	IHAT
Layout and Design	:	M. B. Suresh Kumar (artwist design lab)
Publisher	:	India Health Action Trust
UoM and IHAT Technical Support Team	:	Dr. Faran Emmanuel Dr. James Blanchard Mr. John Anthony Mr. Mohan HL Ms. Parinita Bhattacharjee Mr. Reginald Watts Dr. Shajy Isac Dr. Srinath M Maddur Dr. Stephen Moses Ms. Sunitha BJ Mr. Suresh Chitrapu
The writing team included	:	Mr. John Anthony Ms. Parinita Bhattacharjee Mr. Rajnish Ranjan Prasad

Table of contents

Acknowledgements

The following institutions and individuals have contributed in planning, designing and implementing this initiative: UNFPA, Sri Lanka

UNAIDS, Sri Lanka

World Bank, Sri Lanka

National STD and AIDS-Control Programme, Sri Lanka

Sarvodaya Shramadana Sangamaya

Companions on a Journey

Community Strength Development Foundation

University of Manitoba

India Health Action Trust

Karnataka Health Promotion Trust

Dr. Nimal Edirisinghe, National STD and AIDS Control Programme, Sri Lanka

Dr. David Bridger, UNAIDS, Sri Lanka

Dr. Dayanath Ranatunga, UNAIDS Sri Lanka Dr. Kumari Navaratne, World Bank, Sri Lanka Ms. Revati Chawla, UNFPA

Mr. Sherman deRose, Companions on a Journey, Sri Lanka

Mr. Sagara Prasad Palihawadana, Companions on a Journey, Sri Lanka

Mr. H. A. Lakshman, Community Strength Development Foundation

Ms. A. M. Chandra Kanthi Abeykoon, Community Strength Development Foundation

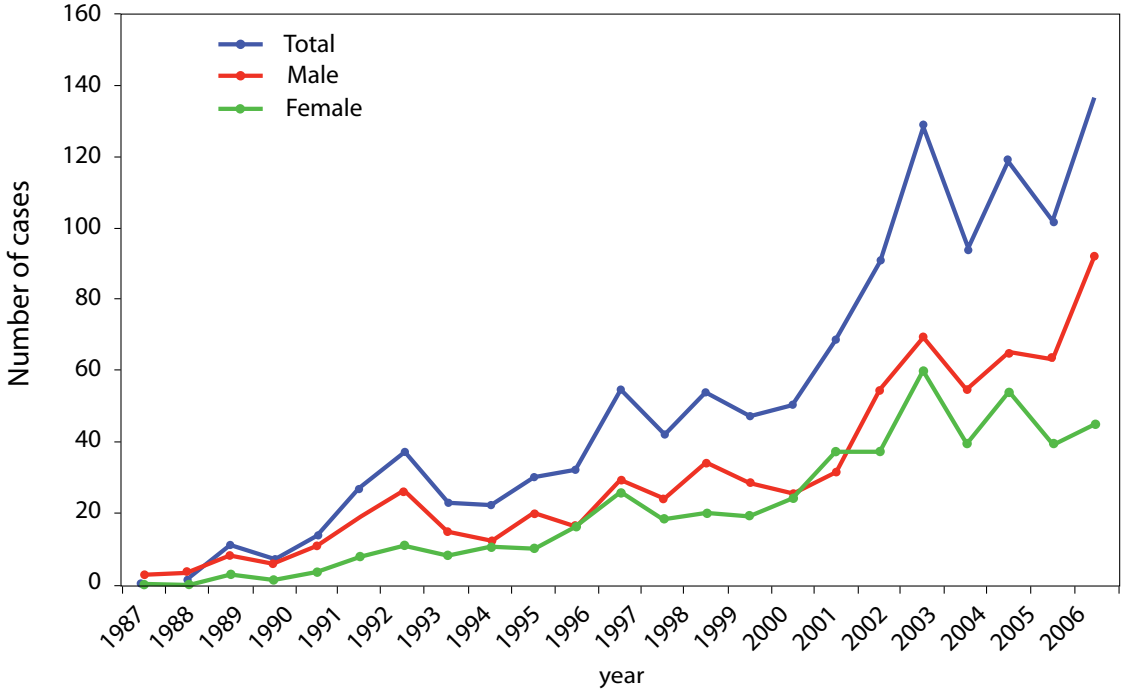
Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
CBO	-	Community Based Organization
CoJ	-	Companions on a Journey
CSDF	-	Community Strength Development Foundation
CSO	-	Civil Society Organization
FSW	-	Female Sex Worker
GFATM	-	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	-	Human Immunodeficiency Virus
HRA	-	High Risk Activity
HRG	-	High Risk Group
IDU	-	Injecting Drug User
MARPs	-	Most at Risk Populations
MoH	-	Ministry of Health
MSM	-	Men having sex with men
MSW	-	Male Sex Worker
NGO	-	Non-Governmental Organization
NSACP	-	National STD and AIDS Control Programme (Sri Lanka)
ORW	-	Outreach worker
PE	-	Peer Educator
STI	-	Sexually Transmitted Infection
SW	-	Sex Workers
UN	-	United Nations
UNAIDS	-	United Nations Joint Programme on HIV and AIDS
UNFPA	-	United Nations Population Fund
UoM	-	University of Manitoba
WB	-	The World Bank

1 INTRODUCTION

Sri Lanka continues to have very low HIV prevalence. The first HIV infection in the country was reported in 1987, and since 2009, a total of 1196 HIV infections and AIDS cases have been cumulatively reported in the country. As per the Report on HIV Estimates and Projections 2009, prepared by the National STD and AIDS Control Programme, HIV prevalence among the adult population is 0.02 percent, and an estimated 3,000 people are living with HIV and AIDS. There has been a steady increase in the number of reported cases over the years, in part due to the increase in HIV testing facilities and the availability of antiretroviral treatment (Figure 1).

Figure 1: Reported HIV/AIDS cases by sex - Sri Lanka, 1987-2009



Source: Report on HIV Estimates and Projections 09

As per available data, HIV is largely concentrated in urban areas; nearly 60 per cent of reported cases are from the western province. The other most affected provinces are northwestern, central and southern provinces[1].

[1] Report on HIV Estimates and Projections 2009

HIV and AIDS among MARPs

In 2006, the first behavioural surveillance survey (BSS) was conducted among sex workers, men who have sex with men (MSM), factory workers, three-wheel drivers and drug users. Key findings of the BSS were: proportion of men buying commercial sex ranged from 1.1 per cent among factory workers to 12.2 per cent among three wheel drivers and 15.5 per cent among drug users; and 0.8 per cent of factory workers and 5.5 per cent of drug users reported having male-to-male sex in the past year. Consistent condom use varied from a low of 46 per cent among MSM with non-regular partners to 80 per cent among factory workers having sex with commercial sex workers[2].

Although HIV surveillance data shows low prevalence among MARPs and suggests an early HIV epidemic phase, the BSS has shown that female sex workers and men who have sex with men practice high risk behaviours, exposing them to the risk of HIV infection. Not only is the presence of MARPs sizeable, the presence of overlapping and concurrent sexual relationships among them may facilitate the spread of HIV to some extent, and change the landscape of a latent epidemic.

Modes of transmission of HIV

The main mode of transmission of HIV is unprotected sex between men and women (82.8%). Men who have sex with men (MSM) account for 11.2 per cent of transmission, while mother to child transmission accounts for 5.4 per cent of cases. Transmission through blood and blood products accounts for 0.4 per cent of cases[2].

Government response to HIV and AIDS

In 1992, the Government of Sri Lanka initiated HIV prevention and control efforts through the National STD and AIDS Control Programme (NSACP) of the Ministry of Healthcare and Nutrition, under the Director-General of Health Services. In addition, the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis and Chest Diseases (NPTCCD) strengthened their responses to reduce transmission and prevent further spread of HIV. Services under these initiatives are provided in collaboration with nine Provincial Directors of Health Services and the respective district staff. The NSACP, in collaboration with the Provinces, undertakes HIV prevention activities and provides care and treatment to people living with HIV. In addition, Sri Lanka has a well-established HIV sero-surveillance system.

Partnership with the University of Manitoba

The World Bank and Government of Sri Lanka invited the University of Manitoba (UOM) to provide technical support for conducting mapping, and later on, to develop two pilot projects in Colombo, Sri Lanka. The mapping was conducted in four districts, and provided quality evidence for designing HIV interventions. A total of 11,683 FSWs were estimated in these four districts, while the estimation for the MSM population was 10,937. The exercise also provided useful information about the places of congregation of FSWs and MSM, and variations on peak days. Post-mapping, a pilot intervention was designed and implemented in Colombo for a period of nine months. A program design workshop was organized at Bangalore, India to design the intervention, in active partnership with UNAIDS, UNFPA, the World Bank, the Government of Sri Lanka and local NGOs, namely Companions on a Journey (CoJ) and Community Strength Development Foundation (CSDF). The implementation of the pilot project was undertaken with the support of all the partners and the Government. The focus of the initiative was to develop a model replicable intervention and build the capacity of the local partners to scale up HIV and AIDS interventions in the country.

[2] UNGASS Report Sri Lanka, 2008-09

2

MAPPING AMONG MOST AT RISK POPULATIONS

Good quality data is critical to design effective interventions. Mapping of most-at-risk populations was conducted by the National STI and AIDS Control Programme, Ministry of Health care and Nutrition, through financial assistance of the World Bank, UNAIDS and UNFPA. Technical support for the work was provided by the University of Manitoba and the India Health Action Trust.

After reviewing the risk situation in Sri Lanka, the National STD and AIDS Control Programme (NSACP), Ministry of Healthcare and Nutrition, prioritized mapping of populations of female sex workers and men having sex with men. Mapping was initially conducted in two districts, Colombo and Anuradhapura and subsequently scaled up to include Batticaloa and Nuwara Eliya districts. Fieldwork was done by local implementation teams from CSDF, COJ and their partners, with supportive supervision from the NSACP,, and the UoM and IHAT technical team. Analysis of the data was done by the IHAT technical team, and the report was finalised after incorporating comments from all partners.

Key findings from mapping

Estimate of FSW population

	Colombo	Anuradhapura	Batticaloa	Nuwara Eliya
Number of Key Informants interviewed (L1)	1884	725	882	967
Number of active spots identified	1066	311	191	370
Number of FSW (usual day)	6726	873	646	879
Number of FSW (peak day)	10396	1402	1016	1414
Number of FSW (final, accounting for duplication)	8332	1138	880	1333

- Maximum numbers of FSWs were found in Colombo, followed by the districts of Nuwara Eliya, Anuradhapura and Batticaloa. The number of FSWs on peak days (holidays/weekends) far outnumbered the number of FSWs found on usual days.
- The most prominent typology of FSWs was street-based, in both Colombo (42.5%) and Anuradhapura (64.4%), followed by home based and "shanty/slum" based FSWs. On the other hand, the largest proportion of FSWs (three-quarters) in Batticaloa and Nuwara Eliya were home/shanty based,, and one-quarter were street-based. Lodge- and hotel-based sex work was also reported from all of the districts.
- A significant proportion of FSWs in Colombo (15%) reported operating indirectly as sex workers at various entertainment-providing establishments, such as night clubs, karaoke bars, massage parlours, etc.

Estimate of MSM population

	Colombo	Anuradhapura	Batticaloa	Nuwara Eliya
Number of Key Informants interviewed (L1)	2057	834	506	947
Number of hot spots/pick up points	652	77	95	122
Number of MSM (usual day)	6015	569	430	587
Number of MSM (peak day)	8846	729	571	1008

- A total of 10,936 (range 9,244 to 12,623) MSM were estimated from 946 spots (pick-up points) from the four study districts. The estimated number of MSM differed significantly on a usual day and on a peak day, e.g., weekends or public holidays. On average, the number of MSM on a peak day was approximately 50 per cent higher than those on a usual day.
- Nearly half of the MSM were categorized as "gay men", followed by Nachchis (33%) and male sex workers (17%). A very small proportion of the MSM were beach boys in Colombo (2%). (Nachchis are effeminate men who have sex with other men. They also operate as MSWs, and pick up clients from various cruising points. In addition to having clients, they often have regular male sex partners, with whom sexual activity takes place without financial transactions.

Based on the mapping, using a regression model approach, it was estimated that there are approximately 41,000 FSWs and 32,000 MSM in the country[3].

The complete mapping report is available from the NSACP, UNAIDS, UNFPA and the World Bank.

"The mapping was very useful and the experience from it will come handy for conducting mapping under GFATM – 9".

Dr. G. Weerasinghe, NSACP

[3] Rationale for estimating HRG in Sri Lanka, University of Manitoba, 2011

3
PROGRAMME DESIGN WORKSHOP

After the mapping exercise, a five-day workshop was organized at Bangalore, India, from 7th to 10th December 2010, to provide exposure to MARP-related interventions and to design a pilot project for HIV prevention among FSWs and MSMs in Colombo. The workshop was participatory and focused on making participants understand the processes involved in planning such interventions.

The programme design workshop included the following components:

3.1 Defining a basic design of the interventions

Participants were oriented on the design of the interventions. Key components of the interventions were outlined:

(i) outreach and communication, which includes the use of micro-planning tools for service delivery and inter-personal communication for sustainable behaviour change; (ii) referral for STI and HIV testing services; (iii) condom distribution; and (iv) advocacy for creating an enabling environment.

3.2 Using mapping data to select intervention sites

Based on the mapping exercise, availability of HRGs, and discussion with different stakeholders, the following areas were selected for pilot interventions:

For interventions with female sex workers - Colombo: With an estimate of 1224 FSW in 130 spots, Dehiwala was selected as the intervention site for FSWs. Since the existing CSDF programme was already covering 2500 FSWs in Colombo (30% of the total estimated FSWs), it was decided that the proposed project would increase the coverage to 44 per cent of the total estimated female sex workers in Colombo.

For interventions with men having sex with men - Colombo: With an estimate of 1185 MSM in 91 spots, District 2A was selected as the intervention site for MSM. Since the existing CoJ programme was already covering 150 MSM in Colombo (2% of all estimated MSM), it was determined that the proposed project would increase the coverage to 14% of estimated MSM in Colombo.

3.3 Designing an Outreach Plan (including services and condoms)

After finalizing the geographical areas to be covered and target to be achieved, the next step was to design an outreach plan. The outreach plan was developed using the following steps:

Step 1: Developing sites - The intervention team made a physical map of the selected districts and plotted the spots identified during the mapping.

Step 2: Developing a site-based outreach plan - The team working with MSM listed the number of Nachchis, male sex workers (MSW) and MSM who solicit in each identified spot. They also indicated whether the site was a soliciting site or sex site. This exercise helped participants profile the sites better. The team also decided to recruit

two peers (1 Nachchi and 1 MSM) from the Old Bus Stand site, one MSW from the New Bus Stand site and one MSM from Puttalam. The site was further analysed to design linkages to services and condoms. The team working with FSWs undertook a similar exercise. In that exercise, instead of sexual identities, typology of sex work was used as basis for planning and selecting peers.

Step 3: Network breaking - Building rapport with the community is necessary for effectively implementing the programme. It was decided that this would be done through 'network breaking'. The initial focus of the initiative has to be on building rapport with the community and gaining their acceptance.

Step 4: Establishing an office, a DIC and recruiting staff – a Drop-In-Centre (DIC) provides safe space, helps in mobilizing community and provides basic services. It was decided that community's help would be taken to identify a convenient place for a DIC. The staff requirement and time line for recruiting key personnel for the project were also decided.

Step 5: Social mapping and micro-planning - It was decided that once the key personnel were identified and an office was established, the teams should go to each of the sites and conduct social mapping. Some of the key tools to be used for social mapping are: site load mapping, spot/site analysis, contact mapping, and peer plan.

Step 6: Hiring peers - Participants were given an orientation to the process of hiring peers. While hiring peers, it was suggested to keep in mind that they represent various sites, typologies / sexual identities and social networks. Training of peers in conducting outreach activities was also discussed.

Step 7: Conducting outreach using both site and population level micro plans - Participants were informed on how peers would develop microplans based on the risk and vulnerability profile of all the MARPs in their line list. Direct distribution and demonstration of condoms by peers was also discussed as part of outreach. Participants were made aware of the importance of establishing condom depots at sex work sites and providing referral to services.

3.4 Enabling Environment

Participants discussed the need for creating an enabling environment. The team shared barriers to an enabling environment in Sri Lanka, and developed plans to address them.

3.5 Capacity Building

The capacity building needs of the personnel, based on their roles and responsibilities, were discussed. It was decided that during the pilot project, three sets of training would be conducted in the following areas

- Training 1: would include project staff and community guides. Training would serve to induct them into the project. Topics of training would include: skills for social mapping; selection of peers; supervision; and reporting.
- Training 2: would focus on project staff and peers to train them on communication skills, micro planning and reporting.
- Training 3: would focus on project staff and peers, and train them on legal rights and developing a crisis management system.

An additional workshop was also planned for field teams at Colombo, to develop basic inter-personal communication (IPC) materials, to be used by the peers and outreach workers to communicate key messages to the community.

3.6 Monitoring & Evaluation

Participants discussed the need for establishing an individualized tracking system. Monitoring tools and reporting formats were discussed and agreed upon.

At the end of the workshop, outputs from the pilot project were listed. These outputs were expected to support the Primary Recipients of the GFATM-Round 9 to scale up their programme:

- Documentation of scale-up strategy
- Social planning / micro planning tools
- Inter-personal communication materials for outreach and peer educators
- Monitoring & Evaluation Framework
- Three training modules

4

IMPLEMENTATION OF THE PILOT PROJECT

4.1. Formation of steering committee

To oversee the implementation of this pilot initiative and coordinate among different partners, a Steering Committee was formed. The committee included representatives from the UoM, UN, World Bank, Ministry of Health and the police department. The committee met about four times during the course of the project and made several crucial decisions.

4.2. Contracting the NGOs

Community Strength Development Foundation (CSDF) was selected to implement the pilot initiative among FSWs, and Companion on Journey (COJ) was selected to implement the initiative among MSM. Both the NGOs were endorsed by the UN agencies involved to implement the pilot project. Both NGOs have local presence in Colombo and have been involved in programme implementation and advocacy activities with the FSW and MSM communities in the city. The UN agencies conducted an initial assessment of the NGOs to understand their statutory systems and compliances.

4.3. Recruitment of staff

The first task under the initiative was to recruit staff and orient them to the project. UNFPA supported CSDF and COJ in recruitment and induction of staff. Area coordinators, outreach staff and counsellors were selected on the basis of their experience, knowledge and skills. Peer educators were selected on the basis of their knowledge about area and acceptability among community members. Appointment letters and terms of reference were given to all hired staff by their respective NGOs.

4.4. Capacity building of staff

Capacity building of staff was given a lot of emphasis by UoM/IHAT. While building capacity of staff, the long-term needs of HIV and AIDS programming in Sri Lanka were considered. During the project, two key strategies were used in building capacity of the project team:

- Training, including class room instructions and field practice
- Field-level mentoring, hand-holding and problem solving

Training programmes under the pilot initiative

Development of IPC materials - A three-day workshop was held from 8th to 10th March at the Chintana Training Centre, Nainamadama, Sri Lanka. The workshop brought together members of the FSW and MSM communities, along with technical experts and artists under one roof, to collectively develop behaviour change materials for different target groups. During the workshop, participants identified target groups, different materials, and their behavioural and communication objectives.

Training on micro planning, outreach and services - The objective of this training was to orient participants on different micro-planning tools and their use in outreach and service planning. The following tools were elaborated upon – Outreach, Site Load Mapping, Site Analysis, Contact Mapping and Peer Plans.

Training on communication skills - The participants were oriented on the importance of communication for bringing about changes in behaviour, different forms of communication, and barriers to communication. Participants were also trained on strategies for improving communication skills and using non-verbal signs for effective communication.

Training on counselling skills - Participants were taken through the objectives and importance of counselling. They were trained on counselling skills and provided with exercises to help them improve their counselling skills.

Training on reporting and monitoring - This training was focused on making participants understand the need for a strong M&E system and its key elements. Different indicators and formats used for measuring the progress of the programme were also detailed. Roles & responsibilities of each staff member were clarified. Participants also practiced filling in different monitoring formats, and their questions were addressed.

In response to a request from various governmental and non-governmental stakeholders, a total of 7 training modules were developed by UNFPA and UNAIDS Sri Lanka, with technical assistance from the University of Manitoba and India Health Action Trust team. All modules were field-tested with the teams of CoJ and CSDF engaged in implementing the pilot project.

Select reflections from training programmes

"The capacity building of female sex workers and MSM is very useful as a precursor to the implementation of HIV prevention under GFATM".

Dr K. A. M. Ariyaratne, NSACP

"The communication materials development workshop was very good and there was buy-in from the community".

Dr. G. Weerasinghe, NSACP

"Mapping training helped the organization to build its skills in the area. It also contributed in improving the social standing of the organization. CSDF was selected as a sub-recipient for the GFATM project because of its experience".

Mr. H. A. Lakshman, CSDF

"Some PEs have developed into ORWs due to the capacity building support provided".

Mr. H. A. Lakshman, CSDF

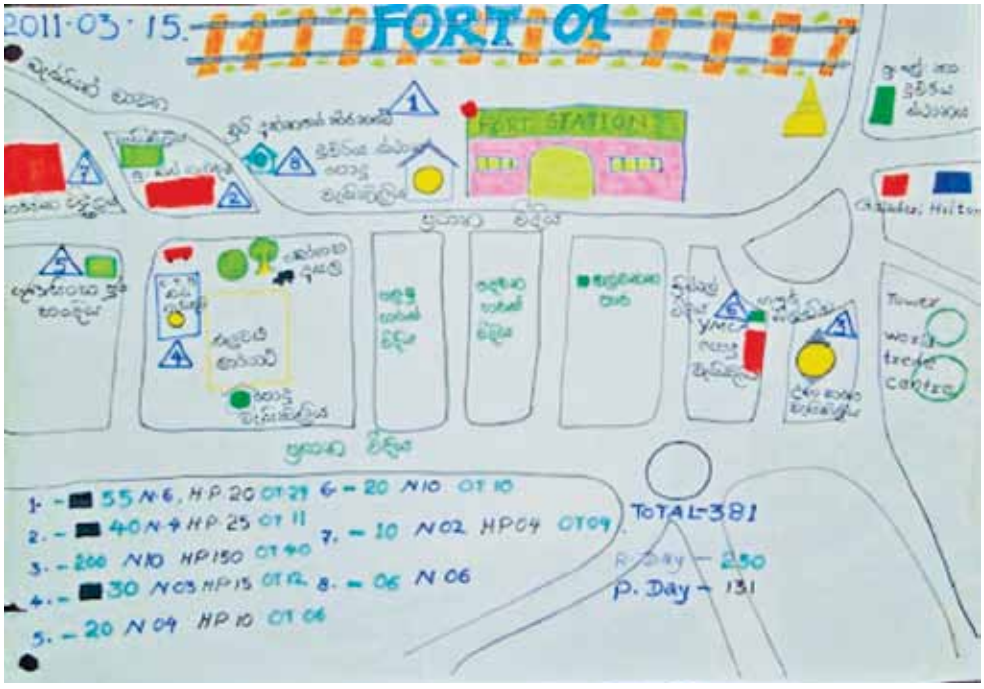
4.5. Validation and finalization of sites

The first step in the planning process was to validate the sites selected for implementation of pilot initiatives. The outreach teams visited all the selected sites for intervention to validate the sites. Visiting the sites helped the outreach teams to understand the location of the venues and soliciting spots. The team updated the list of sites as per the changes observed.

4.6. Development of microplans for outreach

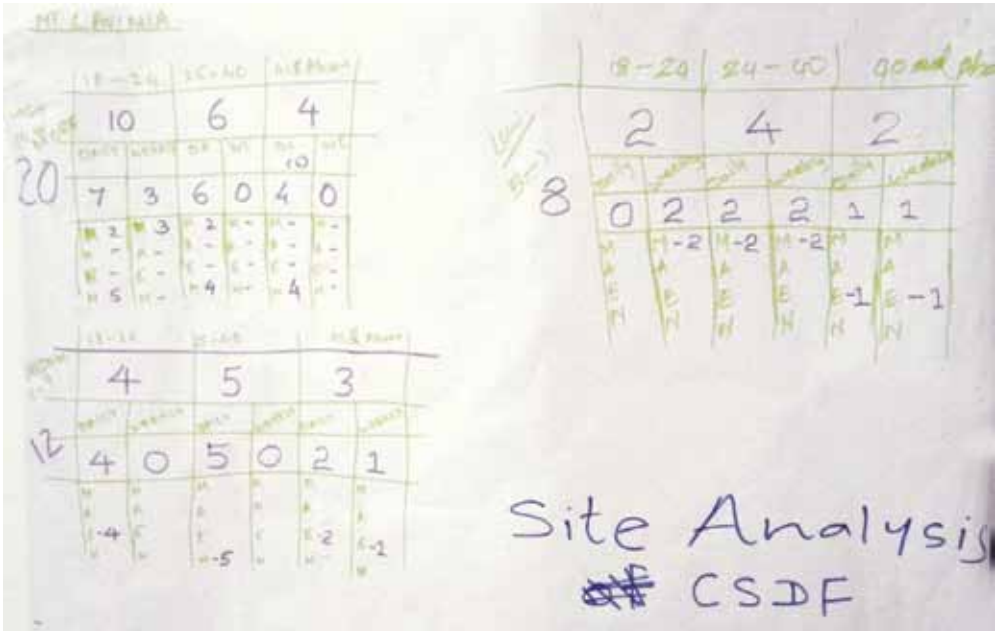
After detailed validation of each site, outreach teams developed outreach microplans using various tools:

Participatory Site Load Map - This tool enabled outreach teams to understand the sex worker load in different sites and determine the gap between estimates, unique contacts and regular contacts. Site maps were created for a given site for a day, a week and a month, and then compared with unique contacts and regular contacts at those sites.



Picture 1: Map developed by MSM-T peers of CoJ, March 2011

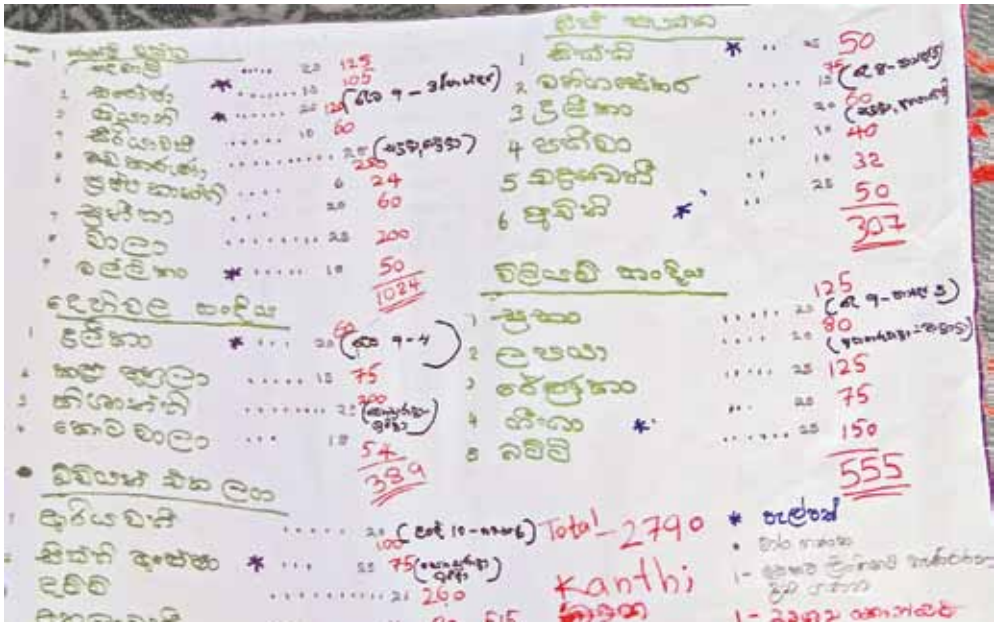
Site Analysis Tool - This tool helped outreach teams to compile and analyze information collected during mapping for each site in their project areas. Site analysis facilitated outreach to a maximum number of sex workers while being responsive to differences in client volume, typology of sex workers, age of sex workers, time of operation, and frequency of operation. It enabled outreach teams to plan their outreach directly to sex workers, or through the sex work circuit. It also enabled prioritization of outreach based on volume of sex work for individuals, or at specific locations (sex work and soliciting sites); or time of day, or season, or special events such as festivals, market days. Shown\ below is the picture depicting site analysis prepared by CSDF.



Picture 2: Site Analysis prepared by CSDF

Contact Mapping: This tool helped peers to map the contacts that they have among most-at-risk-populations at each site, understand who the contacts are, analyze their needs, and plan for outreach. The tool also helped peers to compare their contacts with each other.

Peer plans: This tool helped peers to plan outreach on the appropriate day, time, and place, based on the volume of sex work and typology of each sex worker. It also helped peers to understand the relative risk and vulnerability of each of her/ his contacts and plan outreach accordingly. Given below is the peer plan prepared by a peer educator in which she listed the sites where she operates:



Picture 3: Peer plan prepared by a peer educator

These tools helped the outreach team in micro-planning, based on the need of the site and the need of the populations in the site, focusing on priority sites. Sites with higher number of sex workers were planned to be visited more often that than the others. Site-based peer plans were developed by each peer educator for the sites and community he or she worked with. This tool helped peers to plan their outreach at the appropriate time, day and place. It also helped the peers understand the relative risk of each individual that they reached out to, and to arrive at realistic achievement targets for a peer in relation to the prevention commodities that he / she would have to give to each of the HRGs every week / month. Micro-plans were developed for each site selected for the interventions.

"Micro planning is very important for program implementation in any area".

Mr. H. A. Lakshman, CSDF

4.7. Setting up DICs

Although the DIC was considered as a key strategy to community mobilisation, the high cost of rentals in Colombo made it very challenging to find a DIC. A DIC was finally found in the month of May by CSDF.

4.8. Implementation of the plan

Outreach workers visited the selected sites and met with community members as per the plan. The initial focus was on building rapport with the community members. Once rapport was built, the outreach workers registered the community members with the project. Peer educators ensured that community members were provided with information, referred to STI clinics, and given condoms and lubes.

4.9. Monitoring

Good monitoring systems were developed for this programme. All programme staff were trained on the monitoring tools and reporting formats. This allowed tracking progress on a regular basis and taking corrective action as and when required. Tools such as Opportunity Gap Analysis were used to help the team reflect on and monitor their own work.

Opportunity Gap Analysis

Opportunity Gap Analysis helped outreach teams understand specific gaps and develop site-specific outreach plans to overcome them. Opportunity gaps are obstacles that inhibit an individual or community from moving from one level to the next in the behaviour change process. The gaps may be due to internal factors (e.g. timing of outreach teams) or external factors (high mobility of sex workers), resulting in dropouts from the outreach process or activities in each spot. The outreach activities include, size estimation, contact, registration, regular contact, clinic attendance, follow-up, and regular health check-up.

4.10. Supportive Supervision

UoM/IHAT teams provided supportive supervision through field visits. During these visits, work done by the field team was observed and joint field visits were made. The UoM/IHAT team provided inputs for improving outreach, service delivery and strengthening the monitoring system. They also provided hand-holding support to field teams.

5
MONITORING & EVALUATION

The UoM/IHAT team supported CSDF and COJ to develop and implement an effective M&E system. Key considerations in designing the M&E system were that its usage was understood equally by the community and partner NGOs, and that it should be participatory. It should not be seen as a means to find faults in the implementation process. Rather, it should be able to timely identify opportunity gaps in project implementation.

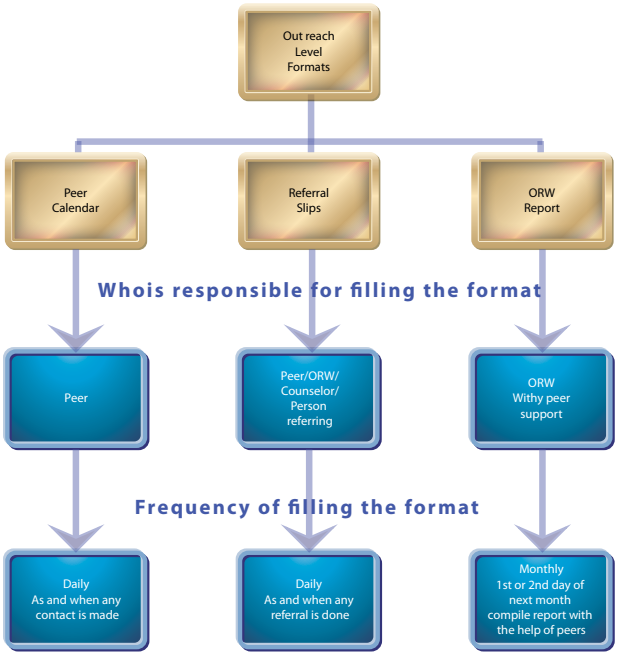
Reporting formats

In order to effectively capture data on critical indicators, formats were developed at two levels: the outreach level and the programme level, as follows:

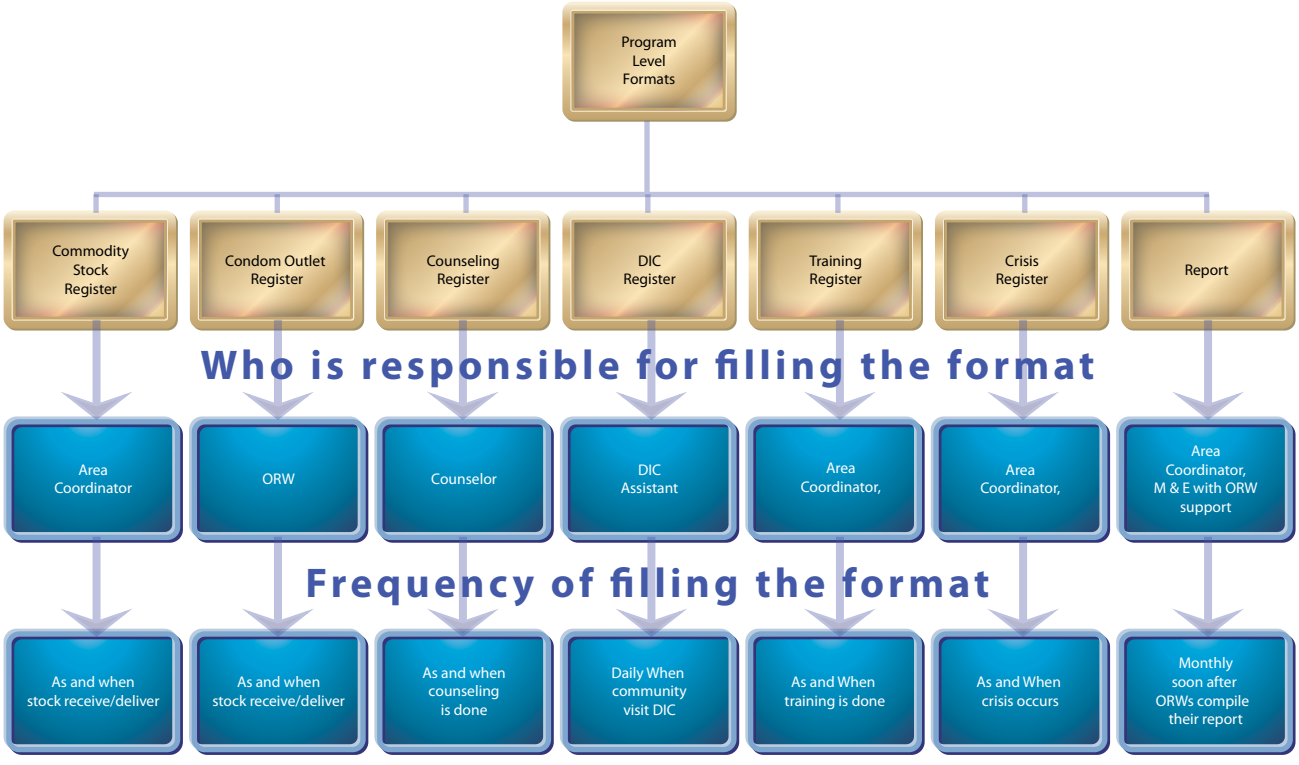
- Registration Form
- Peer Education Calendar
- Referral Slip
- Outreach Worker Report
- Condom Outlet/Depot Register
- Commodity Stock Register
- DIC Register
- Counseling Register

The following charts describe the roles and responsibilities of each format and the frequency of compiling them.

Outreach level formats



Programme level formats



6
RESULTS

The pilot initiative was successful in achieving most of its desired outcomes. All the planned activities and trainings were conducted as per the agreed work plan. A political controversy related to MSM in the country arose in September, resulting in the closured (at least temporarily)of MSM interventions in the project, and this also affected other HIV and AIDS prevention programmes in the country. Because of this development, we were unable to achieve some of the targets related to coverage among MARPs. On the other hand, the project was successful in bringing different stakeholders together, generating good quality data, showcasing a viable programme model, and building the capacity of local teams. Some of the key contributions made by the project are:

"The initiative proves the critical value of community involvement which the country can adopt for scale-up through Global Fund support."

- Dr. David Bridger, UNAIDS

Developed a sound HIV and AIDS programme for demonstration purposes - The pilot project developed in Sri Lanka was evidence-based, scalable, community-friendly, and with strong management systems. It showcases some of the best practices in HIV and AIDS prevention, which can be replicated by other organizations. The project can be used as a demonstration site to build the capacity of practitioners working in the area of HIV and AIDS in Sri Lanka.

"Systems developed under pilot initiatives are very good and same have been incorporated under GFATM project".

- Mr. H. A. Lakshman, CSDF

Build the capacity of local team - Another key contribution made by the project is the strengthened capacity of local staff. Members of staff who were part of the initiative developed knowledge about different programmatic components related to HIV and AIDS programming, including mapping, programme planning, outreach planning, monitoring and evaluation. These staff have grown in their careers because of the capacity building support provided, and can contribute to scaling up HIV and AIDS programmes, and to building capacities of others. One of the implementing partners, CSDF, is already playing a major role in GFATM Round 9 supported HIV and AIDS programming in the country. The focus on capacity building during the design and implementation of the pilot initiative will contribute to strengthening HIV and AIDS programming in the country in the long run.

"The project has build up the capacity of new groups of people to implement the program among FSW and MSM".

- Ms. Revati Chawla, UNFPA

Brought different stakeholders together - The pilot initiative brought different stakeholders together, including, the Government of Sri Lanka, the UN system, the World Bank, the Ministry of Healthcare and Nutrition, and the police department. It helped create a better understanding about HIV and AIDS programming among most-at-risk populations, and helped to enhance the enabling environment within the country.

Base for implementation of GFATM Round 9 project - The pilot project developed a strong base for the implementation of the GFATM Round 9 project in the country. The good-quality evidence generated in the pilot, the strengthened capacities of local teams, the proven effectiveness of the programme, and strong systems for programming and monitoring, will help to quickly scale up the Round 9 supported projects in different parts of the country.

> "The community is very creative, and building their capacity has given good results."
>
> - Dr. Dayanath Ranatunga, UNAIDS

Developed strong systems - Another key contribution of the pilot initiative was in developing strong monitoring and planning systems. During the initiative, local teams were trained on micro-planning tools and different monitoring formats. These tools helped in developing evidence-based programming, with monitoring of progress on a regular basis. The same tools can be incorporated in the GFATM Round 9 project.

Development of training manuals - Seven t raining manuals were developed during the project:

Module 1: Introduction and Overview

Module 2: Induction

Module 3: Outreach and Microplanning

Module 4: Communication

Module 5: Counseling

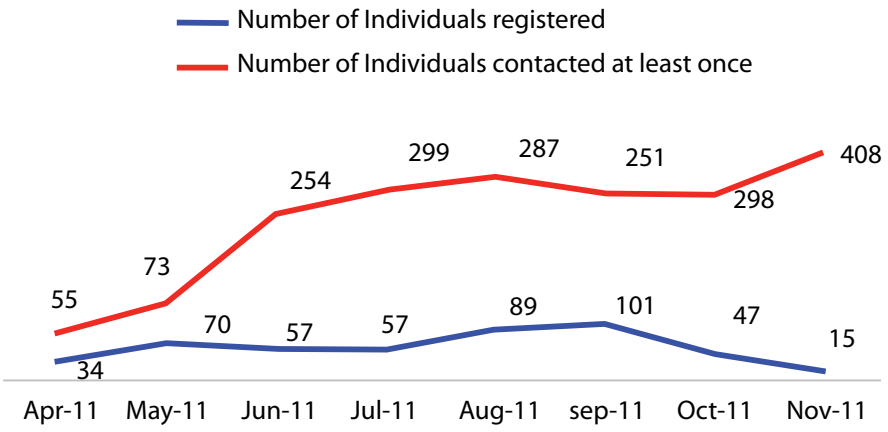
Module 6: Crisis and Violence

Module 7: Monitoring and Reporting

All of these training manuals have been shared with the PRs of the GFATM Round 9 project.

Scale up in coverage among MARPs - Due to adverse media coverage, the COJ programme was closed midway through the project. Nevertheless, CSDF data show impressive growth in coverage over the period. Given below is the chart depicting the number of individuals reached in the period April to November 2011.

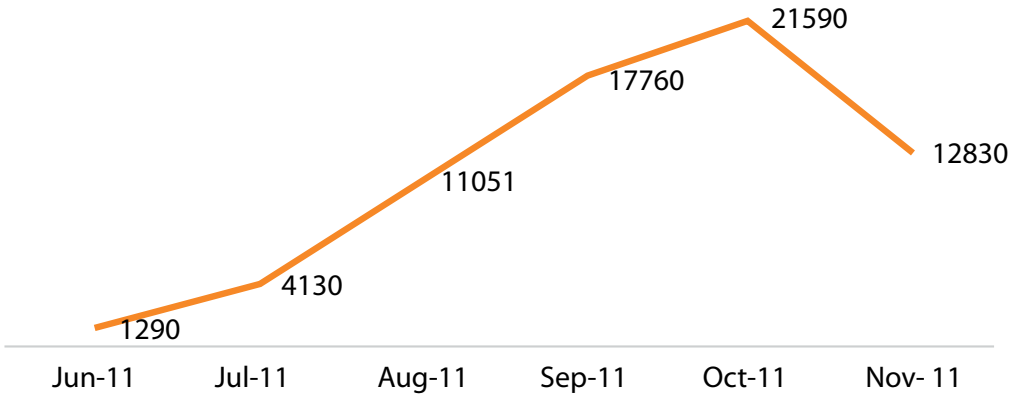
Number of Individual Reached



It can be seen that the project has continuously reached out to more community members. The political controversy around interventions with MSM also had some negative impact on CSDF, and explains the decline in outreach in the months of October and November.

Increase in condom distribution - Ensuring timely and sufficient provision of condoms to MARPs is key to good HIV and AIDS prevention programming. The graph below depicts condom distribution by the project during the period June to November 2011.

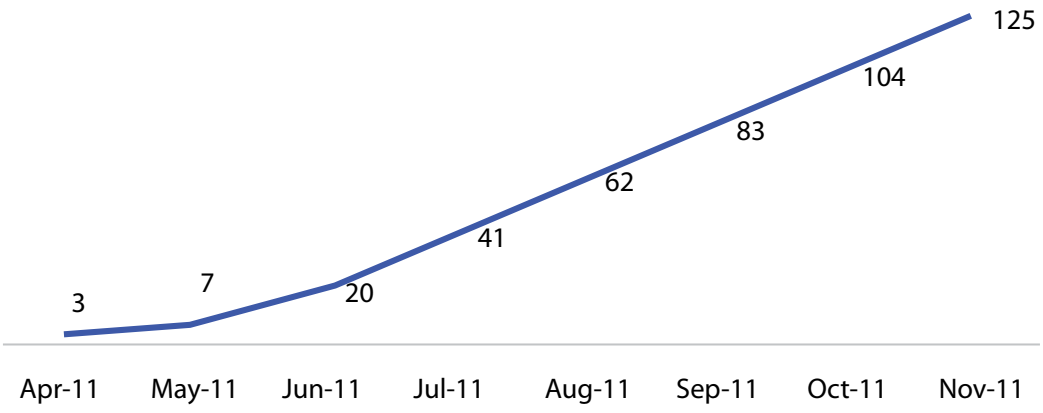
Number of Condoms Distributed



It can be seen that the project has continuously reached out to more community members. The political controversy around interventions with MSM also had some negative impact on CSDF, and explains the decline in outreach in the months of October and November.

Referrals for STI and HIV testing - There has been a steady increase in the number of FSWs referred for STI and HIV testing. In the period from April to November 2011, approximately 25 per cent of the total FSWs registered with the project were referred for testing. Given below is the graph depicting this trend:

Cumulative number of FSWs referred at least once for STI/HIV consultations and services



7
LESSONS LEARNED

This pilot initiative provided some valuable lessons that will be useful for scaling up HIV and AIDS programming in Sri Lanka. Some of the key lessons learned are:

a. **Evidence-based programming produces good results:** In the design and implementation of the pilot initiative, there was always a focus on generating good quality evidence and using the evidence in planning and implementation. Initially, through mapping, high priority sites were chosen for intervention. Then, through micro–planning, effective outreach plans were developed to reach the MARPs in the selected sites, and outreach was prioritised based on risk of the population. Regular monitoring allowed tracking of the progress and taking timely corrective measures.

> "Analysis of data helped in reaching out to large numbers of sex workers".
>
> - Mr. H. A. Lakshman, CSDF

b. **Involvement of the community is extremely important:** The community was involved in the project right from the stages of mapping and planning, to implementation and monitoring. Involving communities helped the project team to understand the ground realties and develop appropriate strategies. This shows the need of involving the community in all the stages of the programme cycle for effective implementation.

c. **Building capacity of field teams strengthens programme implementation:** The pilot initiative focused on building the capacities of the field teams through trainings, supportive supervision and on-field support. This helped improve quality of the programming. The project also developed local trainers who can continue to build capacities of local teams as the project scales up.

d. **The necessary of having good systems in place:** The design of the pilot initiative focused on having good management systems in place at all levels. A Steering Committee was formed, including stakeholders from the Government, UN system, World Bank and partners, to oversee the management of the programme. It helped in creating synergies among different organizations. During the implementation stage, systems for regular monitoring and supervision were developed. This helped in ensuring proper implementation of the project, and highlights the need for focusing on developing good systems for the success of any project.

e. **More focus on creating an enabling environment is required:** Adverse media coverage and its negative impact on the programme shows the need for increased focus on creating an enabling environment. It also shows that when working on culturally sensitive issues, better understanding of the local situation is required, along with a focus on building broader networks with different stakeholders, including media, political and religious leaders. A hostile environment makes it difficult for community- based organisations to survive and function in the interest of the community. COJ as a CBO disintegrated after the adverse

media coverage, and gains from the project were lost as the community dispersed and went into hiding due to fear. Therefore advocacy should start along with program design itself, and should be an integral part of program implementation.

"There is need to build partnerships with other like-minded organizations working on HIV AND AIDS".

- Mr. Jude, CoJ

8

CONCLUSIONS AND WAY FORWARD

This pilot project was the first of its kind in the country. It has brought different stakeholders together and used their strengths to develop a comprehensive response to HIV and AIDS. The project progressed well until September-October 2011, when political controversy affected the implementation of the initiative.

The project was timely, as the country has received funding from GFATM round 9 to scale up MARPs interventions in the country. The capacities built locally will help in scaling up the interventions. Following this project, UoM/IHAT have been involved in conducting Training of Trainers for teams from Sarvodaya and NASCP, which are the Primary Recipients of the GFATM Round 9 grant. The learning and products from the project have been shared with these organisations, for replication.

The project team of CSDF has build its capacity to work with FSWs in a systematic way, which will help them in scaling up interventions as a sub-recipient in the GFATM round 9 project. However, there is a need to further orient them on emerging best practices in the area of HIV prevention. In addition, for field teams, more supportive supervision is required.

The adverse media coverage of MSM in September and October 2011 highlighted the notion that more effort is required to create an enabling environment in the country. There is need to increase the dialogue among different stakeholders, including government, religious leaders, civil society and donors. The UN system and the Ministry of Healthcare and Nutrition need to play a more pro-active role in networking with media and other stakeholders.

Overall, the project was successful in achieving most of its desired outcomes. It has provided some valuable lessons and learnings regarding the implementation of HIV and AIDS prevention programmes in the country. Learnings from the project needs to be incorporated in the next steps, to ensure that the programme increases its efficiency and effectiveness.

"Past experiences and capacity building will help in continuing good work in future".

- Mr. Jude, CoJ

India Health Action Trust
Technical Support Unit , Pisces Building
4/ 13-1, Crescent Road, High Grounds , Bangalore- 560 001
Tel: 080 22 20 1237-9 , Fax: 080 22 20 1373