



**NATIONAL HIV
MONITORING & EVALUATION PLAN
SRI LANKA
2017 - 2022**

**NATIONAL HIV
MONITORING & EVALUATION PLAN
SRI LANKA, 2017-2022**



Prepared by
NATIONAL STD/AIDS CONTROL PROGRAMME,
MINISTRY OF HEALTH, SRI LANKA
in collaboration with
THE FAMILY PLANNING ASSOCIATION OF SRI LANKA

2017

This document was written by Virginia Loo with input from Dr K. A. M. Ariyaratne, M. Suchira Suranga, and Amal Bandara.

The publication of this document was made possible through financial support from the Global Fund to fight AIDS, TB and Malaria (GFATM) grant for Sri Lanka.

The content of this publication may be freely reproduced or distributed with appropriate acknowledgement.

Copies of this publication can be obtained from:

National STD / AIDS Control Programme (NSACP)

No. 29, De Saram Place, Colombo 10, Sri Lanka

+94 11 533 6873, +94 11 268 2859

info@aidscontrol.gov.lk

www.aidscontrol.gov.lk

Sri Lanka Family Planning Association

37/27 Bullers Lane, Colombo 7, Sri Lanka

+94 11 2 555 455

m&e@fpasrilanka.org

<http://www.fpasrilanka.org>

CONTENTS

List of Tables.....	iv
List of Figures	iv
Abbreviations	v
Foreword.....	vi
Background	1
The National M&E Plan	13
Conceptual overview of M&E framework.....	13
National HIV M&E Indicator framework	14
M&E Organizational Structures and Human Capacity	24
Data Collection and Reporting Responsibilities & Processes.....	28
Data Management and Quality Assurance	37
Surveillance, research and evaluation	44
Capacity strengthening activities	48
Costed work plan for 2016-2018.....	50
Annexure 1- Client Registration Form.....	- 1 -
Annexure 2- Peer Calendar	- 1 -
Annexure 3: Clinic Referral Slip Format	- 2 -
Annexure 4 : Community Based Testing Reporting Form	- 3 -
Annexure 5. STD Patient Form (first two pages of male form).....	- 4 -
Annexure 6. Main Register Format	- 5 -
Annexure 7. Outpatient Blood Testing Register	- 6 -
Annexure 8. ANC Specimen Laboratory form	- 7 -
Annexure 9. Details of pregnant women with syphilis	- 8 -
Annexure 10. Congenital syphilis case report form	- 9 -
Annexure 11. Details of Paediatric patients with HIV infection.....	- 10 -
Annexure 12. Details of pregnant women with confirmed HIV infection format	- 11 -
Annexure 13. ART patient information card	- 12 -
Annexure14. ART register	- 13 -

Annexure 15: ART Cross-sectional Database - 14 -

Annexure 16. ART cohort database - 15 -

Annexure 17 : Stock Register Format..... - 16 -

Annexure 18. Distribution Register Format - 17 -

Annexure 19: Stock Update and Distribution Report Format..... - 18 -

Annexure 20: Field Visit Report - 19 -

Annexure 21: Hotspot Based Service and data quality assessment tool..... - 22 -

Annexure 22: Peer Educator Capacity Assessment Tool..... - 28 -

Annexure 23: Request for HIV Confirmatory testing from the Reference Laboratory - 34 -

Annexure 24: Data Quality Assurance Checklist - 38 -

LIST OF TABLES

Table 1 : Key HIV related impact and outcome indicators for key and vulnerable populations	4
Table 2: National Strategy Objectives, Interventions and Implementers.....	11
Table 3: Impact and Outcome indicators.....	15
Table 4: Output Level Indicators.....	17
Table 5: Additional GAM reporting:.....	21
Table 6: Secondary indicators for community based programmes for key populations.....	29
Table 7: Data flow and verification of Peer Educator service data.....	31
Table 8: MEIMS reports.....	41
Table 9: Information and Dissemination Products	43
Table 10: Surveillance Data Sources	45
Table 11: Capacity strengthening activities in M&E	48
Table 12: Budget for M&E costs, 2016-2018	50

LIST OF FIGURES

Figure 1 : Organizing Framework for a Functional National HIV M&E System - 12 Components	1
Figure 2: National Strategic Plan 2013-2017	9
Figure 3: Managerial structure and reporting lines of NSACP M&E system.....	24
Figure 4: Managerial and reporting lines for FPA Sri Lanka M&E system	26

ABBREVIATIONS AND ACRONYMS

- **AIDS** Acquired Immune Deficiency Syndrome
- **ANC** Antenatal clinics
- **ARV** Antiretroviral treatment
- **BCC** Behavioural Change Communication
- **BSS** Behavioural Surveillance Survey
- **CBO** Community Based Organization
- **DAC** District AIDS Committee
- **DHS** Demographic and Health Survey
- **FPA** Family Planning Association
- **FSW** Female Sex Worker
- **GAM** Global AIDS Monitoring
- **GFATM** Global Fund to Fight AIDS, Tuberculosis, and Malaria
- **HIV** Human Immunodeficiency Virus
- **IBBS** Integrated Biological Behavioral Survey
- **KAP** Key Affected Populations
- **MoH** Ministry of Health
- **MOL** Ministry of Labour
- **HIMS** Health Information Management System
- **M&E** Monitoring and Evaluation
- **MSM** Men who have Sex with Men
- **NAC** National AIDS Committee
- **NBTS** National Blood Transfusion Service
- **NIE** National Institute of Education
- **NGO** Non-Government Organization
- **NSACP** National STD/ AIDS Control Programme
- **NSP** National Strategic Plan
- **PWID** People Who Inject Drugs
- **PWUD** People Who Use Drugs
- **PLHIV** Persons Living With HIV/AIDS
- **PMTCT** Prevention of Mother to Child Transmission
- **SIM** Strategic Information Management
- **STD** Sexually Transmitted Diseases
- **STI** Sexually Transmitted Infection
- **TG** Transgender
- **UNAIDS** Joint United Nations Programme on HIV/AIDS
- **VCT** Voluntary Counselling and Testing
- **WHO** World Health Organization

FOREWORD

It is with great pleasure and fulfillment that we present the Monitoring and Evaluation Plan of the national HIV response in Sri Lanka for the strategic period from 2017 -2022. This plan is the fruition of a long collaborative effort of the Strategic Information Management (SIM) unit of the National STD and AIDS Control Programme and will be the sequel to its preceding M & E Plan for 2013- 2017.

Although Sri Lanka is a low HIV prevalent country with an infection rate of less than 0.1% among adult population, concerns as a rising trend in annual case detections, higher prevalence among young people and Men who have sex with men (MSM), reiterate the need for greater vigilance and close monitoring. Presently, the prevalence among those at a higher risk for HIV infection is at a low, less than 1% level, despite Sri Lanka doubling its annual case detection number, since 2010. Evidence shows that risky behavior still exists among Key population (KP) groups and preventing the virus from penetrating into these groups remains one of our key prevention strategies. Sri Lanka has the potential for such exposure with constantly increasing movement of people via external migration and returning migrants, a booming tourist industry increasing arrivals of foreign nationals. Without a vigilant and proactive national response the past and present HIV epidemiological landscape could be adversely and dramatically affected.

Monitoring and Evaluation of the response to HIV itself forms a vital component of the national response. Understanding the current epidemiological situation, emerging trends and the effectiveness of the response will lead to informed decision-making in policy and practice. The preceding M & E plan developed for the period of 2013 -2017, complemented the National HIV Strategic Plan and aided the attainment of the third strategic direction on – Development of Strategic Information Management systems. This was further supplemented by a series of highly consultative reviews and surveillances that included a Mid-term review and two M&E Systems Strengthening Assessments. The reports generated shed light on important gaps to be addressed and stressed the need for a multi-sectoral approach to monitoring the national response.

We are pleased to convey that this National Multi-sector HIV and STI Monitoring and Evaluation Plan for 2017-2022 will build on its predecessor, incorporating key recommendations from the aforementioned reviews. It also subscribes to the third of “Three Ones” principles by upholding one National, Multi-sector HIV M&E System that extends beyond the health sector and donor related activities to encompass the M&E framework and system for Sri Lanka’s multi-sector, national response. Through this plan we aim to describe the current M&E system and set the course for a stronger, coordinated, effective multi-sectoral national system that collects, manages and uses strategic information to better inform Sri Lanka’s HIV/STI epidemic situation. It will monitor progress and performance of the implementation of the National Strategic Plan and thus the National Response. Implementation of this plan will ensure the collective accountability of all stake-holders of the national response and will pave way to the consistent coordination and collaboration across partners, organizations and sectors.

The Monitoring and Evaluation Plan presented here will be implemented by all relevant stakeholders of the state and civil society under the technical guidance of the NSACP and high level leadership and counsel of the National AIDS Committee (NAC). The plan is expected to remain responsive to the emerging situations and adapt to the changing needs our epidemic may present and innovative developments. The National M&E working group will be the focal point of monitoring the implementation of the Plan, ensuring that it is up to date with Global trends, while meeting Sri Lanka’s strategic information needs.

A robust M&E system that generates quality data is the need of the hour that enables us to be sufficiently informed, in order to respond to the dynamic HIV epidemic of the country. Needless to say, the success of the National Response will largely depend on the effective, multi-sectoral implementation of this M&E Plan. We as the lead agency of the National Response look forward to the effective implementation of it, to deliver universal access to HIV prevention, treatment, care and support to all those in need. I wish to express my profound gratitude to all those who contributed, from conceptualizing to printing stages of the plan.

Dr Sisira Liyanage
Director
National STD/AIDS Control Programme
Ministry of Health
Sri Lanka.

17th June 2017

BACKGROUND

INTRODUCTION

The purpose of any monitoring and evaluation (M&E) system is to provide the data needed to monitor progress and evaluate results to inform program decisions and policy formulation. Developing and implementing an effective M&E System requires several steps (i) recognizing the components of a strong M&E system; (ii) determining the current status of a country's system, in particular highlighting major strengths and weaknesses, in relation to these components; (iii) identifying the priority areas for improvement; and (iv) creating a timed and costed realistic M&E plan that addresses priority areas and capacity strengthening needs.

This document, is based on the 12 components described in the Organizing Framework for a Functional National HIV Monitoring and Evaluation System (Figure 1).¹ The components address individual, organizational and functional aspects of a M&E system as well as the mechanisms through which data are collected, verified and used. The 12 components are not 12 steps to be implemented in a sequenced manner but rather inter-related building blocks which can be developed in tandem to ensure a strong M&E system.

In early 2013, the National HIV Monitoring and Evaluation Plan 2013-2017 was developed to compliment the National HIV Strategic Plan (NSP) 2013-2017, and guide the implementation of the NSP's Strategic Direction 3 – *Strategic Information Management Systems*. This document provides an updated M&E Plan for the 2016-2018 period, incorporating recommendations from the Mid-Term Review (MTR) of the NSP 2013-2017, and two in-depth Monitoring and Evaluation System Strengthening Assessments, one focused on the health sector HIV response and one focused on the multi-sectorial HIV response.

This document is for all M&E and program staff involved in the National HIV/STI response, including partners in other units of the Ministry of Health, and other Government line ministries. In addition, the document will be useful for national and international partners and funders of HIV/STI activities.

FIGURE 1 : ORGANIZING FRAMEWORK FOR A FUNCTIONAL NATIONAL HIV M&E SYSTEM - 12 COMPONENTS; UNAIDS, 2008



¹ UNAIDS / Monitoring and Evaluation Reference Group (April 2008): Organising Framework for a Functional National HIV Monitoring and Evaluation System.

ORGANIZATION OF THIS M&E PLAN

This M&E Plan is organized as follows: the first section is the Background, which describes the Sri Lankan context, epidemiological situation, key stakeholders in the response, and the fundamentals of the NSP. The second section presents the goal and objectives of the M&E plan, the conceptual framework and guiding principles. The final sections are dedicated to describing the current HIV M&E system and strategies for addressing key areas of the 12 components of a functional M&E system. The plan spells out by programme areas, details of what information is needed including: indicators data sources, collection methods, flow, analysis, use and reporting, and feedback as well as the responsibilities of implementing partners and stakeholders. It also includes a detailed costed M&E work plan for 2016 and 2017. The Plan also includes a series of annexes that provide details on data collection and reporting, indicator descriptions, M&E costed action plan, and other important details.

COUNTRY CONTEXT

The Democratic Socialist Republic of Sri Lanka is an island country situated in the south Indian Ocean. The country's population is estimated at **21.2 million as of 2016** and is multi-ethnic with three official languages of Sinhala, Tamil and English. Administratively, including under the Ministry of Health, Sri Lanka is divided into 9 provinces and 25 districts. The Western province is the most populous and densely populated, followed by the Central province, while the Northern Province is the least populated.

Sri Lanka is considered a **middle lower income country** and has made great strides economically in the past ten years. Sri Lanka has a strong health sector, particularly in the public sector, and prides itself as one of the **first countries in the Asia Pacific region to offer Universal Health Coverage**.²

Since 2009, Sri Lanka has been in post conflict stage, building up from a civil war that raged for more than two decades in the Northern and Eastern parts of the country. The war led to migration and displacement of populations, destruction of infrastructure, and limited geographic access. As a result, the Northern and Eastern provinces have lagged behind in development compared to the rest of the country, particularly with respect to health care services and health information.

HIV/STI EPIDEMIOLOGICAL SITUATION

Since the first identified AIDS case in 1987, Sri Lanka has remained a low level HIV epidemic. **Adult HIV prevalence is less than 0.1% and the estimated number of adults living with HIV is 4000 (range 2700 to 6000)**.³ Even amongst population groups considered at higher risk for HIV infection, due to their behaviors and/or occupation, prevalence is less than 1% (IBBS, 2014).⁴ **As of end 2016**, there has been a **cumulative total of 2557** people reported as HIV positive to the National STD/AIDS Control

² WHO Country Cooperation Strategy Sri Lanka, 2012-2017

³ Sri Lanka HIV Annual Report for 2016

⁴ Integrated Biological and Behavioral surveillance (IBBS) Survey Among Key Populations at Higher Risk of HIV in Sri Lanka 2014

Programme (NSACP), with **2139** people living with HIV (PLHIV) alive, and **1068** PLHIV alive and on antiretroviral treatment (ART).⁵

Since 2010 the number of reported HIV cases reported each year, has almost doubled. Strategic information suggests that this increase is at least partially due to an increase in case detection through scale up HIV testing, rather than purely an increase in new HIV infections. In fact, HIV testing has increased by 67% since 2010.⁶

Among reported cases, the highest reported mode of transmission is **heterosexual non-commercial sex, with the second highest being through unprotected sex between men, with 8.3% as exclusively homosexual, and 10.6% reporting as bisexual.** There are concerns that the percent of cases reporting as FSW (<1%) is unusually low, and this may be due to the fact that FSW are not identifying themselves as such, and the **current M&E system is failing to categorize PLHIV by correct mode of transmission.**

Just over 76% of cases are between the ages of 25-49 years of age, compared to only 6.3% of cases reported among young adults (ages 18-24 years). HIV cases have been detected in all 25 districts, however, over half of these cases are concentrated in two districts, Colombo and Gampaha.

Of the cumulative PLHIV cases, 60% are male, which is consistent with Asia Pacific trends, where men dominate the epidemic, and this male dominance is increasing over time, moving from 46% of cases in 2003 to 73% of cases in 2014. While it's not clear if this trend is due to changes in the epidemic or changes in who is getting tested, it has important implications on the epidemic and targeting of prevention efforts, and it is critical to better understand the risk profiles and sexual networks of these men through better strategic information. Unfortunately, key demographic and risk characteristics are not obtained comprehensively for all cases, or put systematically into an electronic format that can facilitate in-depth case analysis.

Typical drivers of an HIV epidemic in low prevalence settings in Asia, such as in Sri Lanka, are unprotected paid sex (FSW), the sharing of contaminated needles and syringes by injecting drug users (PWID), and unprotected sex between men (MSM).⁷ However, identifying key drivers of the epidemic in Sri Lanka is challenging, as no particular group has higher rates of infection compared to any other, as all have remained below 1%. Several factors have probably served to "protect" these groups from a concentrated epidemic. **Isolation due to twenty years war limited introduction of HIV at a time it was spreading in the rest of the region, a high development index, a strong public health system moving towards Universal Health Coverage, including many free-of-charge services, high condom use in FSW, low levels of sexually transmitted infections (STI) in the general population, and a low level of injecting practice by drug users are just some contributing factors.**⁸

⁵ NSACP Annual Report 2016

⁶ HIV Epidemiological Stage Report (Draft)

⁷ UNAIDS, 2008

⁸ National Size Estimation of MARPs in Sri Lanka, 2013

TABLE 1 : KEY HIV RELATED IMPACT AND OUTCOME INDICATORS FOR KEY AND VULNERABLE POPULATIONS

Population at Risk	Size Estimate ¹ (range)	HIV prevalence ²	Condom Use Last Sex ²	Contact with Peer Educator last 6 months ²	Coverage Prevention Program ²	HIV Test and Knows Result ²
FSW	14,132 (12,329 – 15,935)	0.81%	93%	14%	30%	35%
MSM	7551 (6547 – 8554)	0.88%	58%	15%	19%	15.4%
Beach Boys	1314 ⁵ (1142 – 1486)	0%	70%	3.5%	7.8%	4.3%
PWID	423 (328 – 516)	0%	24%	4%	4.1%	8.7%
PWUD	17,459 ⁵ (15,338 – 19,542)	not available	<40%	not available	not available	not available
Prisoners	30,000 ³ 100,000 ⁴	0.03% ⁶	N/A	not available	not available	not available

¹National Size Estimates of MARPs in Sri Lanka, 2013,²IBBS 2014, definition of last sexual partner varies by KP and based on GARP definition,³At any given point in time, ⁴Rotating through during 1 year, ⁵Peak day value, ⁶positivity rate

However, there is evidence to suggest that risky behaviors among key populations still exist leading to higher transmission within these groups if the virus were to penetrate their sexual networks.^{9,10} Sri Lanka also must contend with the potential impact on the epidemic that comes from high external migration, returning migrants and a flourishing tourism industry. Anecdotal evidence suggests a thriving underground sex industry, and while condom use in FSW is high, it is quite low in all other population groups.¹¹ In addition, concurrent sexual relationships are common across all key

⁹ Mapping Key Populations for HIV Prevention in Sri Lanka 2010

¹⁰ Integrated Biological and Behavioral surveillance (IBBS) Survey Among Key Populations at Higher Risk of HIV in Sri Lanka 2014

¹¹ Ibid

population group, and include overlaps in commercial, casual, and regular partners, as well as contemporaneous same sex and heterosexual activity.¹²

While no one group is considered the “driver” of the HIV epidemic in Sri Lanka, there are groups that are recognized by the country as being at higher risk for HIV due to their behaviors, nature of their work, or circumstances. These include MSM/ TG, FSW, PWUD/PWID, Beach Boys and prisoners. These groups are described below because they are the target groups for many of the indicators presented in this Plan. Key indicator results are presented in Table 1.

Female Sex Workers (FSW): There are an estimated 14,312 (12,329-15,935) FSW in Sri Lanka, with over half, 51% residing in the Western Province, and the district of Colombo accounting for 44%.¹³ FSW are identified by typology based on their site of solicitation. The **majority of FSW solicit their clients at public places, including streets**. Other common points of solicitation are hotels/guest houses, and homes/shanties. With such diverse venue preferences amongst FSW, not all are equally reachable. In fact, according to program data, outreach workers mainly reach street based FSW, while the hardest to reach are home and hotel-based FSW. This means over 40% of FSW are missed. The IBBS 2014, conducted using respondent driven sampling, found that **only 30% were reached in the previous year through prevention programs and less than half of that had contact with a peer educator in the last 6 months**. This also means that program data is not reflecting most of this hidden unreached population, and innovative strategies are needed to improve surveillance of these missed FSW.

Men who have Sex with Men (MSM) and Transgender (TG): there are an estimated 7,551 (6,547-8,554) MSM in Sri Lanka, with 7 districts accounting for 81% of MSM in the country.¹⁴ In Sri Lanka, MSM refers to all men who have sex with other men as a matter of preference or practice, regardless of sexual identity or orientation. It does not include men who might have had sex with other men at one point in their lifetime as part of sexual experimentation. Further, MSM are identified into three categories, **Nachchi, Male Sex Workers, and other MSM** (Table 3). MSW and Nachchis often engage in sex with more number of partners than other MSMs. The **majority, 73%, of MSM engage in sexual relations in public places/street**, while 16% in home/shanty. The **risk profile for these three groups is quite different and it is important for the M&E system to capture these differences**. Accomplishing this means addressing data collection efforts down to the outreach and peer level with catered data collection tools.

It is important to note that these typologies may be revised per the upcoming review on the prevention to KPs strategy, including whether transgender women (TG) should be categorized separately from MSM. At present, an operational definition of transgender and the equivalent local terminology to use for programme monitoring and surveillance purposes in not exist in Sri Lankan Context. Operational definitions for transgender women will be developed in a way that demonstrates a distinct risk profile and needs from that of other MSM, and enable other strategic information to be collected, such as population size, mapping hotspot maps, ad characterization of

¹² Ibid

¹³ National Size Estimation of MARPs in Sri Lanka, 2013

¹⁴ National Size Estimation of MARPs in Sri Lanka, 2013

risk behaviors. Transgender community based organizations (CBOs) have emerged who are active stakeholders and implementers, and they will play a critical role in collecting much needed data on transgender and the services they need and ultimately receive.

Bisexuality amongst MSM in Sri Lanka is common. **Between 73% and 93% of MSM reported having sex with a women in the last 6 months, and 25% to 40% reporting they were married to a woman (IBBS).** Other countries in Asia have shown that concentrated HIV epidemics involving key populations (KP), even low prevalence ones, can expand quickly within those sub-populations and affect the wider population through “**bridge populations**” - usually men who have sexual partnerships with both members of higher risk populations and lower risk partners.¹⁵ In other words, HIV transmission to other populations will occur depending on the magnitude of the risk behaviors as well as the size of the KPs and “bridge” group. Hence, it is important to recognize that once HIV enters their sexual networks, bisexual men can become a critical bridge population from high risk to general population, and they warrant targeted prevention and additional focus in the HIV response.

Beach Boys (BB): there are an **estimated 1,314 (1142-1486)** BB in Sri Lanka on a peak day, with estimate of 873 (752-993) on average day, up to 2001 (1750-2251) BB in peak month. BB are a **group of males, either homosexual, heterosexual, or bisexual (4%), who cruise in and around beach areas, and are associated with tourists as guides, animators or providers of any form of gratification, including insertion and receptive sex.**¹⁶ They are mostly found in select coastal areas where tourists aggregate, over 80% of BB can be reached through 5 districts in 3 Provinces. The two districts **Galle and Ampara, account for 44% of the estimated BB population.** As this KP is quite visible and reachable, there is sufficient data to characterize and understand their needs. However, program data suggest that these estimates are actually an underestimate as the 2013 size estimate exercise was conducted during the low season and may not have captured the true peak number.

People Who Use Drugs (PWUD): there are an **estimated 17,459 (15,338-19,542)** people who use drugs in Sri Lanka. This estimate is considered on **peak days and refers to current users (using during 3 months preceding size estimate).** Estimates for usual day are 12,618 (11,009 – 14,214). The **Western Province accounts for 42% of all PWUD,** while 8 districts in 4 provinces cover 81% of the population. PWUD have not been included in the most recent IBBS, and hence HIV related outcomes data are not available. Much investment is placed in HIV prevention outreach to PWUD, as there is a large number of drug users. However, their risk profile is not well understood, and hence a focused study on knowledge, attitudes, and behavior of drug users, or as part of a sub-group will be included in the next IBBS. Data for PWUD and prisoners is limited as no comprehensive behavioral study has been conducted on them.

People who Inject Drugs (PWID): there are an **estimated 423 (328-516)** people who inject drugs in Sri Lanka, or **2.4% of all drug users.** The estimate refers to current PWID (injecting during 3 months prior to study) on a peak day. On a usual day the estimate is 218 (164-271). One of the reasons cited for such low injecting rates, is due to the low quality of heroin available in Sri Lanka. Most respondents

¹⁵ HIV in Asia and the Pacific, UNAIDS Report 2013.

¹⁶ Social mapping of Most at Risk Population in selected districts for HIV prevention in Sri Lanka – Drug Users

who said yes to injecting drugs in the 2013 Size Estimates, or 2014 IBBS, reported themselves as “ever” injectors, rather than current injectors, with most having ever injected one or two times.

PWID are not leading in Sri Lanka as the highest risk and highest prevalence group as they often are in other countries. They have maintained zero HIV and Syphilis prevalence according to the IBBS 2014, and case reports confirm as virtually non-existent prevalence. Further, the programmatic goal is to move PWID into being PWUD as described below. The majority of PWID, 61%, reside in the Western Province, (42% in Colombo), and another 21% in the North Western Province. Of injecting users, approximately 50%, 210, are estimated to share needles. This is corroborated by the IBBS 2014, where 55% PWID reported sharing needles.¹⁷

Currently, comprehensive harm reduction services are not offered in Sri Lanka. HIV prevention is provided as outreach to all drug users, but needle exchange and opioid substitution therapy are not. The latter is part of an ongoing debate in country of whether substitution therapy could increase addiction due to the low quality of heroin available. Hence the focus has been to switch injecting drug users to becoming oral drug users and over time rehabilitating them off drugs completely. With respect to needle/syringe exchange program (NSP), the Government of Sri Lanka has agreed to fund a pilot program over the next 2 years. Robust data collection and reporting is part of that pilot, in order to be able to monitor the success of the program.

Prisoners: Prisoners are targeted for HIV transmission in the NSP as many imprisoned have been found to be engaged in behaviors such as drug use/intravenous drug use and risky sexual behaviors that make them vulnerable to HIV transmission. Furthermore it is known that homo-sexual activities are common among the incarcerated within the prison premises.¹⁸ The prison department comprises of 30 different types of prison institutes including closed prisons, remand prisons, work camps, open prison camps and correctional centers for youth offenders.¹⁹ Sri Lanka records an average number of 30,000 convicted prisoners circulating through at any point in time, while over 100,000 cumulative in a year. Prevalence is unknown, however, a positivity rate of 0.03% is observed of all prisoners screened, higher than that of general population - ANC screening (<0.01%). Data on outreach to prisoners and their knowledge base is limited to date because of the logistical challenges of implementing an M&E system in closed settings. However, a new HIV Policy in closed settings and new prevention strategy are in development, and innovative monitoring approaches and tools will be included. Further, scale up of HIV testing through rapid test kits is underway, up to 80% of prisoners in next three years.

STAKEHOLDERS IN THE NATIONAL HIV/STI RESPONSE

The NSACP within the Ministry of Health is the government entity with direct responsibility to lead Sri Lanka’s National Response for sexually transmitted infections (STI) and HIV. Established in 1985,

¹⁷ Annex 2: IBBS, 2014

¹⁸ Annex 8: HIV/AIDS Prevention Programme for the Island wide Prison Community 2011 – 2015, External review Report 2013, National STD/AIDS Control programme, Ministry of Health

¹⁹ Department of Prisons, Sri Lanka

the NSACP is the focal organization tasked with planning and implementing the activities of the National Strategic plan in collaboration with local and international stakeholders. NSACP collaborates with other government stakeholders in the health sector response, including the **National Blood Transfusion Services (NBTS), the National Program for Tuberculosis and Chest Diseases (NPTCCD), and the Family Health Bureau.** Coordinators of the programme areas within NSACP lead the implementation of the health sector portion of HIV response, with provision of free HIV/STI prevention, treatment and care services through public STD clinics and ART centers. NSACP is also the designated as a primary recipient of Global Fund AIDS grants to Sri Lanka, primarily for HIV diagnosis, care and treatment.

The Family Planning Association of Sri Lanka (FPA Sri Lanka) is the key umbrella organization for NGOs and CBOs implementing HIV activities. Established in 1953 by a group of volunteers comprising medical professionals and philanthropists, FPA Sri Lanka, has evolved to providing full spectrum of Sexual and Reproductive Health (SRH) services, including HIV prevention services. The HIV/AIDS prevention programme attempts to increase awareness, promote usage of condoms and strengthen the Prevention of Mother to Child Transmission (PMTCT) strategies, while protecting and promoting the rights of the people living with HIV/AIDS. FPA Sri Lanka serves as the primary recipient of Global Fund AIDS grants to Sri Lanka for community based services for key populations.

The National AIDS Committee (NAC) serves as the high level umbrella body to guide and monitor the inter-ministerial support extended to the national response to fight HIV/AIDS. The NAC is chaired by the Secretary of the Ministry of Health and meets once every six months. The membership is drawn from the National STD/AIDS Control Programme (NSACP), other ministerial secretaries, development partners, and civil society, including NGOs, CBOs, PLHIV, and the private sector. The NAC is supported by six technical subcommittees on (i) information/education/ communication (IEC), (ii) policy, legal and ethical issues, (iii) sectoral issues, (iv) prevention, (v) HIV care, treatment, counselling, laboratory services, and (vi) strategic information management. Provincial AIDS committees and district AIDS committees have been formulated as multi-stakeholder advisory bodies at provincial and district level. Twelve line ministries are engaged in the National Response and include the National Institute of Education, the Ministry of Labour, the Foreign Employment Bureau, the Department of Prisons, the Vocational Training Authority, the Ministry of Fisheries, the National Child Protection Authority, the National Youth Services Council, the Army, the Navy, the Air Force and the Police. Joint activities with NSACP and non-government sec includes advocacy, improving HIV prevention awareness and knowledge of available facilities, encouraging condom use among the armed services, and introducing HIV testing and counseling services.

Through the NAC, the NACP coordinates and collaborates with numerous Civil Society and Non-governmental Organizations.

Given that a significant portion of the HIV funding is through Global Fund, the Country Coordinating Mechanism (CCM) plays a key role in decision making and oversight in the National Response. Although the CCM monitors all three diseases (HIV, TB and Malaria), strong linkages have been forged between the CCM and NSACP, in terms of planning and decision making. Ministry of Health has services as the Government Principal Recipient, while FPA Sri Lanka serves as the non-government Principle Recipient.

THE NATIONAL STRATEGIC PLAN FOR HIV/AIDS 2013-2017

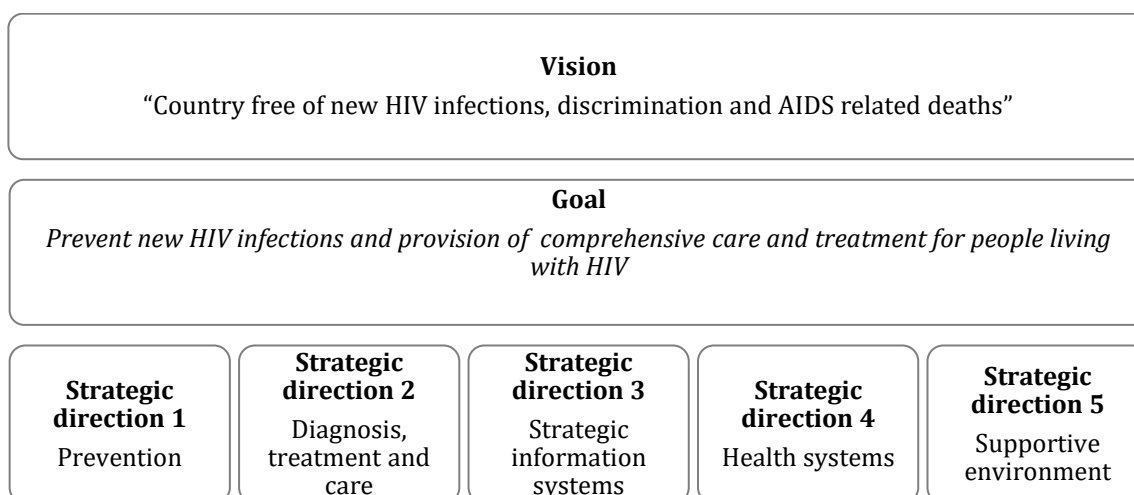
The National Strategic Plan (NSP) 2013-2017 provides the framework for Sri Lanka's response to HIV/AIDS and STI control and work of the NSACP as well as non-government implementing entities. It draws on lessons learned in responding to HIV and AIDS in the last decade, and more particularly in the past five years. The NSP builds on existing strengths and successes, considers the policy and legal environment, developments in scientific evidence, international practices, estimated needs for treatment and current coverage rates, and demonstrable capacities. It guides the NSACP in prevention efforts with multi-sector collaboration and coordination.

The goals of the program are:

1. To maintain the current low level of HIV prevalence among the key populations and general population.
2. To improve the quality of life among people infected or affected by HIV

Through inclusive stakeholder consultation, the NSP identified 5 Strategic Directions, which include implementation of innovative and effective interventions (Figure 2).

FIGURE 2: NATIONAL STRATEGIC PLAN 2013-2017



The **first strategic direction** focuses on prevention, and is the main strategy involving key populations, FSW, MSM, and PWID. The components of the program for KPs as well as Beach Boys, and Drug Users are: improve access to HIV testing and counselling, condom programming, BCC modification through outreach and peer education, STI prevention and diagnosis, testing and treatment, community involvement and implementing a comprehensive HIV prevention program for PWUD/PWID.

Vulnerable groups such as prisoners, migrants, armed forces and police personnel and those in the tourism trade are also included as key groups to address. The strategy also addresses prevention in the general population via IEC through mass media, community awareness, radio and street plays etc. Priority is given to interventions aimed at eliminating new HIV infections in children (EMTCT) and preventing HIV transmission in health care settings. All these aspects are monitored by the National M&E system with responsibility split between Government and non-government sectors.

The **second strategic direction** addresses diagnosis, treatment and care for HIV for children, adolescents and adults. This strategy emphasizes early enrollment and adherence to antiretroviral treatment (ART), management of co-infections and co-morbidities among people living with HIV, reducing the burden of Tuberculosis among PLHIV, and increasing access to HIV testing and counseling. The majority of indicators for collecting and monitoring are under the responsibility of NSACP, with some community-based activities under non-government.

The **third strategic direction** is the backbone of this M&E Plan. It ensures that the NSP strategies are based on evidence to ensure that all activities are effective, i.e. contribute to the national goals of preventing new infections and improving the lives of those affected. Evidence will guide the design of the programs, prioritization of strategies and approaches, as well as monitoring of the program, to guide design.

This strategy aims at strengthening strategic information systems for HIV to guide health policy and planning, resource allocation, program management, service delivery and accountability. As Sri Lanka scales up their HIV response towards universal access, there is an increasing need to invest in strategic information to guide program planning and to sustain national and international commitment and accountability. Clinical/epidemiologic, socio- behavioral and health systems research is also an important component in this strategy.

Under the third strategic direction, the NSP lays out the following key activities: improve the mechanisms of monitoring HIV related data from all sectors, including civil society organizations by moving towards standardized data collection and reporting tools, and electronic data systems; Strengthen size estimations and mapping capacities to better characterize key populations and mount a more effective response; Implement surveillance and research to detect the potential for a rising epidemic among the key populations, vulnerable populations, and bridge populations that can spread the HIV infection to general population, particularly in areas where vulnerabilities are known but risks and prevalence are lesser known e.g. prisoners, military personnel, young people, etc.; and strengthen operations research and drug resistance monitoring.

The **fourth strategic direction** refers to strengthening health systems for effective integration of health services. This addresses the needs in human resources and health financing, equity issues and support for leadership and governance. The measurable outcomes of this direction include expanding availability for HIV services at public sector facilities and increasing the proportion of domestic funding used for HIV and AIDS.

The **fifth strategic direction** also addresses KPs and calls for fostering a supportive environment to ensure equitable access to HIV services and to minimize HIV-related stigmatization and discrimination, promote gender equality, human rights and health equity along with the broad participation and collaboration of stakeholders and for mobilizing resources needed to continue scaling-up of HIV services, and to keep pace with increasing demand to implement the programs.

Progress of the NSP is monitored by the National Aids Committee whose mandate is to facilitate a coordinated response to HIV and STI in the country and embodies multi-sectoral membership.

TABLE 2: NATIONAL STRATEGY OBJECTIVES, INTERVENTIONS AND IMPLEMENTERS²⁰

Objective	Intervention	Implementation
1.To increase the scale and quality of comprehensive interventions for most at risk populations	1.1. Provide sexual health services for female sex workers and their clients	Except for the activities of creating and supporting the enabling environment, the provision STI care and training of staff at STI clinics which will be carried out by the governmental PR, Ministry of Health (MOH) rest will be carried out by FPA Sri Lanka.
	1.2. Provide sexual health services for men who have sex with men (including male sex workers and transgender women)	Except for the activities of creating and supporting the enabling environment and the provision STI care which will be carried out by the MOH, rest will be carried out by FPA Sri Lanka.
	1.3. Provide sexual health services for beach boys	Except for the activities of creating an enabling environment and provision STI care which will be carried out by the MOH, rest will be carried out by FPA Sri Lanka.
	1.4. Prepare for provision of comprehensive harm reduction services for drug users	Except the advocacy programmes rest of the activities in this Intervention will be implemented by FPA Sri Lanka.
	1.5. Provide sexual health services for prisoners	Entire INTERVENTION will be implemented by the MOH.
	1.6. Procurement of health products	All procurements in this INTERVENTION will be done by the MOH.
2. Provide care, treatment and support for people living with HIV and AIDS	2.1. Increased quality and use of voluntary confidential counseling services	Entire INTERVENTION will be implemented by the MOH.
	2.2. Increased quality and coverage of HIV and AIDS treatment services	Entire INTERVENTION will be implemented by the MOH.
	2.3. Increased quality and coverage of home and community based care for people living with HIV	Entire INTERVENTION will be implemented by FPA Sri Lanka. This activity was conducted from 2014-2016 but is not part of planned activities for 2017-2018.

²⁰Source: Global Fund Round 9 Proposal submitted by Country Coordination Mechanism (CCM), Sri Lanka: August , 2009

3. Generating and using strategic information and planning and administration of project	3.1. National integrated biological and behavioral surveillance implement, document and disseminate	Completed by the MOH in 2015.
	3.2. Formative and operational research implemented documented and disseminated	Operational research will be conducted by the MOH.
	3.3. Planning, administration, monitoring and evaluation of project	The intervention will be implemented by both PRs- the MOH and FPA Sri Lanka.
	3.4. National size estimation of female sex workers, men who have sex with men, beach boys and drug users	Completed by the Ministry of Health in 2015.
4. Health systems	4.1 Expand districts with government facilities providing ART 4.2 Initiatives to increase domestic funding for HIV.	MOH
5. Supportive environment	5.1 Implementation of Sensitization interventions to minimize stigma related to being PLHIV and KP in government health care settings	MOH

THE NATIONAL M&E PLAN

This National HIV/STI M&E Plan aims to provide the framework, guidance, and processes for how the M&E system is and should be functioning to generate the evidence base for Sri Lanka's National HIV/STI Response.

The plan includes the following sections:

- Conceptual overview of the M&E framework
- National M&E Indicator framework
- M&E roles and responsibilities of key stakeholders in the National Response
- Data collection and reporting responsibilities and processes
- Data management and quality assurance mechanisms
- Review and programmatic use of routine monitoring data
- Surveillance, research, and evaluation efforts
- Capacity strengthening activities
- Costed work plan for 2016-2018

CONCEPTUAL OVERVIEW OF M&E FRAMEWORK

GUIDING PRINCIPLES

The conceptualization and implementation of this M&E Plan is based on a set of guiding principles underlying the M&E system.

“One agreed country level Monitoring and Evaluation System”: the underlying principle of all activities in this plan is to move towards a comprehensive and highly integrated monitoring and evaluation system. The goal is to avoid parallel systems and ensure all strategic information processes of the response link to each other. This document consolidates the M&E plans of both primary recipients of the Global Fund to form a comprehensive overview of the national strategy for HIV. This is particularly important given the need for continuity of service delivery for key populations most at risk and efforts to integrate prevention efforts with diagnosis, care, and treatment.

Building on existing systems: where possible, the strengthening components of the M&E system builds and expands from what is already existing. This has the advantage of avoiding duplication and parallel processes, as well as providing a more cost effective means to enhance the M&E system.

Evidence and Results based: the M&E system aims to promote decision making based on evidence and results. All activities are geared to ensure the highest quality of evidence towards this means.

User driven: if resources and efforts to generate evidence are not meeting the end users' needs, then the M&E system is not effective. Sri Lanka's M&E system aims to provide evidence based on end users' needs, various stakeholders at different levels, who can range from international organizations to individuals in the community, There will be direct link between data collection, analysis, reporting and decision making at all levels.

Commitment to quality: data are only as useful as the integrity of what they represent. All aspects of the M&E system will aim for high standards of quality. Protocols for quality assurance will be institutionalized in all processes of data generation, reporting and analysis. In addition, the culture of quality will be created by incorporating into trainings and supervision.

Harmonization and standardization: indicators, data collection and reporting tools, data management and quality assurance practices, will all follow international and national levels of standardization and quality. As much as is possible, these elements will be harmonized across all users to ensure quality and comparability.

A living document: The National M&E Plan is aligned with the strategic priority areas of the results based HIV/STI NSP (2013 – 2017). Any M&E plan requires periodic updates to reflect the current phase of implementation, changes in the epidemic situation, and to keep pace with environmental factors which influence resources and technical guidance on good practices.

In order to efficiently implement the M&E plan, it is important to ensure the following cross cutting elements are in place:

Policy Environment: Creating policy support, and “M&E Champions” for adequate investment in strengthening capacity and infrastructure for a comprehensive M&E system for the National program is critical. This needs to be taken up with high level officials and policy makers of the Ministry.

Capacity Strengthening: continuous improvement is the motto – from the grassroots to provincial, regional and national level on setting up and managing monitoring and evaluation system. Strengthening capacity of stakeholders in relevant aspects of M&E system, from data collection, management, analysis and reporting.

Institutional Mechanism: Establishing a strong and committed team within the M&E infrastructure is crucial for a smooth delivery of the system. People with right skill and attitude needs to spearhead the implementation of the system. They should be available in adequate number at all levels – National, regional, Provincial and on the ground. Adequate infrastructure in terms of computer hardware and software and other requirements will be ensured at all levels so that M&E system can be operationalized across board.

NATIONAL HIV M&E INDICATOR FRAMEWORK

KEY INDICATORS

The NSACP and its stakeholders considered indicators based on their critical programme management needs and other internationally accepted indicators used for **Global AIDS Monitoring (GAM)** and **Universal Access (UA) reporting**. As such, the national M&E indicator framework encompasses all indicators in the Global Fund Performance Indicators used by NSACP and FPA Sri Lanka as the primary recipients of the GF HIV funding. There are 9 core indicators specified in the national strategy, reflecting the key outcomes for each strategic direction.

The targets for each indicator are aligned with the NSP 2013-2017 and Global Fund agreements, were applicable. It is important to realize that targets have been set based on national goals and objectives and current knowledge about the direction the National Response is moving. However, as the HIV/STI epidemic is a dynamic one, affected by multi-factorial and multi-sectoral influences, targets may need to be modified to reflect the reality of implementation in the current situation.

TABLE 3: . IMPACT AND OUTCOME INDICATORS

S. No	Indicator level	Strategic direction	Indicator and Target by 2018	Indicator reference	Numerator	Denominator	Format/ Source	Frequency of collection
1	Impact	SD 1	Percentage of sex workers who are living with HIV Target: <1%	GAM, GF	Total no. positive	Total No. tested	HSS, IBBS	2-3 yearly
2	Impact	SD 1	Percentage of MSM who are living with HIV Target: <1%	GAM, GF	Total no. positive	Total No. tested	HSS, IBBS	2-3 yearly
3	Impact	SD 1	Percentage of Beach boys who are living with HIV Target: <1%	GF	Total no. positive	Total No. tested	IBBS	2-3 yearly
4	Impact	SD 1	Percentage of PWID who are living with HIV Target: <1%	GAM, GF	Total no. positive	Total No. tested	HSS, IBBS	2-3 years
5	Impact	SD 1	Annual rate of reported cases of congenital syphilis per 100,000 live births Target: <50	EMTCT guidelines	Number of reported cases of congenital syphilis (including stillbirths)	Actual number of deliveries and still births	PMTCT register of NSACP, FHB (H 509)	Yearly
6	Impact	SD 1	Annual rate of reported cases of MTCT of HIV per 100,000 live births Target: <50	EMTCT guidelines	Number of children born in a defined calendar year to mothers living with HIV, who were diagnosed as positive	Estimated number of live births within the same defined calendar year	PMTCT register of NSACP, FHB (H 509)	Yearly
7	Impact	SD 2	Percentage of infants born to mothers living with HIV, who tested positive for HIV (MTCT rate) Target: <2%	EMTCT guidelines	Number of infants born to HIV-positive mothers, who were diagnosed as HIV positive in a defined calendar year	Reported number of infants born to HIV-positive mothers within a defined calendar year, with definitive diagnosis (HIV positive and negative)	PMTCT register of NSACP	Yearly

8	Outcome	SD 1	Percentage of female sex workers reporting the use of a condom with their most recent client Target: 95%	GAM, GF	Number who reported that a condom was used with their last client	Had commercial sex in the last 12 months	BSS /IBBS	2-3 yearly
9	Outcome	SD 1	Percentage of men reporting use of a condom the last time they had anal sex with a male partner Target: >80%	GAM, GF	Number who reported that a condom was used last time they had anal sex	Number who reported having anal sex with a male, last 12 months	BSS /IBBS	2-3 yearly
10	Outcome	SD 1	Percentage of other vulnerable populations (beach boys) reporting the use of a condom at last sexual intercourse Target: 80%	GF	Number who reported that a condom was used last time they had anal sex	Number who reported having casual sex partners in the last 12 months	BSS /IBBS	2-3 yearly
11	Outcome	SD 2	Number and percentage of people receiving ART who have suppressed viral load	GAM	Number of people receiving ART who have suppressed viral load	Number of people on ART	ART patient record and SIM database	ongoing
12	Outcome	SD 2	Number and Percentage of PLHIV who have been tested HIV-positive, i.e. who know their status	GAM	Number of PLHIV who have been diagnosed with HIV	Number of PLHIV (alive)	HIV case reporting	ongoing
13	Outcome	SD 2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART Target: 93%	GF, GAM	Number of PLHIV started on ART up to 12 months prior to the reporting period who remain on treatment 12 months after initiation (by adult & children)	Number of PLHIV started on ART up to 12 months prior to the reporting period	ART cohort data	ongoing

TABLE 4: OUTPUT LEVEL INDICATORS

S. No	Indicator level	Strategic direction	Indicator	Indicator reference/ source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
1	Output	SD 1	Percentage of FSW reached with HIV prevention programmes Target: 68%	GF	Number of FSWs reached with basic package of HIV prevention services. Basic Package includes a) Awareness on HIV and STD, b) Awareness by distribution of IEC/BCC materials, c) Condom Demonstration, d) Condom Distribution	Size estimate of FSW	MEMIS (FPA Sri Lanka)	Ongoing
2	Output	SD 1	Percentage of FSW who have received an HIV test in past 12 months and know results (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community) Target: 83%	GF	Number of FSW who have been tested for HIV during the last 12 months and who know the results, (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community)	Size estimate of FSW	STD register, MEMIS (FPA Sri Lanka)	Ongoing
3	Output	SD 1	Percentage of MSM reached with HIV prevention programmes Target: 70%	GF	Number of MSM reached with basic package of HIV prevention services. Basic Package includes a) Awareness on HIV and STD, b) Awareness by distribution of IEC/BCC materials, c) Condom Demonstration, d) Condom Distribution	Size estimate of MSM	MEMIS (FPA Sri Lanka)	Ongoing
4	Output	SD 1	Percentage of MSM that have received an HIV test in past 12 months and know results (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community) Target:78%	GF	Number of MSM who have been tested for HIV during the last 12 months and who know the results (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community)	Size estimate of MSM	STD register, MEMIS (FPA Sri Lanka)	Ongoing

S. No	Indicator level	Strategic direction	Indicator	Indicator reference / source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
5	Output	SD 1	Percentage of BB reached with HIV prevention programmes Target: N=2300 (87%)	GF	Number of BBs reached with basic package of HIV prevention services Basic Package includes a) Awareness on HIV and STD, b) Awareness by distribution of IEC/BCC materials, c) Condom Demonstration, d) Condom Distribution	Size estimate of BB	MEMIS (FPA Sri Lanka)	Ongoing
6	Output	SD 1	Percentage of Beach boys tested for HIV in past 12 months and know results (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community) Target: N=2200 (84%)	GF	Number who have been tested for HIV during the last 12 months and who know the results (disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community)	Size estimate of BB	STD register MEMIS (FPA Sri Lanka)	Ongoing
7	Output	SD 1	Percentage of PWUD/PWID reached with HIV prevention programmes Target 70.5%	GF	Number of PWUD/PWID reached with basic package of HIV prevention services disaggregated by PWUD and PWID. Basic Package includes a) Awareness on HIV and STD, b) Awareness by distribution of IEC/BCC materials, c) Condom Demonstration, d) Condom Distribution	Size estimate of PWUD/PWID	MEMIS (FPA Sri Lanka)	Ongoing
8	Output	SD 1	Percentage of PWUD/PWID tested for HIV in past 12 months and know results (disaggregated by PWUD & PWID STD clinic-facility testing, STD clinic outreach testing, and community based testing by community) Target: 20%	GF	Number who have been tested for HIV during the last 12 months and who know the results Disaggregated by PWUD and PWID and disaggregated by STD clinic-facility testing, STD clinic outreach testing, and community based testing by community)	Size estimate of PWUD/PWID	STD register MEMIS (FPA Sri Lanka)	Ongoing
9	Output	SD 1	Percentage of Prisoners reached for voluntary HIV testing. Target: 70%	GF	Number who have been tested for HIV during the last 12 months and who know the results	Size estimate of prison population	STD register	Ongoing
10	output	SD 1	Percentage of pregnant women attended antenatal care services Target: ≥ 95 %	EMTCT guidelines	Number of mothers who reported to have received antenatal care (reported at delivery)	Number of deliveries during the given year	FHB (H 509)	Yearly
11	output	SD 1	Percentage of pregnant women tested for HIV- Target: ≥ 95 %	EMTCT guidelines	No: women who has been screened for HIV as reported at delivery	Number of deliveries during the given year	FHB (H 509)	Yearly

12	output	SD 1	Percentage of pregnant women tested for syphilis Target: ≥ 95 %	EMTCT guidelines	No: women who has been screened for syphilis as reported at delivery	Number of deliveries during the given year	FHB (H 509)	Yearly
13	output	SD 2	Percentage of ART among HIV positive pregnant women Target: ≥ 95 %	EMTCT guidelines	No: HIV positive women who has been received ART and delivered in a year	Total number of HIV positive women who delivered during that year	PMTCT register of NSACP	Yearly
14	output	SD 1	Percentage of syphilis-seropositive pregnant women who were appropriately treated Target: ≥ 95 %	EMTCT guidelines	Number of pregnant women treated for syphilis	Estimated number of syphilis-positive pregnant women	PMTCT register of NSACP	Yearly
15	Output	SD 2	Percentage of eligible adults and children currently receiving antiretroviral therapy among all adults and children living with HIV Target: >80%	GAM, GF	Number receiving ART	Estimated number of PLHIV (Note: From 2016 forward all PLHIV are eligible for ART)	ART register	Ongoing
16	Output	SD 2	Percentage adults and children living with HIV and who have been diagnosed who are currently receiving antiretroviral therapy Target: 90%	2 nd 90	Number of adults and children living with HIV who have been diagnosed and are currently receiving antiretroviral therapy	Number of adults and children living with HIV who have been diagnosed.	N: ART register D: HIV case reporting	Ongoing
17	Output	SD 2	Percentage of people living with HIV that initiated ART with CD4 count of <200 cells/mm³ Target:<30%	GAM, GF	Number of HIV positive adults initiating ART within the past 12 months with a baseline CD4 count =<200 cell/mm ³	Number of HIV positive adults initiating ART within the past 12 months	ART register	Ongoing
18	Outcome	SD 2	Percentage of adults and children enrolled in ART, with an undetectable viral load at 12 months (<1000 copies/ml) Target: 94%	GAM, GF	Number of PLHIV who initiated ART who have suppressed viral load at 12 months after initiating ART	Number of PLHIV with a viral load at 12 months conducted during the reporting period	ART register	Ongoing
19	Output	SD 2	Number and percentage of newly diagnosed HIV positive people newly enrolled in and receiving care Target: >90%	GAM	Number of people newly (diagnosed and) enrolled in HIV care and received clinical HIV care services in the past 12 months	Number of people newly diagnosed with HIV within the past 12 months	Pre-ART and ART registers	Ongoing

S. No	Indicator level	Strategic direction	Indicator	Indicator reference / source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
20	Output	SD 3	Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines Target: >90%	GF	Number of NSACP STD clinics which submit their quarterly reports on time (within 20 days of the end of the reporting period.)	Number of NSACP STD clinics	SIM unit	Ongoing
21	Outcome	SD 3	Percentage of districts covered by mapping for size estimation (in the last 4 years) Target: 80%		Number of districts covered	Total number of districts	SIM unit	Once in 4 years
22	Output	SD 4	Percentage of districts with government facilities providing ART		Number of districts with at least one government ART facility	Total number of districts	NSACP Coordinator	Yearly
23	Outcome	SD 4	% of HIV response financed domestically Target: >70%	GAM,	Amount of HIV response financing from domestic sources	Total amount of HIV response financing	NASA	2-5 years
24	Outcome	SD 5	[Stigma measure] Percentage of FSW, MSM, or PUD/PWID who report experience with KP-related stigma or discrimination at government health care facilities in the last 12 months Target: <20%	GAM	Number of respondents who report that they were denied health services, including dental care, in the previous year because of their HIV status	Total number of respondents	HIV stigma index	2-5 years
25	Outcome	SD 5	Percentage of PLHIV who report experience with HIV-related stigma or discrimination at government health care facilities in the last 12 months Target: <20%	GAM	Number of respondents who report that they were denied health services, including dental care, in the previous year because of their HIV status	Total number of PLHIV interviewed.	HIV stigma index	2-5 years

TABLE 5:. ADDITIONAL INDICATORS FOR GAM REPORTING:

S. No	Indicator or level	Strategic direction	Indicator	Indicator or reference/ source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
1	Impact	SD 1	New infections	GAM	Number of new infections	Per 1000 uninfected population (i.e. Total population minus PLHIV)	SPECTRUM	Annual
2	Impact	SD 2	AIDS-related deaths	GAM	Total number who have died of AIDS-related illness in a 12 month period	Per 100,000 population	SPECTRUM	Annual
3	Impact	SD 1	People with HIV	GAM	Number of people living with HIV, disaggregated by pregnant women)	NA	SPECTRUM	Annual
4	Outcome	SD 1	Percentage of PWID reporting the use of a condom at last sexual intercourse	GAM	Number of PWID who reported that a condom was used last time they sex	Number PWID who reported having sex last 12 months	BSS/IBBS	2-3 yearly
5	Output	SD 1	Percentage of FSW reached by prevention programmes	GAM	Number of FSW who received condoms from outreach and know a place for testing	Number of FSW in the sample	IBBS/BSS	2-3 years
6	Output	SD 1	Percentage of MSM reached by prevention programmes	GAM	Number of MSM who received condoms from outreach and know a place for testing	Number of MSM in the sample	IBBS/BSS	2-3 years

S. No	Indicator level	Strategic direction	Indicator	Indicator or reference source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
7	Output	SD 1	Percentage of PWID reached by prevention programmes	GAM	Number of PWID who received clean needles from outreach and know a place for testing	Number of PWID in the sample	IBBS/BSS	2-3 years
8	Output	SD 1	Percentage of FSW who received an HIV test in the last 12 months and know their result	GAM	Number of FSW who received an HIV test in the last 12 months and know their result	Number of FSW in the sample	IBBS/BSS	2-3 years
9	Output	SD 1	Percentage of MSM who received an HIV test in the last 12 months and know their result	GAM	Number of MSM who received an HIV test in the last 12 months and know their result	Number of MSM in the sample	IBBS/BSS	2-3 years
10	Output	SD 1	Percentage of PWID who received an HIV test in the last 12 months and know their result	GAM	Number of PWID who received an HIV test in the last 12 months and know their result	Number of PWID in the sample	IBBS/BSS	2-3 years
11	Output	SD 1	Percentage of HIV exposed infants who initiated ARV prophylaxis	GAM	Number of HIV exposed infants born within the past 12 months who were started on ARV prophylaxis	Number of HIV positive women who delivered within the past 12 months (live births?)	PMTCT register	Ongoing
12	Output	SD1	Percentage of HIV exposed infants receiving a virological test for HIV within 2 months of birth	GAM	Number of HIV-exposed infants born within the past 12 months who received an HIV testing within two months of birth	Number of HIV positive pregnant women who delivered within the past 12 months	PMTCT register	Ongoing
13	Outcome	SD 2	Percentage of adults and children with HIV known to be on treatment 24 and 60 months after initiation of antiretroviral therapy	GAM	Number alive and on treatment 12, 24 and 60 months after initiating ART	Total number of PLHIV who initiated ART 12, 24 and 60 months ago	ART cohort data	Ongoing

S. No	Indicator level	Strategic direction	Indicator	Indicator or reference source	Numerator	Denominator	Format/ Source of data	Frequency of data collection
14	Outcome	SD 2	Percentage of adults and children with HIV alive at 12, 24, 36 months after ART initiation	GAM	Number of PLHIV alive at 12, 24, 36 months after initiating ART	Number of people in the respective cohort	ART cohort data	Ongoing
15	Output	SD 2	Percentage of newly registered TB patients with documented HIV status	GAM	Number of new and relapsed TB patients registered during the reporting period who had an HIV test result recorded in the TB register	Number of new and relapsed TB patients registered in the TB register	TB register	Ongoing
16	Output	SD 2	Number and Percentage of PLHIV who are receiving HIV care (including ART)	GAM	Number of PLHIV who received HIV care in the last 12 months	Number of PLHIV	N: ART register D: SPECTRUM	Ongoing
17	Output	SD 2	Number of PLHIV who initiate ART	GAM	Number of PLHIV who initiate ART in the last 12 months	NA	ART register	Ongoing
18	Output	SD 2	Percentage of health facilities dispensing antiretroviral (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months	GAM	Number of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	Number of health facilities dispensing ARVs	ART dispensing register	Ongoing
19	Output	SD 2	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	GAM	Number of people with advanced HIV infection who received ART and who were started on TB treatment, within the reporting year	Estimated number of incident TB cases in people living with HIV.	ART register	Yearly
20	Output	SD 2	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	GAM	Number of adults and children started in HIV care during the reporting period who also start (i.e. are given at least one dose) isoniazid preventive therapy	Number of adults and children started in HIV care during the reporting period	ART register	Yearly

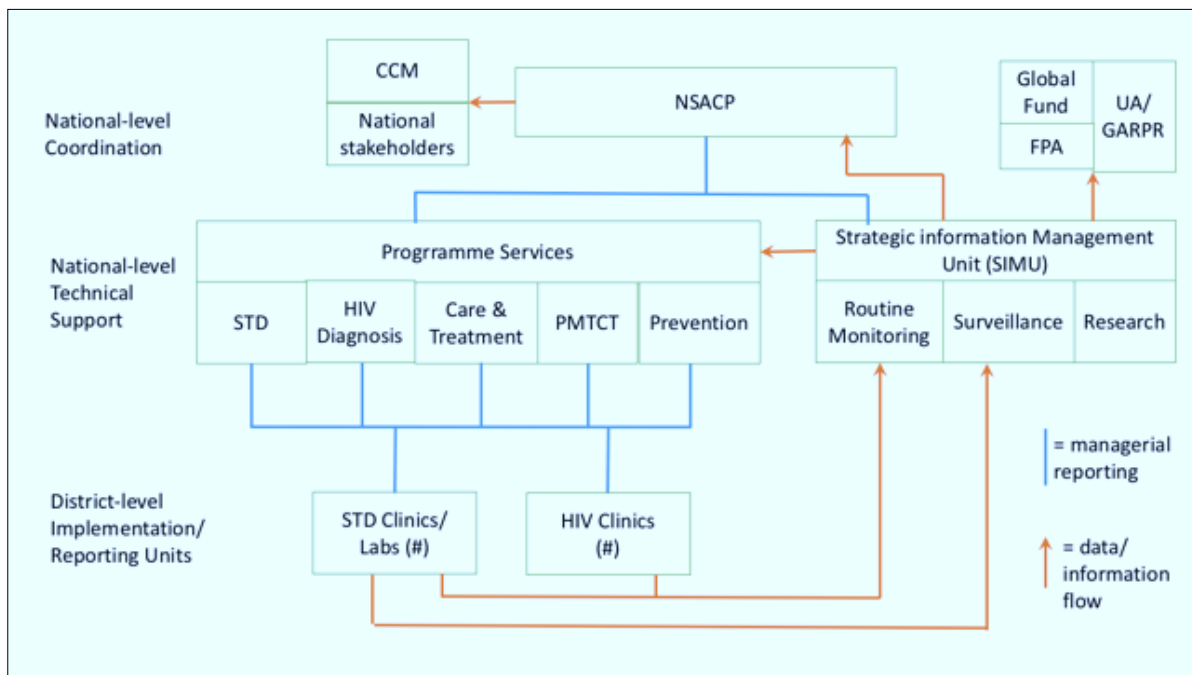
M&E ORGANIZATIONAL STRUCTURES AND HUMAN CAPACITY

ROLES AND RESPONSIBILITIES

I. NSACP

The NSACP plays three distinct roles in monitoring and evaluation of the national programme: 1) as an overall coordinating authority for HIV/AIDS related activities; 2) As a service provider of HIV and STI related services; 3) as a technical resource for analysis and triangulation of strategic information.

FIGURE 3: MANAGERIAL STRUCTURE AND REPORTING LINES OF NSACP M&E SYSTEM



At the Central level the SIM unit of the NSACP is responsible for the following:

Coordination role --

- Develop and ensure implementation the National M&E plan
- Provide data for planning and budgeting
- Share the data to the relevant national stakeholders (e.g. CCM, MOH Epi unit, etc.) and development partners
- Repository and nodal unit for disseminating strategic information about the HIV and STD epidemic and response in the country, including programme monitoring, surveillance and operations research. Prepare reports for the reporting international requirements such as GAM and UA
- Prepare the periodic reports to national and global stakeholders

Implementation role –

- Coordinate with the STD and HIV clinic reporting units to get quality data and carry out data quality audits
- Provide feedback to reporting units to improve on data quality
- Provide feedback to the implementing units on performance
- Capacitate and guide the reporting units in the field on collection, validation and analysis of data of their own
- Prepare reports for Global Fund for activities implemented by NSACP

Technical role –

- Develop and implement the Operation Research with other institutions/ consultants such as client satisfaction, quality of service etc.
- Triangulate data for epidemic tracking and overall performance at National Level
- Design and carry out biological and behavioural surveillance
- Design and carry out or commission specific evaluation studies and program assessments

The following staff comprise the Central Level SIMU at NSACP:

The SIM unit is headed by the coordinator-strategic information. Staff consists of two full-time medical Officers, three data management officers whose specific job titles are Public Health Nursing Officer, Information & Communication Technology officer and Development Officer. The Epidemiology unit is consisting of an epidemiologist and a medical officer. In addition, to these dedicated positions, M&E is integrated into the work of the other programme coordinators and their supporting staff.

At the reporting unit level ,NSACP STD and HIV/ART clinics are responsible for collecting and sending reports on the activities of their units. The responsibilities of the reporting units are to,

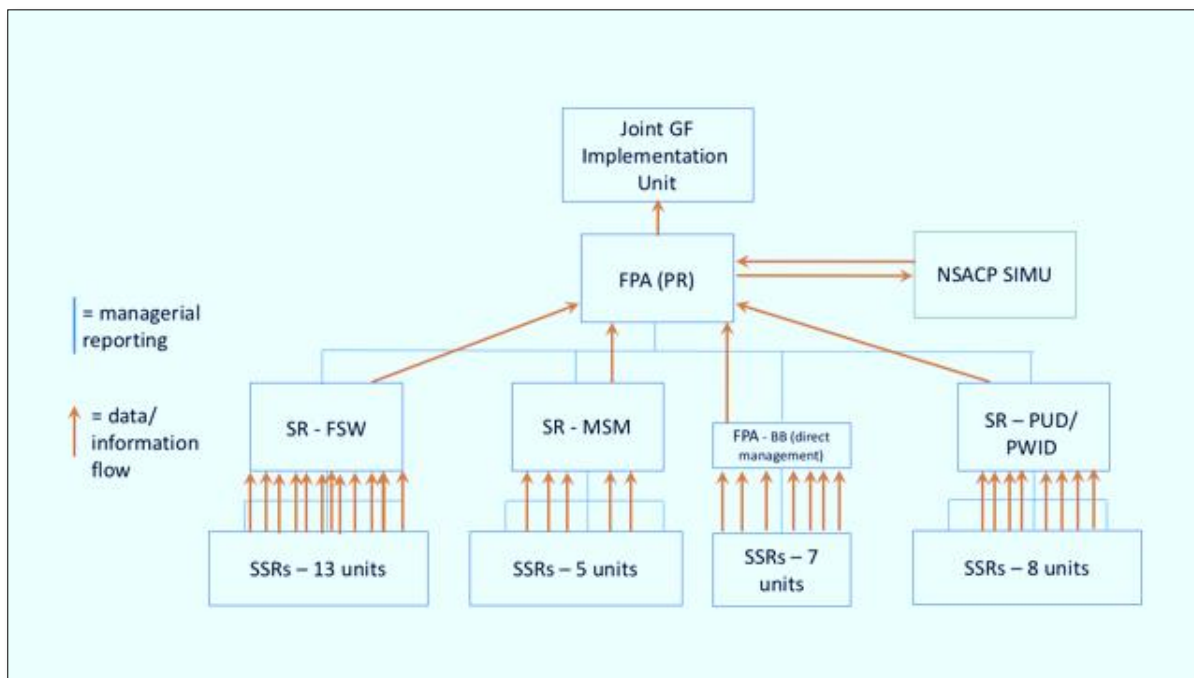
- Record the details of the patients/clients/services offered in the specified registers in the specified formats
- Verify and validate the data, including making registers available for periodic quality assessment
- Periodic (weekly) backup of data from the computers, if the records are computerized.
- Prepare and send the reports to SIM unit of NSACP in the specified time frame.

At service provision units of NSACP (STD and HIV clinics) M&E activities are shared between clinical staff and public health staff. Medical officer-in-charge of the clinic (Venereologist or a senior medical officer) is responsible to oversee data management functions of Public Health Inspectors, Public Health Nursing Sisters or Nursing Officers.

II. FPA SRI LANKA

As a primary recipient, FPA Sri Lanka oversees and supports routine programme monitoring functions for community based programs for key populations supported through the Global Fund. The organizational structure and data flow between implementing levels is shown in Figure 4.

FIGURE 4: MANAGERIAL AND REPORTING LINES FOR FPA SRI LANKA M&E SYSTEM



The primary roles and responsibilities of the central M&E team at FPA Sri Lanka are:

- Oversee the quality of monitoring and evaluation functions for project activities as per the requirements of the national M&E plan
- Adopt/implement national M&E plan including data collection and management methods, tools and templates and ensure timely collection of data
- Assist PR, SRs and SSRs in the development of project Performance Framework including indicators, targets and sources of verifications
- Develop and Maintain an electronic M&E Information Management System (MEIMS)
- Provide technical support for the implementation of M&E plans for (SRs) and (SSRs) and build capacity of GFATM project staff at all levels
- Review periodic M&E reports submitted by SRs and SSRs and conduct field visits to provide appropriate feedback on improving M&E data collection and use
- Build and implement a data quality audit system for SRs/SSRs
- Organize and participate in periodic project progress review meetings and provide feedback
- Consolidate and ensure timely submission of project progress reports to Global Fund and other stakeholders

- Coordinate with PR2 national technical experts, National STD/AIDS Control Program (NSACP), Local Funding Agent (LFA), Global Fund and M&E units of other project stakeholders on project M&E related activities, information requests and queries

These efforts are led by the M&E unit of FPA Sri Lanka. The unit is headed by the Head of Monitoring and Evaluation and project M&E staff consists of a full-time M&E Officer, two assistant M&E Officers and two MIS Assistants. In addition, to these dedicated positions, M&E is integrated into the work of the FPA Sri Lanka project director, project manager and program staff, including finance and accounting staff.

At Sub-recipient (SR) level, there are three organizations, each one overseeing one key population (FSW, MSM, and PWUD, including PWID). M&E responsibilities of the sub-recipient reporting units are to:

- Follow M&E procedures as specified in the M&E plan
- Verify MEIMS data with means of verifications and ensure timeliness, completeness, accuracy and consistency
- Prepare SR monthly report and share with FPA Sri Lanka
- Conduct regular data quality and service quality assessments of the SSRs in consultation with FPA Sri Lanka.
- Follow-up the implementation of recommendations provided by FPA Sri Lanka M&E unit with SSR.
- Coordinate with central M&E unit of FPA Sri Lanka for all related M&E activities
- Use project monitoring information for routine project management and improve performance at the SR / SSR level

At the sub-recipient levels these responsibilities are largely carried out by an M&E Officer and an Assistant M&E Officer, hired on a full-time basis for the project.

At SSR level, there are 33 organizations implementing key population programmes reporting on activities. The M&E responsibilities of the SSR reporting units include:

- Ensure M&E guidelines, procedure, templates for data collection and data quality assurance are followed
- Enter data to MEIMS for all services provided in a timely fashion
- Conduct regular field visits and verify recorded data
- Conduct bi-monthly pocket meetings, produce minutes and shared with SRs
- Maintain safe storage of project documentation and safeguard client confidential information
- Follow-up on recommendations provided by SR and FPA Sri Lanka staff based on review of M&E data
- Participate and contribute to project progress review meetings
- Coordinate with M&E officer of SR and FPA Sri Lanka for all M&E related tasks
- Conduct field supervision to complete M&E forms and check the filled forms
- Use project monitoring information for routine project management and improve performance

At the SSR level these responsibilities are largely carried out by the program coordinator who has broader responsibilities for the project.

DATA COLLECTION AND REPORTING RESPONSIBILITIES & PROCESSES

The data flow from reporting units for routine programme monitoring data can be described in terms of the **community based programmes for key populations implemented by FPA Sri Lanka and the health facility based programmes implemented by NSACP.**

COMMUNITY BASED PROGRAMMES FOR KEY POPULATIONS

The key indicators collected by community based programmes for key populations include:

- Percentage of FSW reached with HIV prevention programmes
- Percentage of FSW who have received an HIV test in past 12 months and know results – community based testing
- Percentage of MSM²¹ reached with HIV prevention programmes
- Percentage of MSM who have received an HIV test in past 12 months and know results – community based testing
- Percentage of Beach boys reached with HIV prevention programmes
- Percentage of Beach boys who have received an HIV test in past 12 months and know results – community based testing
- Percentage of PUD/PWID²² reached with HIV prevention programmes
- Percentage of PUD/PWID who have received an HIV test in past 12 months and know results – community based testing

In addition, a number of secondary indicators have been identified by FPA Sri Lanka which are used for day to day management of program implementation:

²¹ As described earlier, the definition used for MSM for purposes of programming and M&E includes men who sell sex to other men (MSW) and transgender women. However, data collection tools (e.g. STD clinic tools to measure HIV testing) are being developed to enable MSM indicators to be disaggregated for transgender women.

²² From 2017 moving forward indicators for PWUD and PWID are to be collected in a way that enables disaggregation between the two groups of drug users. This is intended to enable consistency in reporting for globally defined indicators which are limited to PWID. However, it is recognized that in Sri Lanka the absolute number and proportion of PWID among all drug users is very small (e.g. <800) nationally, and an important HIV strategy is to include PWUD in HIV prevention efforts with the intent of preventing PWUD from becoming PWID.

TABLE 6.: SECONDARY INDICATORS FOR COMMUNITY BASED PROGRAMMES FOR KEY POPULATIONS

Level of Measurement	Secondary Indicator (SI)
Peer Educator level	SI- 01) Number of Peer Educators among key population groups in position
	SI-02) Average number of clients among key population groups served by a Peer Educator
Client level	SI-03) Number of new clients who received any kind of service during the month
	SI-04) Total number of clients who received any kind of service during the year - Cumulative Progress of SI-03
	SI-05) Total number of clients who received any kind of service during the month
	SI-06) Rate of Drop outs - Percentage of clients who permanently or temporally drops from the project during the particular month
	SI-07) Percentage of key population clients reached
Level of integrations between the KP and PE	SI-08) Average number of Interactions/Contacts by a Peer Educator per key population client during the month
Service Level	SI-09) No of condom demonstrations conducted
	SI-10) No of awareness sessions conducted
	SI-11) No of IEC events conducted through distribution of IEC materials
Coordination with STD clinic services	SI-12) Proportion of key population clients to STD clinic who are escorted by SSR staff (Numerator from MEIS, Denominator from STD clinic quarterly return)

There are **5 paper-based formats** used for collecting and verifying routine monitoring data from community based programs for key populations. Four formats are used for collecting key indicators used in the Global Fund Performance Framework:

- Client registration forms
- Peer educator Diary
- Peer Educator Calendar
- Clinic Referral Slip
- Community based testing formats

CLIENT REGISTERS AND REGISTRATION FORMS

The data collection process begins with the client registration by peer educators (PE). At the time of registration each client will receive an identification/registration number. A client registration number must be unique for a particular client and should not be duplicated. The registration number is used to identify the person throughout the project period. (*Annexure 1: Client Registration Form.*)

The client registration forms are filled and signed by the PE. Thereafter, a field supervisor (FS) checks the filled forms and certify. Thereafter, the completed and duly signed client registration forms are handed over to respective SSRs within one to two weeks from registration. SSR enters client registration data in to the FPA Sri Lanka MEIMS before the 5th of following month. Separate registers are maintained for clients from each key population group.

B- PE DIARY AND PE CALENDAR

Each Peer Educator (PE) maintains a diary book to record daily interactions with his/her peers. The diary should be made available to FS and other project staff at SR, PR when requested.

Based on the daily records maintained in the PE diary book each PE fills a PE calendar (*Annexure 2: PE Calendar format*) bi-weekly. For each day PE records his/her daily activities in the calendar using codes appear below. The PEs and FSs are trained on how to record data in the calendar with use of these codes. The FS has to support PEs with low literacy and ensure that the data is recorded accurately and clearly in the PE calendar.

Table 6. Codes used for PE calendar

H – Awareness on HIV/AIDS	C – Condom Distribution
S – Awareness on STI	CD – Condom Demonstration
L - Awareness using IEC materials	E – Escort to clinics

The completed calendars are submitted by the PE to the respective FS at SSR. Field supervisor at SSR level verify the peer calendars with the peer educator diary and sign in both peer calendars and peer educator diary before taking over the peer educator calendar.

The completed, checked and duly signed PE calendar are submitted to the respective SSR by the Field Supervisor bi-weekly. SSRs have to enter all PE calendars to the system and the original PE calendar is sent to the SR.

Assistant M&E officer at SR checks the all data (100%) entered in the system with the PE calendars and confirms the system data at FPA Sri Lanka. If there are discrepancies, those are informed to SSR by the SR for correction.

After the completion of data verification, the original PE calendars are submitted to FPA Sri Lanka. The MIS Assistant at FPA Sri Lanka randomly checks system data with the calendars received. If inconsistencies or errors detected, those are immediately informed to SSR for correction. The service data is blocked in the system on 15th of every month to avoid alternations to the entered data in the previous month. Subsequently, the compilation of data and preparation of FS/ORW report and SR monthly report takes place.

TABLE 7: DATA FLOW AND VERIFICATION OF PEER EDUCATOR SERVICE DATA

By whom ?		Peer Educator	Field Supervisor - SSR	Project Coordinator - SSR	M&E Officer – SR	MIS Assistant - PR2
What ?		Fill the PE calendar using the diary records Submit the calendar to FS	Check the calendar data with the PE diary (Submit the signed calendars to SSR)	Data Entry to MEIMS by SSR Submit the original PE calendars to the SR Check the entered data for consistency	Check system data with the PE calendars Send the original PE calendars to PR2	Check system data with the PE calendars
When ?	1-15th PE Calendar	By 17 th of the same month	At the time of collection of PE calendars	By 25 th of the same month	By 30 th of the same month	By the 10 th of the following month
	16-31st PE Calendar	By 3 rd of the following month	At the time of collection of PE calendars	By the 10 th of the following month	By 18 th of the following month	By 25 th of the following month

C- Clinical Escort Data

Escorts to clinics are tracked through collection of referral slips (*Annexure 3: Clinic Referral Slip Format*) Clinical referral slip consists of three main sections. There are fields to be completed by the PE in section 1 and 2. Once all required information is filled, section 2 and 3 are detached from the referral slip book and taken to the clinic by the PE escorting the patient. The FS checks the filled referral slips by the PE and ensures a referral slip is taken for every escort. (Four different colour slips i.e. FSW - Pink; MSM – Blue; BB – White; DU - Yellow are used to distinguish each key population component). At the STD clinic, peers request the Doctor’s signature and stamp for the referral slip to verify the patient was escorted to the clinic.

The process is used for both first and subsequent escorts, e.g. to retrieve test results. The referral slips are collected by relevant SSRs as sources of verification from STI clinics on a monthly basis. Counts of referral slips are also important because they are used as the basis for reimbursement of services performed by SSRs. At the same time, data about patient escorts are recorded in the STD patient form/Main Registers or the Outpatient Blood Testing Register at the STD clinics. STD clinic data and client referral data can be triangulated with each other to validate the number of KP tested/escorted.

D- Community Based Testing

In line with the newly developed HIV testing guidelines by the National STD and AIDS Control Programme of Sri Lanka, FPA Sri Lanka is expected to introduce a Community Based Testing from 2017. Since this is a new initiative, it is expected to gradually scale-up the community based rapid testing to increase HIV testing coverage up to 80-90% of KP reached by end of 2018. **Inclusion in the indicator is defined as having received rapid HIV test via outreach worker or lab technician, and having received the results of the test.** Reporting will be based on data collected by all SR/SSRs using a unique identifier

and common online database tool (MEIMS) to avoid double counting of individual clients reached on a regular basis. The community Based Tester will use the format available in Annexure 4 to record the community based testing (Annexure 4: Community Based Testing Reporting Form). The tester will complete one form per HIV testing session and handover the duly completed forms to the respective district project coordinator. The project coordinator enter the data in to the MEIMS and handover the first copy of the form to the respective SR. The M&E Officer at SR level verify the data and submit the original forms to PR2. PR2 report the progress of the indicator to the SIM unit at the end of each quarter.

Health Facility Based Programmes

The key indicators collected by health facility based programmes can be divided into those reported by STD clinics and ART clinics.

STD clinic reporting:

- Percentage of (FSW, MSM, beach boys, PWUD/PWID, and prisoners) that have received an HIV test in the past 12 months and know their results (Numerator)
- Percentage of ANC attendees who were tested for syphilis
- Percentage of syphilis seropositive ANC attendees treated for syphilis
- Percentage of pregnant women with known HIV status
- Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines (combined with ART reporting units statistics)

ART clinic reporting:

- Number and percentage of PLHIV on ART who are virologically suppressed
- Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART
- Percentage of eligible adults and children currently receiving antiretroviral therapy among all adults and children living with HIV
- Percentage of adults and children living with HIV and who have been diagnosed who are currently receiving antiretroviral therapy (Numerator)
- Percentage of people living with HIV that initiated ART with CD4 count of <200 cells/mm³
- Percentage of adults and children enrolled in ART with an undetectable viral load at 12 months (<1000 copies/ml)
- Percentage of newly diagnosed adults linked to HIV care (Numerator)
- Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings
- Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines

The numbers diagnosed with HIV used in the following indicators come from the HIV case reporting system which tracks confirmed diagnoses and vital status of those diagnosed:

- Percentage HIV infected among HIV-exposed infants born in the past 12 months
- Number and percentage of PLHIV who have been diagnosed
- Percentage of adults and children living with HIV and who have been diagnosed who are currently receiving antiretroviral therapy (Denominator)
- Percentage of newly diagnosed adults linked to HIV care (Denominator)

There are 8 paper-based formats used for collecting/collating data from STD clinics for the national indicators:

- STD patient form
- Main Register
- Outpatient Blood Testing Register
- Prison outreach screening programme Register
- Antenatal Syphilis Register
- Details of pregnant women with confirmed HIV infection form
- Details of pregnant women with syphilis form
- Congenital syphilis case report form

There 4 paper-based formats used for collecting/collating data from ART clinics:

- ART patient card
- ART Register
- ART Cohort database (paper-based format)
- Details of Paediatric patients with HIV infection form

A. STD PATIENT FORM AND MAIN REGISTER

Individuals who come to the STD clinic with symptoms or for screening tests (e.g. syphilis, HIV, Viral Hepatitis, etc.) are classified as STD patients. STD patients include key populations, members of the general population with STD symptoms, or sexual contacts of STD patients. ANC attendees (or their specimens) who are screened for HIV and syphilis are not considered STD patients unless diagnosed with an infection. Information about STD patient visits are recorded on an STD Patient Form. (*Annexure 5. STD Patient Form*) Patients who are visiting a government STD clinic for the first time are given a Master Number which is used for all subsequent episodes of care conducted at an STD clinic, even if at a different site. An episode of care is defined as a single visit or series of visits made by an STD patient to resolve an STD complaint. Many episodes require multiple visits to either get back test results or to ensure appropriate treatment and resolution of a diagnoses.

All STD patients are generally screened for syphilis and HIV²³ at the first visit of each episode of care, unless they already know they are HIV positive, or if they have recently undergone testing (e.g. in the

²³ The reference laboratory in Colombo performs all confirmatory tests for HIV (i.e. western blot) on samples sent from other STD clinics and private laboratories providing HIV testing.

last 6 months for key populations, and in the last year for non key population STD patients). The STD patient form is used by the health care provider team to record information about patient episodes including confirmed diagnoses, receipt of test results, adequate/appropriate treatment, whether the patient is a member of key populations, and whether the patient was escorted to the clinic by peer educators/outreach staff (if key populations).

For each episode of care, critical information from the STD Patient Form is entered into a Main Register. (*Annexure 5. Main Register Format*) For the purposes of the core indicators for the national M&E plan, these data include: Age, HIV diagnoses, whether result was received, key population status, and whether escorted. The Main Register format is designed to aid in collating data for the core indicators of the national M&E plan which is reported quarterly to the Central SIMU through the STD Quarterly Return format.

B. OUTPATIENT BLOOD TESTING REGISTER AND PRISON OUTREACH SCREENING

Individuals who come (or whose specimens are sent) to the STD clinic exclusively for screening (e.g. syphilis, HIV, viral hepatitis) and who do not receive a routine exam are not considered STD patients. This group includes ANC attendees, pre-employment/visa screening clients, and key population members who come for routine HIV/STI screening but who do not get an exam. The volume of HIV testing among “non-STD” patients is significant, and proportionally may comprise a significant portion of key population members. The Outpatient Blood Testing Register is another source of data for the core indicators on HIV testing of key populations. This register includes age, key population status, escort status, and which tests were conducted and whether positive. (*Annexure 7. Outpatient Blood Testing Register*) Anyone included in the Outpatient Blood Testing Register who tests positive for syphilis, HIV, or hepatitis is reclassified as an STD patients and assigned a Master Number (if not already received). As such their information is then recorded in an STD Patient Form, and entered in the Master Register. For the purposes of the core indicators of the national M&E plan, the main use of the Outpatient Blood Testing Register is to accurately count key population members (escorted and not escorted) who are tested for HIV and know their result but are negative.

Similar registers are maintained for prison populations who are brought to the clinic in groups for HIV and STD screening as well as those who are screened as part of outreach services conducted by STD clinic staff. However, prisoners who are brought to the clinic due to symptoms and who receive more comprehensive exams are considered STD patients and will be included in the counts from the Main Register.

C. ANC SPECIMEN LAB LOGS AND POSITIVE PREGNANT WOMEN FORMS

Specimens from ANC attendees are processed at the STD Clinic laboratory for syphilis and HIV. Laboratory logs from these specimens provide information on the number of attendees tested for each disease and the number who test HIV positive or positives for syphilis (early or late). (*Annexure 8. ANC Specimen Laboratory form*) Pregnant women who knew they were HIV positive prior to pregnancy, will be added to the ANC specimen lab log counts for the numerator and denominator of the indicator for ‘percentage of ANC attendees who know their HIV status.’ Confirmed HIV positive results among ANC attendees are cross-checked with data from the HIV case reporting system.

In addition, attendees who test positive for HIV or syphilis are referred to the STD/HIV clinic for further management to ensure appropriate treatment. For each positive pregnant woman the relevant form for Details of pregnant women with syphilis and/or Details of pregnant women with confirmed HIV

infection is filled as care is provided. (*Annexure 9. Details of pregnant women with syphilis format; Annexure 9. Details of women with confirmed HIV infection format, Annexure 10. Details of Paediatric patients with HIV infection*) These formats contain the details on type of treatment provided and adherence for pregnant women who are followed according to EMTCT guidelines. Both formats also include information about the infants' diagnosis (i.e. as a confirmed congenital syphilis case or paediatric HIV case). Forms on details of pregnant women with syphilis are considered completed at the time of delivery and submitted quarterly to the Central NASCP SIMU. Forms on details of pregnant women with confirmed HIV infections are considered completed 8 weeks after delivery (or at the time of early diagnostic test) and are submitted quarterly to the Central NASCP SIMU.

D. CONGENITAL SYPHILIS CASE REPORT

Congenital Syphilis reporting is part of routine mandatory disease surveillance reporting. (*Annexure 10. Congenital syphilis case report form*) These figures are used to cross check the number of congenital syphilis cases reported through the Details of pregnant women with syphilis forms.

E. PAEDIATRIC PATIENTS WITH HIV INFECTION

Data from Paediatric patients with HIV infection are collated and included in a special paper-based form to track the date of their confirmed diagnoses, their ongoing laboratory results, treatment status, and clinical stage. (*Annexure 11. Paediatric patients with HIV infection form*) This information is used to cross check the number of HIV-exposed infants who are diagnosed as positive as reported from the details on pregnant women with confirmed HIV form (Annexure 12).

F. HIV CARE AND ART PATIENT INFORMATION CARD AND PRE-ART/ART REGISTER, AND COHORT DATA TOOL

In Sri Lanka, only designated public sector ART clinics can provide ART to PLHIV. This includes the availability of ART drugs which are stored only at the central STD /AIDS pharmacy and are distributed to other ART centers depending on the need. Since 2016, any person diagnosed with HIV is eligible to receive ART regardless of CD4 count. In theory, there should be no difference between the proportion of diagnosed patients who are enrolled in HIV care and those who have initiated ART, however, delays in initiating ART due to management of co-infections, etc. may result in some gaps between these two indicators.

Patients enrolled in HIV care or ART have a longitudinal patient card which records information about the course of patient management. (*Annexure 13. ART patient information card*) This includes socio-demographic information about the patient (age, sex, residence, etc.) and data about clinic visits, start or change in ART regimen, adherence to treatment, laboratory results (e.g. CD4 and viral load), etc.

For all patients managed by the HIV/ART clinic, selected data from the ART patient information card is transcribed into a longitudinal ART Register which summarizes the course of patient treatment over a one-year period. (*Annexure14. ART register*) At the start of each year, patients continuing on ART are listed in the new year's Register and new enrollees of ART are entered sequentially after. *An Excel based database is used for analysis. (Annexure15. ART cross-sectional database)*

In addition, a paper-based ART cohort data Tool, adapted from WHO guidance, is completed listing all patients on ART according to the year they began ART. (*Annexure 16. ART cohort database*) These data are used to calculate indicators of retention on ART at 12, 24, and 60 months, as well as levels of virologic suppression at 12 months (24 months, and 60 months)

In addition to these eight paper-based formats used to generate the national indicators for health facility programmes, STD clinics are mandated to maintain and report data from a number of other formats on a quarterly basis. These include:

- Subsequent Visit Register
- Outpatient Blood Testing Register
- Interview and Contact Tracing Register
- IEC/BCC/ Awareness Programme Register
- HIV testing and counseling Register
- Condom Distribution Register
- Commercial Sex Worker Register
- Outreach Blood Survey Register
- Defaulter Register
- Antenatal Syphilis Register
- Pre-employment/Visa Screening

Specific guidance for using these formats and generating quarterly returns of STD clinic data are available in *Guidelines for Maintaining Registers and Returns in STD Clinics, 2014*. Published by the NSACP.

DATA MANAGEMENT AND QUALITY ASSURANCE

DATABASES

To capture data used for monitoring community based programmes for key populations, FPA Sri Lanka uses an M&E Information Management System (MEIMS) for data recording, management and reporting. It is a web based system with remote access facilities for service sections (Client Information Management System - CIMS) which is under the umbrella of a broader data management system. Financial information dissemination system has been linked with the IMS for synchronization of both the programme and financial data. The system has been upgraded to align with Global Fund monitoring and reporting requirements. Password protected user accounts have been created for all system users at FPA Sri Lanka, SR and SSR levels. All MEIMS users are trained on system data entry and use of information. The processes of data collection, recording, storage and management steps are detailed in the following section.

Currently, there is no electronic web-based data system for health facility based monitoring by NSACP. However, an individual patient-level, longitudinal, electronic data base is under development by the SIMU and is expected to be functioning in service delivery sites (i.e. STD and HIV clinics) by 2018. The purpose of this system is to aid in the collation and accurate reporting of data from STD clinics and HIV/ART clinics for the core indicators. Until the electronic data base is available and adopted by all reporting units, M&E data are collated on paper-based systems on a quarterly basis. Manual collation of these data in a format that allows the accurate calculation of key indicators continues to be a time consuming challenge to clinic staff. An interim set of Excel spreadsheets has been developed for use by some high volume clinics to simplify the process of collating data over the quarter. These Excel spreadsheets mimic a type of electronic register, allowing for automated calculation of the numerators and denominators required for the core indicators.

To avoid duplication of effort, clinics are encouraged to transcribe information directly from STD Patient forms and PLHIV Patient information cards, and Details of pregnant women with syphilis/confirmed HIV into the electronic spreadsheets, and as needed, print the data in the register format from the spreadsheet for use in clinic operations/management. This process avoids the additional effort of recording data manually in paper-based registers.

There are four such Excel Spreadsheets:

- ART cross-sectional Patient Database
- ART cohort database
- STD database
- PMTCT Patient Database

For each of these spreadsheets, an automated method for calculating key indicators is pre-programmed and updated regularly to ensure that clinics using these tools are calculating the key indicators in a standardized fashion. Operational definitions used for completing each field are the same as are used for paper-based data collection/collation

BACKUP SYSTEMS AND DATA SECURITY²⁴

FPA Sri Lanka focal person for M&E or a junior person with delegated authority under the overall supervision of M&E focal person may act as the administrator of the MEIMS. MEIMS is developed with role based authentication facilities to maintain privacy and confidentiality of the data entered into the system. Role maintenance, user maintenance, project maintenance and other key system administration roles are conducted only by the administrator.

All the MEIMS users are required to agree on the below user responsibility agreement statement prior to commencement of use.

“I am responsible for log on/log off, all actions pertaining to the use of my assigned log on ID, and will not provide my log on ID to another person, for any reason. I know that I am responsible for all the actions and transactions that will be take place using the logon ID assigned to me. I agree that, I will use all the information in the M&E information management system only for FPA Sri Lanka business purposes and will not use it for any other purposes and will not provide any information in this system to any person outside of the organisation without prior-approval from the Executive Director”

FPA Sri Lanka IT unit is responsible for development of data security systems for MEIMS and routine back up. Routine data backup must be created at least once a day in a separate server within the FPA premises. Off-site data base back up (outside FPA premises) must be created at least once a week to ensure data security. The IT unit is responsible for monitoring and protecting the regular backup system. In case the maintenance of MEIMS is being out-sourced, the agreement must clearly indicate that the external service provider is solely responsible for data security. However, the IT unit must closely monitor all the activities of the external service provider.

The MEIMS may contain private and confidential data such as clients’ personal information, sales data, etc. Any confidential data must not be accessed by any person unless otherwise, it is a part of his/her duty within the organisation. User passwords and confidential data must be encrypted to avoid unwanted access and misuse of data. Further, all the online applications including MEIMS use https// to avoid unauthorised access (Ex: - <https://me.fpasrilanka.org/login.htm>). Any unauthorised access and/or misuse of data is considered as a misconduct and the HR Unit is responsible for initiation of disciplinary actions.

All electronic records of the NSACP (including interim spreadsheet based tools for the Main Register, ART patient database, and PMTCT patient database) will be maintained as per the Government regulations. The computerized records will be backed up every week/ month according to the size of the database. The weekly/monthly back up will be under custody of the Medical officer in charge of STD Clinic. The annual backup will be stored at SIM unit of NSACP. Online Patient Information Management System (PIMS) is password protected. Individual clinic staff can see only their own data. At Central level, authorize personnel can see data for all clinics. Quarterly STD return and Quarterly ART return workbooks are password protected to enhance data security.

²⁴ Source:- FPA Sri Lanka Monitoring and Evaluation Standard Operational Procedure Manual

DATA QUALITY ASSURANCE

To ensure standardized use of data collection and reporting tools used by community based programmes for key populations and clinic based HIV service providers, written user-guides provide detailed instructions for completing each format and the use of electronic databases. As reporting units submit their data on a monthly or quarterly basis, central M&E units review the reports and interact with individual reporting units to obtain the necessary clarifications or missing data elements.

Several paper-based formats are used to measure data quality at the time of periodic data quality audit visits. These formats are considered tools for routine programme management rather than data collection tools strictly for generating standard indicators:

- Condom Stock register
- Condom Distribution register
- Stock Update and Distribution Report

At SSR office, condom stock data are recorded in a stock registry (*Annexure 17: Stock Register Format*) while the condom distribution is recorded in a distribution registry (*Annexure 18: Condom Distribution Register Format*). These registries are maintained and updated by FPA Sri Lanka, SR and SSR programme staff. The condom distribution data as recorded in PE calendars are entered to the M&E information management system by SSR. The condom distribution data is verified with the stock and condom distribution registry by M&E staff of SR and FPA Sri Lanka at the data quality audit field visits. A condom stock update and distribution report (SUDR) is shared with FPA Sri Lanka by the SRs and SSRs using the given format (*Annexure 19: Stock Update and Distribution Report Format*) at every six month period.

In addition, FPA Sri Lanka conducts onsite data verification (OSDV) in conjunction with supervisory visits. These exercises serve as a data quality assurance mechanism to verify routinely reported data with original data sources. FPA Sri Lanka will conduct OSDVs in conjunction with contracting and implementing NGOs, during scheduled supervisory visits. The OSDV will encompass multiple levels, including the PE diary and calendar and peers/clients. OSDV's maybe conducted in conjunction with routine supervision visits. In addition to the OSDV, PR2 and SR M&E staff conduct data quality assessment at the peer/client level using the hotspot based data and service quality assessment tool (*Annexure 20*). The processes and procedures for this assessment is discussed in detail under the section service quality assurance.

For clinic based services, the NSACP SIMU conducts periodic site visits to all reporting units to assess both systemic aspects of a properly functioning M&E system and verify reported data. The systemic assessment includes: ensuring existence of supporting documents for all the reported indicators, the standard forms/formats are in use for recording/reporting, guidelines and procedures are understood and practiced, and infrastructure and capacity exist and are up to date for effective M&E. The data verification process involves tracing the aggregated data reported by NSACP down to what was reported at the service delivery level – STD and ART clinics. The protocol will follow the Global

standardized RDQA tool with some adaptation to local context.²⁵ Because RDQ is resource intensive, it will be conducted once per year and in conjunction with FPA Sri Lanka. Three indicators for prevention and two indicators for treatment and care will be selected based on decision by JPIU.

Review and assessment of performance

Review Meetings

The community based programs for key populations conducts progress reviews at district level and national level.

District Progress Review Meeting

District level progress review meetings are planned with the objective of capturing district level progress for each component. These are scheduled semi-annually for each project operating district. The meetings take place with the participation of FPA Sri Lanka, SR and SSR programme, finance and monitoring staff and NSACP district medical officers. The half yearly project progress is presented by SSRs and SRs. The emphasis is made on programme strategic aspects based on the findings from analysis of monitoring data during the six months period. The meetings are chaired by the FPA Sri Lanka Project Manager.

National Progress Review Meeting

National progress review meetings are planned with the objective of capturing overall yearly project progress. The review takes place with the participation of FPA Sri Lanka, SR, SSR programme, finance and monitoring staff and NSACP. The yearly project progress is presented by FPA Sri Lanka, SSRs and SRs. The review focuses on programmatic strategic aspects based on the findings from analysis of monitoring data during the six months period. The meeting is chaired by FPA Sri Lanka Project Director.

SACP conduct quarterly review meetings with the staff of peripheral STD and HIV clinic staff on a regular basis. During these meetings, data related issues are discussed and necessary guidance is given. In addition, M&E staff of SIM unit is visiting peripheral clinics to conduct supporting supervisory visits.

Routine Performance Reports

Following reports are prepared and are available for programmatic evidence based decision making.

A. MEIMS System Generated Reports

Data from the FPA Sri Lanka MEIMS are used to generate routine performance reports summarizing key aspects of service delivery for different types of programme managers. These reports are used for day to day supervision as well as for periodic review of site and staff performance.

²⁵ Routine Data Quality Assessment Tool (RDQA), Guidelines. GFATM, PEPFAR, USAID, WHO, UNAIDS, Measure Evaluation, 2008.

TABLE 8: MEIMS REPORTS

Name of the Report	Purpose	Information Available
Peer Educator Calendar	Identifies the services and items provided by each Peer Educator to his/her peers	Service Static ID, Date, Client Ref No Service Provided, Items distributed, No of Items
PE Performance	Captures the performance of each peer educator for a given period of time	Out Reach Worker Area, Name of the peer educator, No of people availed, No of visits, Types of services provided, No of services provided, Types of items distributed, No of items distributed, No of Referrals
FS/ORW Monthly Report	Illustrates the monthly performance of all the Peer Educators under a particular outreach worker	Name of the Peer Educator, No of people availed , No of visits, Types of services provided, Types of items distributed, No of items distributed
Full Project Report	Provides an overview of the project and the project achievements as per the targets	Overview of the project and the summary status of the Project-Programmatic Progress and Financial Progress
Client History Report	Tracks the history of a particular client with respect to the given time period	<u>Client information</u> District, Age, Gender, Location <u>Service Data</u> Date, Category of services, Name of the Service, Items Provided, Quantity, Referred Organization
District Level Report	Provides client and service information by district	<u>Service Details</u> District, Services given to clients (disaggregated by age), Percentage of services (district wise) <u>Client Details</u> No of People / Clients District, No of clients (disaggregated by age), Percentage of clients availed in each district
Raw Data Report	Gives all the data in raw format as it entered to the system.	<u>Client Details</u> Age, Gender, District, Location <u>Service Details</u> Service Offered , Items distributed and quantity, Referred Organization Service Provider, Peer Educator

In addition to the automated reports generated from the MEIMS, a variety of progress reports are generated using routine reporting data and supervisor observations.

B. Field Visit Report

Monitoring and programme staffs of PR2 and SR have to document details of field visits using field visit report format (*Annexure 20: Field Visit Report Template*). The visit report contains general information on the visit including duration of the visit, accompanied staff, places visited, tasks carried out along with observations, recommendations and follow-up actions.

C. Progress Review Report (District and National)

This report is synthesized by the M&E officer of FPA Sri Lanka summarizing the proceedings districts and national progress review meetings. The report includes key discussions and action plan for agreed action points with timelines and responsibilities.

D. Progress update and disbursement request (PUDR)

The PUDR is prepared by FPA Sri Lanka for a semester period as per the Global Fund reporting requirements. The report contains programmatic, monitoring and financial information for the previous disbursement period alongside the disbursement request for the next disbursement period. The M&E Officer (FPA Sri Lanka) is responsible to complete programmatic progress on impact, outcome and output Indicators.

ASSESSMENT OF QUALITY OF SERVICES

Assessing the quality of services provided by the health sector response is key component to monitoring. The following approaches will help review and provide feedback on quality of service delivery to health centers providing HIV/STD services.

- i. Pre and post-test evaluations of in-service training programs
- ii. Peer Educator Capacity Assessment – Periodic Peer Educator Capacity Assessment will be conducted using a standard capacity assessment tool (*Annexure 22 - Peer Educator Capacity Assessment*).
- iii. Hotspot based service and data quality assessment - Regular hotspot based service quality assessments are conducted among randomly selected peers / clients to measure the quality of services provided by the peer educators (*Annexure 21 - The hotspot based service and data quality assessment tool*). The service quality assessments will be conducted by the M&E staff at PR2 and SR level at pre-agreed interval.
- iv. Supervision checklists which assess knowledge and practice based on standard operating procedures/guidelines for STI management, VCCT, HIV care & treatment, PPTCT, etc.
- v. Operations research
- vi. Annual use of standardized tools such as Global Fund's quality of services tool on random selection of facilities

- vii. Data needs to be presented in a way that is useful for capturing the main messages, and informing progress and decisions. The who, what and how are key for information products to have an impact on end users. The National M&E System has a range of information products and dissemination strategies to help stakeholders and interested parties understand epidemiology and progress of the HIV/STI Response.

Table 9 presents the primary information products produced by the two main coordinating bodies, NSACP and FPA Sri Lanka.

TABLE 9: INFORMATION AND DISSEMINATION PRODUCTS

INFORMATION/ DISSEMINATION PRODUCT	NSACP	FPA
NSACP Annual Report	X	
NSACP Quarterly Report of HIV and STIs	X	
IBBS Report	X	
Size Estimation Reports	X	
Research Publications	X	X
NSACP website http://www.aidscontrol.gov.lk/nsacp		
MEIMS reports		X
Progress Review Report		
Global Fund PUDR	X	X
Supervision Reports	X	X
Global AIDS Response Progress Report	X	
Peer Educator Capacity Assessment Reports		X
Service and Data Quality Assessment Reports		X

Drawing from the old adage, '*you can only manage what you can measure*', it is important to note that measurement of progress alone is not enough. Understanding and interpreting findings obtained from the M&E process are the final critical steps for rendering data useful. In fact, *strategic information is not strategic without the knowledge of how to use it for programming and policy making*. Building the capacity of end users to actually understand and interpret data for decision bolsters this demand side of M&E. Having a clear data use plan that describes data dissemination and target audiences and that is tied to national objectives can provide the framework for making M&E data strategic.

SURVEILLANCE, RESEARCH AND EVALUATION

There are six main objectives of the Sri Lanka HIV and STI surveillance system.

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

To achieve these objectives, six main data sources comprise the HIV and STI surveillance system. These include:

1. HIV testing and case reporting
2. STI testing
3. Population Size Estimates (PSE) for Key Populations
4. Integrated bio-behavioral surveys (IBBS)
5. HIV Sentinel Surveillance (HSS)
6. Behavioral Tracking Surveys (BTS)

These components are designed to generate data from specific geographic locations at different periodicities to enable the analyses necessary to understand and adjust the response to the epidemic in a timely fashion. This triangulation of data from multiple sources of surveillance data follows global recommendations for using HIV and STI surveillance data effectively.²⁶

Table 10 describes the types of data collected, populations addressed, geographic locations, frequency/timing, and methodology of each of the six main data sources included in the Sri Lanka HIV and STI surveillance system.

²⁶ HIV drug resistance surveillance is another activity which is being planned and budgeted. At this time, details about the type of surveillance, sampling, and frequency have not yet been determined.

TABLE 10: SURVEILLANCE DATA SOURCES

Component	Type of data to collect	Which Populations to Include	Geographic locations	Frequency and Timing	Methodology (sampling approach, sample size, consent procedures, etc)
1. HIV Testing and Case Reporting	Information about demographic/ risk characteristics and mode of transmission <ul style="list-style-type: none"> - For people tested - For detected HIV cases 	All people tested for HIV in STD clinics	All Districts	Ongoing	Routine data collection
2. STI testing	<ul style="list-style-type: none"> o Population specific reported STIs (recent syphilis, N. Gonorrhoea) 				
3. Population Size Estimation (PSE) for Key Populations)		<u>Criteria</u> <ul style="list-style-type: none"> - Populations with highest HIV/STI positivity rates as compared with general population - Populations with highest levels of risky behaviour 			
3a. PSE Part I Initial Assessment	<p>Proxy variables that can be used to assign districts to high, medium and low strata (including rough size estimates of KPs from key informants</p> <ul style="list-style-type: none"> - Reported HIV cases by mode of transmission/key population - Reported STIs (recent syphilis, N. Gonorrhoea) by key population - Previous NGO mapping data - Anecdotal information from key informants - Rough size estimates from key informants - Data from behavioural surveys or rapid assessments 		All Districts	Every 3-4 years	<ul style="list-style-type: none"> - Select proxy variables that can be obtained for every district - Collate proxy variables for every district - Use the district level proxy data to define strata - Select districts within each strata to prioritize for direct size estimation data collection (see 3b)
3b. PSE Part II Direct and Extrapolated Size Estimates	Direct Size Estimates	<u>Data Sources</u> <ul style="list-style-type: none"> - Mapping - IBBS/BSS surveys with multiplier method 	District selected in PSE Part I	Every 3-4 years	<u>District Level Mapping</u> <ul style="list-style-type: none"> - Level I - listing of venues - Level II - estimated # of KPs at venues plus data to adjust for mobility,

		<u>Proposed populations</u> <ul style="list-style-type: none"> - FSWs - MSM - PWIDs - Beach Boys 			<p>frequency of visiting sites and hidden population</p> <ul style="list-style-type: none"> - Mapping of virtual sites <p><u>Multiplier method</u></p> <ul style="list-style-type: none"> - In districts with IBBS surveys <ul style="list-style-type: none"> ▪ With service based multipliers ▪ With unique object multipliers
4. Integrated bio-behavioural survey	<ul style="list-style-type: none"> - HIV prevalence among KPs - HIV risk behaviour data - Program coverage data 	KPs for whom interventions are taking place	<u>For each Key Population</u> <ul style="list-style-type: none"> - Districts where programs are being implemented and which have more than 500 estimated key population members 	<u>Every 3-4 yrs</u> <ul style="list-style-type: none"> - 2017 - 2021 	<ul style="list-style-type: none"> - RDS or time location sampling depending on: <ul style="list-style-type: none"> ▪ Estimated proportion of KP that are venue based (for TLS) ▪ Evidence that populations are sufficiently networked (for RDS) - Sample size of at least 400 per sampling domain (i.e. district)
5. HIV Sentinel Surveillance for KPs	<ul style="list-style-type: none"> o HIV status o Syphilis status - Hep B and C status 	<u>Criteria</u> <ul style="list-style-type: none"> o Populations with highest HIV/STI positivity rates as compared with general population²⁷ o Populations with highest levels of risky behaviour <p><u>Proposed groups</u></p> <ul style="list-style-type: none"> o FSWs o Clients of FSWs o MSM o PWIDs 	All provinces	<u>Biannual</u> <ul style="list-style-type: none"> o 2016 o 2018 o 2020 o 2022 	<ul style="list-style-type: none"> o Convenience sample of all KP members recruited as follows: <ul style="list-style-type: none"> - FSWs at STD clinics, brothels, massage parlours, hotels and on the street - Male clients of FSWs from among STD clinic attendees who paid for sex with women in past year - PWID at rehabilitation camps and NGO drop-in centers - MSM with help of NGOs and at STD clinics o Sample size of 250 for all with exception of FSWs and clients of FSWs in Colombo,

²⁷ The categories for mode of transmission will be improved with implementation of updated confirmatory HIV testing form

					<p>where sample size will be 400.</p> <ul style="list-style-type: none"> ○ Linked confidential testing with consent <p>(Details in HSS survey protocol)</p>
6. Behavioural tracking surveys	<ul style="list-style-type: none"> - HIV risk behaviour data - Program coverage data 	<p><u>Proposed groups</u></p> <ul style="list-style-type: none"> ○ FSWs ○ MSM ○ DUs/PWIDs ○ Beach Boys 	All districts where KP programming is in place	<p>Alternate years</p> <ul style="list-style-type: none"> - 2018 - 2020 - 2022 	<ul style="list-style-type: none"> - RDS or TLS - Sample size of 250 per district

RESEARCH AND SPECIAL STUDIES

In addition to the regular surveillance activities conducted, responding effectively to the HIV and STI epidemics requires supplemental operational research and special studies to be conducted. Topics addressed by operational research and special studies will be selected on the basis of need as identified by the Strategic Information Management sub-committee of the NAC in consultation with relevant technical experts. Special studies to be conducted in 2017-2019.

- HIV and risk profile of youth at risk
- HIV transmission among intimate partner
- Intimate partner violence/Gender based violence leading to increased risk of HIV
- Special study on violence against children and vulnerability to HIV.
- STI treatment seeking behavior and patterns
- Epidemiology and profiling of general population for HIV and syphilis (indicator survey)
- Rapid Assessments on Transgender People and Drug Use Patterns

INTEGRATED NASA INTO NATIONAL HEALTH ACCOUNTS

- Post intervention KABP study of plantation workers
- Estimation and profiling of children affected by AIDS
- Size estimates for PWID, profiling, injecting behaviours
- Special study on transgender communities and their vulnerabilities to HIV
- Internally displaced people and their vulnerability to HIV

CAPACITY STRENGTHENING ACTIVITIES

The national strategy requires multiple forms of capacity strengthening for M&E takes many forms. These include formal training for staff with M&E responsibilities and onsite supervisory support. The production of guidelines and user guides for M&E formats are additional tools to improve data quality and the interpretation of strategic information.

Planned activities from 2016-2019 for formal training opportunities to support M&E of community based programmes for key populations and clinic based programmes include the following:

TABLE 11: CAPACITY STRENGTHENING ACTIVITIES IN M&E

Activity	Expected Participants	Source of Funding	Budget (LKR)	Year
Capacity Building of FPA Sri Lanka, SRs and SSRs on M&E AND M&E system strengthening at all level				
Training of peer educators on basic M&E AND utilization of data collection and reporting tools. Fifth day of the five day peer educator training to be allocated for M&E	All the Peer Educators	Global Fund	No separate budget line. Captured in the programmatic budget	2016, 2017 and 2018
Training of field supervisors on basic M&E AND utilization of data collection and reporting tools. Fifth day of the five day ToT training to be allocated for M&E	All the field supervisors	Global Fund	No separate budget line. Captured in the programmatic budget	2016, 2017 and 2018
M&E Capacity Strengthening: General M&E training (35 participants, 1 day)	M&E Officers – SR	Global Fund	86,850	2016
M&E Capacity Strengthening: Global fund specific M&E training (35 participants, 1 day)	Programme staff – PR and SR	Global Fund	86,850	2016
Offer a short course on M&E for SRs and SSRs in collaboration with a reputed technical partner (35 participants)	Project Coordinators - SSR	FHI-360	887,500	2017
Capacity Building of FPA on M&E AND M&E system strengthening and PSE methods				
International M&E training for two participants	M&E Staff - PR	Global Fund	1,117,200	2016
International training for two participants (one from M&E and one from programmatic) on size estimation. Both FPA Sri Lanka and NSACP staff to be participated	M&E Staff – PR Programmatic Staff - PR	Global Fund	No separate budget allocation. 2016 savings to be utilized to cover the cost	2016

Improvement of Routine Data Systems, policies and procedures of three sub recipients				
Development of M&E Policy and Procedure guidelines for 3 sub-recipients	Sub recipient staff (M&E, Programmatic and finance) at all level	Global Fund	1,384,500	2016
Training of the staff at 3 sub-recipient organizations on implementation of M&E policy at organizational level (3 workshops, 20 participants each, 2 days)		Global Fund	320,000	2016
Capacity Building of FPA, SRs and SSRs on M&E data utilization for improved programmatic decision making				
Training on Use of Tools for Risk Profiling and Segmentation (35 participants)	M&E Officers – SR Programme staff – FPA and SR	FHI-360	757,500	2017
Training of FPA, SR and SSRs on M&E data utilization for improved programme decision making in collaboration with a reputed technical partner (35 participants)	Project Coordinators - SSR	To be identified	887,500	2018
Capturing and documentation of lesson learnt				
Capturing and documentation of lesson learnt of the community outreach program of the national HIV prevention programme (2012-2018)	Representatives of NSACP, FPA, SRs, SSRs and other NGOs, multilateral and by lateral actors of the sector	FHI-360	1,158,000	2019
Strengthening capacity for data quality	STD & ART clinic staff	Global Fund	1,850,400	2016
Strengthening capacity for data analysis, interpretation, and use	NSACP & FPA staff	Global Fund	1,364,100	2016
Roll out of Electronic Patient Database				
Initial training	STD & ART clinic staff	Global Fund	132,000	2017
Follow-up training for clinic staff			300,000	
Training on HIV-related research	Selected participants	Global Fund	2,605,800	2017

COSTED WORK PLAN FOR 2016-2018

This costed plan reflects national precedence based on recommendations and NSP priorities. It is subject to modification as priorities are updated to comply with the dynamic nature of the epidemic. The SI sub-committee will monitor progress of this plan and needed reallocation of funds with changing priorities.


The approved budget for M&E related activities to support the National AIDS strategy in 2016 is \$730,098. Projected costs for 2017 is \$1,045,756. Table 9 below shows the main budget allocations by category. The largest costs are required for funding surveillance activities such as rapid assessments, population size estimation, and the IBBS. The electronic patient information system for clinic based services will also require significant resources. Projected M&E costs for 2018 primarily reflect recurring expenses such as personnel, supervisory visits, and review meetings.

TABLE 12: BUDGET FOR M&E, 2016-2018

	2016	2017	2018 (Recurring costs)
PERSONNEL (Government of Sri Lanka)	\$128,955.00	\$132,376.00	\$97,426.00
ICT	\$0.00	\$57,105.00	\$17,640.00
CAPACITY STRENGTHENING	\$97,076.41	\$60276.18	\$24,524.18
M&E PRODUCT DEVELOPMENT	\$434,269.38	\$735,004.75	\$13,879.75
REVIEW MEETINGS	\$29,363.78	\$43,160.78	\$15,630.78
COMMUNICATION & ADVOCACY	\$33,774.00	\$11,174.00	\$0.00
OVERHEAD	\$6,660.00	\$6,660.00	\$0.00
TOTAL	\$730,098.57	\$1,045,756.71	\$169,100.71

ANNEXURE 1- CLIENT REGISTRATION FORM

(First page of the Beach boys registration form)



කම් පුද්ගලයාගේ අංකය
Client Registration No

NB				
----	--	--	--	--

කම් පුද්ගලයාගේ පිටපත් පත්‍රිකාව Client Registration Form

1. දිස්ත්‍රික්කය (District) :
2. ඔබගේ පදිංචිය (Residence)

i. ග්‍රාමීය (Rural)	ii අර්ධ නගරීය (Sub Urban)	iii. නගරීය (Urban)	iv. වේරලාසයක (Beach area)	<input style="width: 100%;" type="text"/>
---------------------	---------------------------	--------------------	---------------------------	---
3. සම්පූර්ණ නම (Name in Full):
4. වෙනත් නම් (Other Names):
5. සඳහාම ලිපිනය (Permanent Address):
6. වර්තමාන ලිපිනය (Current address):
7. වයස (අවුරුදු) (Age) :
8. හැඳුනුම්පත් අංකය (NIC no) :
9. දුරකථන අංකය (Telephone Number):
10. විවාහ / අවිවාහක (Marital Status) (පළමු කොටුවේ පමණක් කුඩු කිරීමට සූදානම්/ Put "x" on the relevant box)

i. පුංචි විවාහකයි (Married)	<input type="checkbox"/>	
ii. කිසිදිනක විවාහ වී නොවූවක (Never married)	<input type="checkbox"/>	
iii. වියකලු (Widow)	<input type="checkbox"/>	
iv. එකට ජීවත්වෙමින් සිටින විවාහක (Living together)	<input type="checkbox"/>	
v. වෙන්වී ගිය (Divorced)	<input type="checkbox"/>	
vi. විදේශික පුරුෂයෙකු සමඟ ජීවත් වේ. (Living with a foreign man)	<input type="checkbox"/>	
vii. විදේශික කාන්තාවක සමඟ ජීවත් වේ. (Living with a foreign woman)	<input type="checkbox"/>	
viii. වෙනම ආසන/අභ්‍යන්තර වූවක (separate)	<input type="checkbox"/>	
11. විධිමත් අධ්‍යාපනය ලබා ඇති වසර ගණන (අවු.) (Years of formal education)
12. රැකියාව/වෙනත් ආදායම් මාර්ග (Occupation):
13. ඔබ විදේශිකයන් සමඟ ලිංගික සබඳතා පවත්වන්නේ, (The purpose of your sexual relationships with foreigners)

1. ආදායම් සඳහා (As an income source) <input type="checkbox"/>		2. විදේශීය සංචාර සඳහා (For Foreign tours) <input type="checkbox"/>
3. පෞද්ගලික (personal) <input type="checkbox"/>		4. වෙනත් වාසි (Other benefits) <input type="checkbox"/>
5. එය ව්‍යවස්ථාපිත නිසා (As it is the job) <input type="checkbox"/>		6. වෙනත් (other) <input type="checkbox"/>
14. ඔබ නිවස/විකිටුවේ නම (Name of hotspot):
15. ආපසුගිය කාලය සිට විදේශිකයන් සමඟ ලිංගික සබඳතා පවත්වන්නේද? (Since when do you keep sexual relationships with foreigners?)
16. ඔබ ලිංගික සබඳතා පවත්වන්නේද. (Have sexual relationships)

1. විදේශිකයන් සමඟ පමණි <input type="checkbox"/>	2. ස්වදේශිකයන් සමඟ පමණි <input type="checkbox"/>	3. දෙපාර්ශවයේ සමඟ <input type="checkbox"/>
(Only with foreigners)	(Only with local people)	(Both)
17. පුද්ගලික මිනිස් කාලය තුළ ලිංගික සබඳතා පවත්වන්නන්ගේ ප්‍රමාණය (Number of males who had sexual encounters with you during the last month)

1. විදේශීය (Foreign) <input style="width: 50%;" type="text"/>	2. දේශීය (Local) <input style="width: 50%;" type="text"/>
---	---
18. පුද්ගලික මිනිස් කාලය තුළ ලිංගික සබඳතා පවත්වන්නන්ගේ ප්‍රමාණය (විවාහ නොවූ) (Number of females (except your spouse) who had sexual encounters with you during the last month)

<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
---	---

ANNEXURE 3: CLINIC REFERRAL SLIP FORMAT

<p style="text-align: center;">1 <small>(To be completed by the Peer educator)</small></p> <p style="text-align: center;">Referral Card/පොදු පත</p> <p>District:- <small>(දිස්ත්‍රික්කය)</small></p> <p>Clinic : - <small>(කොටස)</small></p> <p>Client No : <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <small>(සාමාන්‍ය අංකය)</small></p> <p>Referred by :..... <small>(පොදුකරු අයත් නම)</small></p> <p>PE ID No : <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <small>(අත්සන)</small></p> <p>Signature:Date: <small>(අත්සන) (දිනය)</small></p> <p>Checked by the Field supervisor :- <small>(සෞඛ්‍ය නිලධාරියා විසින් පරීක්ෂාකරන ලදී)</small></p> <p>Signature:Date: <small>(අත්සන) (දිනය)</small></p> <p style="text-align: center;"><small>GFATM- Sri Lanka HIV Program NFM</small></p>	<p style="text-align: center;">2 <small>(To be completed by the Peer educator)</small></p> <p style="text-align: center;">Clinic Copy/සායන සටහන</p> <p>Clinic/කොටස:</p> <p>Client No/සාමාන්‍ය අංකය : <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <div style="border: 2px solid black; padding: 5px;"> <p style="text-align: center;">3 <small>(To be completed by the Doctor at STI Clinic)</small></p> <p>Population Type</p> <p>FSW <input type="checkbox"/> MSM <input type="checkbox"/> BB <input type="checkbox"/> DU <input type="checkbox"/> Other <input type="checkbox"/></p> <p>Clinic No: <input type="text"/></p> <p>Services</p> <p>STI Screening: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>HIV Counselling: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>HIV Testing: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>HIV Test Type: Routine <input type="radio"/> Rapid <input type="radio"/></p> <div style="border: 2px solid black; padding: 5px; text-align: center;"> <p>Result of the HIV test: Given to the Client/Patient YES <input type="checkbox"/> NO <input type="checkbox"/></p> </div> <p style="text-align: center;">.....</p> <p style="text-align: center;">Signature</p> <p>Date: - Stamp</p> <p style="text-align: center;"><small>GFATM - Sri Lanka HIV Program NFM</small></p> </div>	<p style="text-align: center;">4</p> <p style="text-align: center;">Client Receipt</p> <p style="text-align: center;">.....</p> <p style="text-align: center;">සායන දානය</p> <p style="text-align: center;">දිනය</p>
---	---	--

ANNEXURE 4 : COMMUNITY BASED TESTING REPORTING FORM

S- Number

Community Based HIV Rapid Test Report

Date:- Time From:- Time To:- Place:-

Service provider (Name):- Type: MLT ORW: Other:

	Client Registration No	Pre-test counseling (Y/N)	HIV rapid test (Y/N)	Post test counseling for positive client – (Y/N)	Post test counseling for negative client – (Y/N)	Referred to STD Clinic (N or Clinic Name)	STD Clinic Escort Number	**Client Consent (Signature)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

****Client Consent:** I have been informed about HIV testing and its benefits and limitations. I confirm that I have tested/not tested for HIV and know/ don not know the status. Further, I understood that this rapid test requires a second specimen to be taken from me for further testing and confirmation. I consent to be tested. (sign above)

Authentication: I, here by certify that the above services were provided to the client after receiving informed consent.

..... Date: ___/___/___ Date: ___/___/___
 Service provider signature

ANNEXURE 5. STD PATIENT FORM (FIRST TWO PAGES OF MALE FORM)

<p style="text-align: center;">- 1 -</p> <p style="text-align: center;">Confidential STD PATIENT FORM - REGISTRATION</p> <p>National STD/AIDS Control Programme, Central STD Clinic, Colombo 10</p> <p>Patient Registration Number: <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> Date of registration: <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/></p> <p>Drug Sensitivity / Allergy <input style="width: 100%; height: 20px;" type="text"/></p> <p>First name/Initials: Last name:</p> <p>Current address: Phone:</p> <p>..... Phone:</p> <p>..... Phone:</p> <p>Permanent address: Phone:</p> <p>..... Phone:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Sex</td> <td style="width: 30%;">1. Male</td> <td style="width: 30%;">2. Female</td> <td style="width: 20%;"></td> </tr> <tr> <td>Date of birth (dd/mm/yy)</td> <td colspan="3"><input style="width: 100%; height: 20px;" type="text"/></td> </tr> <tr> <td>Marital status</td> <td>1. Single/Never married</td> <td>2. Married/ Living together</td> <td>3. W/S/D</td> </tr> <tr> <td>Nationality</td> <td>1. Sri Lankan</td> <td>2. Others</td> <td></td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Preferred mode of contact</td> <td style="width: 20%;">1. Do not contact</td> <td style="width: 20%;">2. Letter</td> <td style="width: 20%;">3. Email</td> <td style="width: 20%;">4. T. phone</td> <td style="width: 20%;">5. Visit</td> <td></td> </tr> </table> <p><i>(If contact details are changed during subsequent visits, update new details below)</i></p> <p>Contact address: Phone:</p> <p>Contact address: Phone:</p> <p>E-mail address: Phone:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Date</th> <th>Comment</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Sex	1. Male	2. Female		Date of birth (dd/mm/yy)	<input style="width: 100%; height: 20px;" type="text"/>			Marital status	1. Single/Never married	2. Married/ Living together	3. W/S/D	Nationality	1. Sri Lankan	2. Others		Preferred mode of contact	1. Do not contact	2. Letter	3. Email	4. T. phone	5. Visit		Date	Comment																																											<p style="text-align: center;">- 2 -</p> <p style="text-align: center;">MALE PATIENT FORM - EPISODE OF CARE</p> <p>Patient file number: <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> Episode Number: <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; border: 1px solid black;" type="text"/></p> <p>Seen By (Name/Designation):</p> <p>Time In: Time Dr:</p> <p>Age of the Patient:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">1. Date of visit (dd/mm/yy)</th> <th style="width: 20%;">2. Highest level of education</th> <th style="width: 20%;">3. Occupation (12 months)</th> <th style="width: 20%;">4. Reason for attendance</th> <th style="width: 20%;">5. Symptoms</th> <th style="width: 20%;">6. Duration of symptoms (days)</th> <th style="width: 20%;">7. Medication (14 days)</th> <th style="width: 20%;">8. Sex contacts (12 months)</th> <th style="width: 20%;">9. Type of partner (12 months)</th> <th style="width: 20%;">10. Sex of Partner's (12 months)</th> <th style="width: 20%;">11. Number of partners (12 months)</th> <th style="width: 20%;">12. Condoms use at last sex</th> <th style="width: 20%;">13. Condoms use in last 3 months</th> <th style="width: 20%;">14. Substance abuse (12 months)</th> <th style="width: 20%;">15. Previous STD</th> <th style="width: 20%;">16. Blood risk (12 months)</th> <th style="width: 20%;">17. Ever had an HIV test</th> <th style="width: 20%;">18. Age at first sex (in years)</th> </tr> <tr> <td></td> <td>1. 1-5 grade 4. G.C.E A/L</td> <td>2. 6-10 grade 5. Dip Degree</td> <td>3. G.C.E O/L 6. No schooling/NA</td> <td>1. UE 4. Retired</td> <td>2. Student 5. Employed as</td> <td>3. CSW 3</td> <td>1. Voluntary 4. Ref. GP 7. Contact 10. Other</td> <td>2. Ref. OPD 5. Ref. Courts 8. Clinic follow up</td> <td>3. Ref. Ward 6. Ref. Blood bank 9. Medico-legal</td> <td>1. None 4. Warts 7. Scrotal swelling</td> <td>2. Genital disch. 5. Genital ulcer 9. Others</td> <td>3. Dysuria 6. Rash 5</td> <td>1. NA 4. 9-14</td> <td>2. 1-3 5. Over 14</td> <td>3. 4-7 6. Unknown</td> <td>7</td> <td>1. None/NA 4. (2&3)</td> <td>2. Marital/Regular Partner 3. Non-regular P 4. Commercial Partner/Client</td> <td>1. Male only 3. Female only</td> <td>2. Male & Female 4. None/NA</td> <td>15</td> <td>1. One 4. Four</td> <td>2. Two 5. Five or more</td> <td>3. Three 6. None/NA</td> <td>16</td> <td>1. NA 4. Always</td> <td>2. No 5. Sometimes</td> <td>3. Yes 6. Sometimes 18</td> <td>1. None/NA 3. Alcohol</td> <td>2. Narcotics (inhalation/oral) 4. IDU</td> <td>19</td> <td>1. None 4. Herpes 7. Others/Not Sure</td> <td>2. GC 5. Chlamydia/NGU</td> <td>3. Syphilis 6. Warts 20</td> <td>1. None 3. Needle prick</td> <td>2. Blood-blood product 4. Other</td> <td>21</td> <td>1. Never 4. Indeterminate 6. Don't know</td> <td>2. Negative 5. Tested but result not sure</td> <td>3. Positive 22</td> <td>23</td> </tr> </table> <p><i>Regular partner - refers to marital partner or cohabiting (live-in) partner. Non-regular partner - refers to casual or non-cohabiting partner (girl) or boy friend. Commercial partner/Client - refers to sex worker or client of sex worker</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="5" style="text-align: center;">SUMMARY OF SEXUAL HISTORY</th> </tr> <tr> <th colspan="2">When / Whom</th> <th>Type of sex</th> <th>Condom Y / N</th> <th>SL / Overseas</th> </tr> </thead> <tbody> <tr> <td>LST</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>PSI</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>PSI</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <p>Total number of partners last 3 months <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/></p> <p>Total number of partners last 1 year <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/></p> <p>Total number of partners life time <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/></p> </div> <div style="text-align: right;"> <table style="margin-left: auto; margin-right: 0;"> <tr> <td style="text-align: right;">Male</td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: right;">Female</td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> </tr> </table> </div> </div>	1. Date of visit (dd/mm/yy)	2. Highest level of education	3. Occupation (12 months)	4. Reason for attendance	5. Symptoms	6. Duration of symptoms (days)	7. Medication (14 days)	8. Sex contacts (12 months)	9. Type of partner (12 months)	10. Sex of Partner's (12 months)	11. Number of partners (12 months)	12. Condoms use at last sex	13. Condoms use in last 3 months	14. Substance abuse (12 months)	15. Previous STD	16. Blood risk (12 months)	17. Ever had an HIV test	18. Age at first sex (in years)		1. 1-5 grade 4. G.C.E A/L	2. 6-10 grade 5. Dip Degree	3. G.C.E O/L 6. No schooling/NA	1. UE 4. Retired	2. Student 5. Employed as	3. CSW 3	1. Voluntary 4. Ref. GP 7. Contact 10. Other	2. Ref. OPD 5. Ref. Courts 8. Clinic follow up	3. Ref. Ward 6. Ref. Blood bank 9. Medico-legal	1. None 4. Warts 7. Scrotal swelling	2. Genital disch. 5. Genital ulcer 9. Others	3. Dysuria 6. Rash 5	1. NA 4. 9-14	2. 1-3 5. Over 14	3. 4-7 6. Unknown	7	1. None/NA 4. (2&3)	2. Marital/Regular Partner 3. Non-regular P 4. Commercial Partner/Client	1. Male only 3. Female only	2. Male & Female 4. None/NA	15	1. One 4. Four	2. Two 5. Five or more	3. Three 6. None/NA	16	1. NA 4. Always	2. No 5. Sometimes	3. Yes 6. Sometimes 18	1. None/NA 3. Alcohol	2. Narcotics (inhalation/oral) 4. IDU	19	1. None 4. Herpes 7. Others/Not Sure	2. GC 5. Chlamydia/NGU	3. Syphilis 6. Warts 20	1. None 3. Needle prick	2. Blood-blood product 4. Other	21	1. Never 4. Indeterminate 6. Don't know	2. Negative 5. Tested but result not sure	3. Positive 22	23	SUMMARY OF SEXUAL HISTORY					When / Whom		Type of sex	Condom Y / N	SL / Overseas	LST					PSI					PSI					Male		Female	
Sex	1. Male	2. Female																																																																																																																																																											
Date of birth (dd/mm/yy)	<input style="width: 100%; height: 20px;" type="text"/>																																																																																																																																																												
Marital status	1. Single/Never married	2. Married/ Living together	3. W/S/D																																																																																																																																																										
Nationality	1. Sri Lankan	2. Others																																																																																																																																																											
Preferred mode of contact	1. Do not contact	2. Letter	3. Email	4. T. phone	5. Visit																																																																																																																																																								
Date	Comment																																																																																																																																																												
1. Date of visit (dd/mm/yy)	2. Highest level of education	3. Occupation (12 months)	4. Reason for attendance	5. Symptoms	6. Duration of symptoms (days)	7. Medication (14 days)	8. Sex contacts (12 months)	9. Type of partner (12 months)	10. Sex of Partner's (12 months)	11. Number of partners (12 months)	12. Condoms use at last sex	13. Condoms use in last 3 months	14. Substance abuse (12 months)	15. Previous STD	16. Blood risk (12 months)	17. Ever had an HIV test	18. Age at first sex (in years)																																																																																																																																												
	1. 1-5 grade 4. G.C.E A/L	2. 6-10 grade 5. Dip Degree	3. G.C.E O/L 6. No schooling/NA	1. UE 4. Retired	2. Student 5. Employed as	3. CSW 3	1. Voluntary 4. Ref. GP 7. Contact 10. Other	2. Ref. OPD 5. Ref. Courts 8. Clinic follow up	3. Ref. Ward 6. Ref. Blood bank 9. Medico-legal	1. None 4. Warts 7. Scrotal swelling	2. Genital disch. 5. Genital ulcer 9. Others	3. Dysuria 6. Rash 5	1. NA 4. 9-14	2. 1-3 5. Over 14	3. 4-7 6. Unknown	7	1. None/NA 4. (2&3)	2. Marital/Regular Partner 3. Non-regular P 4. Commercial Partner/Client	1. Male only 3. Female only	2. Male & Female 4. None/NA	15	1. One 4. Four	2. Two 5. Five or more	3. Three 6. None/NA	16	1. NA 4. Always	2. No 5. Sometimes	3. Yes 6. Sometimes 18	1. None/NA 3. Alcohol	2. Narcotics (inhalation/oral) 4. IDU	19	1. None 4. Herpes 7. Others/Not Sure	2. GC 5. Chlamydia/NGU	3. Syphilis 6. Warts 20	1. None 3. Needle prick	2. Blood-blood product 4. Other	21	1. Never 4. Indeterminate 6. Don't know	2. Negative 5. Tested but result not sure	3. Positive 22	23																																																																																																																				
SUMMARY OF SEXUAL HISTORY																																																																																																																																																													
When / Whom		Type of sex	Condom Y / N	SL / Overseas																																																																																																																																																									
LST																																																																																																																																																													
PSI																																																																																																																																																													
PSI																																																																																																																																																													
Male		Female																																																																																																																																																											

ANNEXURE 7. OUTPATIENT BLOOD TESTING REGISTER

OPD Blood Testing Register																							
S. No	Date DD/MM/YYYY	OPD/HI, OPD/FF Number	Reason for attendance 1. Contact of patient (write the slip number) 2. Voluntary 3. Referral for Medicolegal examiner 4. Other	Name, Address, Telephone Number and Email	Sex (M/F)	Age (Years)	Name of the Blood test (Indicate testing status and results in each column)				Age < 18 years	Age 18-24 years	Age 25-49 years	Age 50 or over	HCO recorded	Sex marker	HBH	DU	LDH	Bilirubin	PT/APTT	HIV 1/2/3	Rapid HIV results
							VDRL	TPHA	HIV	HCV													
1																							
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							
11																							
12																							
13																							
14																							
15																							

© Prepared and Distributed by Strategic Information Management (SIM) Unit, National STD/AIDS Control Programme, 23, B- Seven floor, Colombo 03. Tel: 91 2622553, 91 2627468

Please insert a mark for relevant reference for the patient. This will be helpful for the recalling purpose.

ANNEXURE 8. ANC SPECIMEN LABORATORY FORM

**NATIONAL STD/ CONTROL PROGRAMME
MINISTRY OF HEALTH.**

NSACP/ANC/14/V/2

REQUEST FORM FOR SYPHILIS/HIV TESTING IN ANTENATAL MOTHERS.

Institution/clinic

MOH area

Date of sample collection

Patient No (ANC)	Age	Parity.	POA	HIV Results	VDRL Results

..... Name of collecting officer. Designation Signature.
..... Name of Medical officer Designation Signature
Lab use only .		

Date/Time of receipt of samples:.....am/pm
MLT:.....	Medical officer STD/Lab:.....
Date	Date

ANNEXURE 9. DETAILS OF PREGNANT WOMEN WITH SYPHILIS

Details of pregnant women with syphilis			
STD clinic:	<input style="width: 100%;" type="text"/>		
Master No:	<input style="width: 100%;" type="text"/>	Date:	<input style="width: 100%;" type="text"/>
Age:	<input style="width: 50%;" type="text"/>	EDD:	<input style="width: 100%;" type="text"/>
LMP:	<input style="width: 100%;" type="text"/>	TPPA:	<input style="width: 100%;" type="text"/>
VDRL:	<input style="width: 50%;" type="text"/>		
Staging: Early Syphilis / Late Syphilis			
Diagnosed: during pregnancy / already diagnosed			
If already diagnosed whether adequately treated before pregnancy: YES / NO			
<u>If diagnosed during pregnancy</u>			
POA at the time of diagnosis (week):	<input style="width: 100%;" type="text"/>		
Treatment given:	<input style="width: 100%;" type="text"/>		
Adequately treated before 36/52 of POA: Yes / No			
<u>Partner:</u> Managed Satisfactory: Yes / No			
<u>Baby</u>			
VDRL	<input style="width: 50%;" type="text"/>	TPPA	<input style="width: 50%;" type="text"/>
		EIA IGM	<input style="width: 50%;" type="text"/>
Management – Benzathine penicillin prophylaxis / congenital syphilis treatment			
If congenital syphilis, case definition:			
1. Case definition 01			
2. Case definition 02			
3. Case definition 03			
Baby's last VDRL	<input style="width: 50%;" type="text"/>	Age	<input style="width: 50%;" type="text"/>
Baby's last TPPA	<input style="width: 50%;" type="text"/>	Age	<input style="width: 50%;" type="text"/>
		 Consultant Venereologist /MO STD

ANNEXURE 10. CONGENITAL SYPHILIS CASE REPORT FORM

Details of babies diagnosed with Congenital Syphilis	
STD clinic:	<input type="text"/>
Master No.	<input type="text"/>
Date:	<input type="text"/>
Age:	<input type="text"/>
VDRL:	<input type="text"/>
TPPA:	<input type="text"/>
EIA IgM:	<input type="text"/>
Case definition of Congenital Syphilis	
1. Case definition 01	
2. Case definition 02	
3. Case definition 03	
Given treatment	<input type="text"/>
.....	
Consultant Venereologist/MO STD	

ANNEXURE 11. DETAILS OF PAEDIATRIC PATIENTS WITH HIV INFECTION

Details of Paediatric patients with HIV infection

STD Clinic:

Master Number:

Date of Registration

Age at the time of diagnosis

Sex: Male / Female

Baby confirmed diagnosis on (Date):

Reason for diagnosis: Mother knows HIV Positive/Symptoms/Others

Date of Last CD 4 count/ CD4%:

CD%/ CD4 count:

WHO clinical stage at the diagnosis:

Is child on ART: Yes/No

Date ART started:

Reason to start ART:

ART regimen:

Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory

Current WHO clinical Stage now:

Remarks:

.....

Consultant Venereologist/MO STD

ANNEXURE 12. DETAILS OF PREGNANT WOMEN WITH CONFIRMED HIV INFECTION FORMAT

Details of pregnant women with confirmed HIV infection			
STD Clinic:	<input style="width: 100%;" type="text"/>		
Date of registered:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Master No:	<input style="width: 100%;" type="text"/>
Age:	<input style="width: 40px;" type="text"/>	LMP :	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> DD: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
CD 4 count in early pregnancy (Date):	<input style="width: 100%;" type="text"/>		
Diagnosed: During pregnancy / Already diagnosed			
If already diagnosed: on ART / not on ART			
If already diagnosed POA at the time informed pregnancy:		<input style="width: 100%;" type="text"/>	
Pregnancy: Planned / Unplanned			
<u>If diagnosed in Pregnancy</u>			
POA-at the time confirmed test positive		<input style="width: 40px;" type="text"/>	ART for: her own health / for PMTCT
ART regimen:		<input style="width: 100%;" type="text"/>	
ART started at POA:	<input style="width: 40px;" type="text"/>	Date:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory			
Close to term viral load (Date):		<input style="width: 100%;" type="text"/>	
		CD 4 Count (Date): <input style="width: 100%;" type="text"/>	
Delivery Date:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>		
Elective LSCS/Emergency LSCS/ NVD			
Any Invasive procedure during delivery: None/Forceps/ Vacuum			
Family planning method after delivery:		<input style="width: 100%;" type="text"/>	
Baby			
Feeding method: Formula feeding/Breast feeding under ART covers			
ART syrup for 6 weeks: Completed / Defaulted			
Age of First DNA PCR:	<input style="width: 40px;" type="text"/>	Positive/Negative	
Age of second DNA PCR:	<input style="width: 40px;" type="text"/>	Positive/Negative	
HIV antibody test at 18 months: Positive/Negative			
Partner: Screened – Yes / No		If yes: Positive / Negative.	
.....			
Consultant Venereologist/MO STD			

ANNEXURE 13. ART PATIENT INFORMATION CARD

HIV CARE & ANTIRETROVIRAL TREATMENT (ART) PATIENT RECORD H 1235

(To be stored in a locked cabinet at the health centre and arranged serially BY REGISTRATION NUMBER) (Revised 2017)

1. Patient Identification Data (Write complete information)											
Patient Registration Number : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Clinic code, M/F, XXXX)											
Name of the Clinic: _____ District: _____ Date of registration : _____ Age at registration : _____											
Name and address of Patient/Client Contact No: _____ Name : _____ Address : _____											
Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other (-----) Date of Birth : ___/___/____ dd mm yyyy											
Marital status <input type="checkbox"/> a. Single/Never Married <input type="checkbox"/> b. Currently Married & Living with spouse <input type="checkbox"/> c. Living together <input type="checkbox"/> d. W/S/D											
Occupation <input type="checkbox"/> a. Unemployed <input type="checkbox"/> b. Student <input type="checkbox"/> c. Employed as: _____ <input type="checkbox"/> d. NA											
District of Residence: _____ Nationality <input type="checkbox"/> a. Sri Lankan <input type="checkbox"/> b. Other _____											
Ethnicity <input type="checkbox"/> a. Sinhalese <input type="checkbox"/> b. Tamil <input type="checkbox"/> c. Moor <input type="checkbox"/> d. Other (specify) _____											
Date of confirmed HIV + test : ___/___/____ Place : _____ dd mm yyyy											
Reason for HIV testing (Entry point) <input type="checkbox"/> 1. Voluntary Testing <input type="checkbox"/> 6. Contact screening <input type="checkbox"/> 12. Screening before medical / surgical procedures <input type="checkbox"/> 2. STD clinic attendees <input type="checkbox"/> 7. Blood donor <input type="checkbox"/> 13. Screening as part of a survey <input type="checkbox"/> 3. Provider initiated testing (Asymptomatic) <input type="checkbox"/> 8. EMTCT <input type="checkbox"/> 14. TB <input type="checkbox"/> 4. Clinical symptoms suggestive of HIV <input type="checkbox"/> 9. Visa screening – local <input type="checkbox"/> 10. Foreign job screening <input type="checkbox"/> 11. Screening for legal and insurance purposes <input type="checkbox"/> 15. Prison <input type="checkbox"/> 5. Referred by NGO <input type="checkbox"/> 16. Others _____											
Sexual Exposure <input type="checkbox"/> a. Sexual Contact with Regular Partner of Opposite Sex <input type="checkbox"/> b. Sexual Contact with Non-Regular Partner of Opposite Sex <input type="checkbox"/> c. Sexual Contact with Both Sexes <input type="checkbox"/> d. Sexual Contact with Person of Same Sex <input type="checkbox"/> e. No sexual exposures											
Ever sold sex to clients? <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No Ever bought sex from sex workers? <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No											
Ever gone abroad? <input type="checkbox"/> a. Yes, countries: _____ <input type="checkbox"/> b. No											
Ever had sex with a foreigner? <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Not Applicable (e.g. Foreign Nationality)											
2. Information about the partners and family											
History of Blood Exposure <input type="checkbox"/> a. No <input type="checkbox"/> b. Injecting Drug Use <input type="checkbox"/> c. Receipt of Blood/Tissue/Organ/Sperm <input type="checkbox"/> d. Needle stick injury/mucosal splash Specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>											
Acquired from mother to child transmission <input type="checkbox"/> a. No <input type="checkbox"/> b. Yes <input type="checkbox"/> c. Not Known											
Possible ongoing risk factors for transmitting the infection to the others <input type="checkbox"/> a. None <input type="checkbox"/> b. MSM <input type="checkbox"/> c. Sex Worker (now or former) <input type="checkbox"/> d. Multiple Sex Partners <input type="checkbox"/> e. Injecting drug user <input type="checkbox"/> f. Not Known											
HIV status of spouse/regular partner <input type="checkbox"/> a. Positive <input type="checkbox"/> b. Negative <input type="checkbox"/> c. Not Known <input type="checkbox"/> d. Not Applicable											
Has spouse ever gone abroad? <input type="checkbox"/> a. Yes, countries: _____ <input type="checkbox"/> b. No <input type="checkbox"/> c. Not Known <input type="checkbox"/> d. Not Applicable											
Risk factors for HIV in spouse/live-in partner <input type="checkbox"/> a. None <input type="checkbox"/> b. MSM <input type="checkbox"/> c. Sex Worker (now or former) <input type="checkbox"/> d. Multiple Sex Partners <input type="checkbox"/> e. Injecting Drug User (now or former) <input type="checkbox"/> f. Not Known <input type="checkbox"/> g. Not Applicable											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Family member : Relationship</th> <th style="width: 10%;">Age</th> <th style="width: 15%;">HIV status</th> <th style="width: 15%;">ART Y/N</th> <th style="width: 30%;">Registered No: if on care</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Family member : Relationship	Age	HIV status	ART Y/N	Registered No: if on care						
Family member : Relationship	Age	HIV status	ART Y/N	Registered No: if on care							
3. Antiretroviral treatment history											
Was ART received before <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No Reason for starting ARV <input type="checkbox"/> a. PMTCT <input type="checkbox"/> b. Earlier ART <input type="checkbox"/> c. PEP <input type="checkbox"/> d. PrEP											
Drugs and duration _____											

ANNEXURE 15: ART CROSS-SECTIONAL DATABASE

S. No.	Date of registration mm/dd/yyyy	Clinic No	Any other clinic no.	SEX	Date of Birth mm/dd/yyyy	Age at registration (years)	Pre ART/ART	Year of ART initiation	Clinic of ART initiation/ Registration (Pre ART)	Date of ART initiation mm/dd/yyyy	Age at ART initiation	Viral load at start of ART (+/- 3 months)	Viral Load after 12 months after ART initiation (+/- 3 months)	Last Viral load in 2016	CD 4 at start of ART (+/- 3 months)	Outcome as of end of 4th Quarter 2016 (OT 1st ,OT 2nd,S, D, LFU)	Transfer in/ Transfer out/ same clinic	The clinic of currently followed up (by 4th Quarter 2016)	Current ART regime by (4th Quarter 2016)	
	8-Nov-16	MM/F/0046	F/0342/16KT	F	4-Apr-81	34	Pre ART		Galle					not done		Pre ART	Transfer In	Kalutara		
	10-Oct-16	KG/F/0004	F/234/16	F	22-Nov-86	29	Pre ART		Kegalle					1,153		Pre ART	same clinic	Kegalle		Planning to
	28-May-07	CO/F/0353	None	M	12-Nov-70	36	Pre ART		Colombo					822		Pre ART	same clinic	Colombo		
	9-Dec-16	CO/M/1216	None	M	1-Nov-82	34	Pre ART		Colombo					385		Pre ART	same clinic	Colombo		
	24-Oct-16	NG/M/0009	None	M	28-May-71	45	Pre ART		Negambo					362		Pre ART	same clinic	Negambo		
	2-Feb-12	CO/M/0784	KU/M/047	M	29-Apr-64	48	ART	2012	Colombo	17-Aug-12	48.0	Not done	9452	35,124	180	OT1	Transfer In	Kurunegala	AZT+3TC+EFV	Transfer fr
	16-Dec-16	CO/M/1219	None	M	22-Sep-80	36	ART	2016	Colombo	31-Dec-16	36.0	38734	NA	38,734	400	OT1	same clinic	Colombo	TDF+FTC+EFV	
	8-Dec-17	CO/M/1215	None	M	11-Nov-62	54	ART	2016	Colombo	24-Dec-16	53.0	101214	NA	101,214	537	OT1	same clinic	Colombo	TDF+FTC+EFV	MP-
	15-May-15	MM/M/0022	None	M	22-May-52	63	Pre ART		Galle					38		LFU	same clinic	Galle		
	12-Oct-16	CO/M/1208	None	M	12-Dec-74	42	ART	2016	Colombo	25-Oct-16	42.0	20087	NA	20,087	171	OT1	Same Clinic	Colombo	TDF+FTC+EFV	
	10-Oct-16	CO/M/1207	None	M	26-Jan-91	25	ART	2016	Colombo	10-Nov-16	25.0	5463	NA	5,463	304	OT1	Same Clinic	Colombo	TDF+FTC+EFV	INAH
	5-Oct-16	CO/M/1205	None	M	12-May-81	34	ART	2016	Colombo	12-Nov-16	35.0	3297	NA	3,297	581	OT1	same clinic	Colombo	TDF+FTC+EFV	
	4-Oct-16	CO/M/1204	None	M	6-Nov-85	31	ART	2016	Colombo	1-Nov-16	30.0	3244	NA	3,244	701	OT1	Same Clinic	Colombo	TDF+FTC+EFV	
	23-Sep-16	CO/M/1203	None	M	30-Jul-91	25	ART	2016	Colombo	7-Nov-16	25.0	52148	NA	52,148	714	OT1(SUB)	Same Clinic	Colombo	TDF+FTC+EFV	INAH
	6-Sep-16	CO/M/1201	None	M	1-Jan-78	38	ART	2016	Colombo	6-Dec-16	38.0	25100	NA	25,100	466	OT1	same clinic	Colombo	TDF+FTC+EFV	INAH
	5-Sep-16	CO/M/1200	None	M	10-Mar-80	36	ART	2016	Colombo	28-Oct-16	36.0	33545	NA	33,545	531	OT1	Same Clinic	Colombo	TDF+FTC+EFV	
	31-Aug-16	CO/M/1199	None	M	15-Mar-82	32	ART	2016	Colombo	26-Sep-16	34.0	493414	NA	493,414	22	OT1	same clinic	Colombo	TDF+FTC+ATV/r	
	16-Aug-16	CO/M/1196	None	M	9-Mar-71	45	ART	2016	Colombo	25-Aug-16	45.0	Not done	NA	NA	57	D	Same Clinic	NA	TDF+FTC+EFV	DEATH 3/9
	13-Aug-16	CO/M/1195	None	M	3-Oct-78	38	ART	2016	Colombo	28-Aug-16	38.0	14198	NA	14,198	559	OT1	Same Clinic	Colombo	TDF+FTC+EFV	
	28-Dec-15	KU/F/0077	F/1554/15	F	16-May-86	29	ART	2016	Kurunegala	5-Mar-16	29.0	32255	Not done	<34	327	OT1	same clinic	Kurunegala	TDF+FTC+EFV	
	31-Aug-16	CO/M/1192	None	M	17-Oct-80	36	ART	2016	Colombo	31-Oct-16	36.0	12235	NA	12,235	636	OT1	Same Clinic	Colombo	TDF+FTC+EFV	INAH

ANNEXURE 16. ART COHORT DATABASE

ART DATABASE 2015/2016 Cohort - All Clinics																
S.No	Year of ART initiation	Clinic of ART initiation	Date of ART Started on	Clinic No	Any other clinic No. (if relevant)	Age at ART initiation	SEX	AGE AT 2015 4th Quarter	Age Range	Date when 60 month completes	60 month Cohort Outcome (OT1, OT2, S, D, LF)	Date when 24 month completes	24 month cohort outcom	Date when 12 month completes	12 month cohort outcor	followed up clinic at the outcome
1																
2																
3	1	2010	Colombo	12-Jan-2010	CO/M/553	None	27	M	32	15+	12-Jan-2015	D				Colombo
4	2	2010	Colombo	12-Jan-2010	CO/M/318	None	26	M	31	15+	12-Jan-2015	LFU				Colombo
5	3	2010	Ragama	15-Jan-2010	CO/M/560	RG/M/0032	40	M	45	15+	15-Jan-2015	D				Ragama
6	4	2010	Colombo	1-Feb-2010	CO/F/461	AN/HF/07	38	F	43	15+	1-Feb-2015	OT1				Anuradapura
7	5	2010	Colombo	15-Feb-2010	CO/M/563	None	36	M	41	15+	15-Feb-2015	OT1				Colombo
8	6	2010	Colombo	15-Feb-2010	CO/M/216	None	33	M	38	15+	15-Feb-2015	OT1				Colombo
9	7	2010	Colombo	17-Feb-2010	CO/M/565	None	3	M	8	<15	17-Feb-2015	OT1				Colombo
10	8	2010	Colombo	19-Feb-2010	CO/M/246	None	40	M	45	15+	19-Feb-2015	D				Colombo
11	9	2010	Colombo	2-Mar-2010	CO/M/572	RG/M/0034	29	M	34	15+	2-Mar-2015	OT1				Ragama
12	10	2010	Colombo	3-Mar-2010	CO/F/458	None	35	F	40	15+	3-Mar-2015	OT2				Colombo
13	11	2010	Colombo	4-Mar-2010	CO/F/523	None	35	F	40	15+	4-Mar-2015	OT1				Colombo
14	12	2010	Colombo	6-Mar-2010	CO/F/573	None	0.25	F	5.25	<15	6-Mar-2015	OT2				Ragama
15	13	2010	Colombo	10-Mar-2010	CO/M/428	None	31	M	36	15+	10-Mar-2015	OT1				Colombo
16	14	2010	Colombo	10-Mar-2010	CO/F/350	None	33	F	38	15+	10-Mar-2015	OT1				Colombo
17	15	2010	Colombo	18-Mar-2010	CO/M/555	None	55	M	60	15+	18-Mar-2015	OT1				Colombo
18	16	2010	Colombo	19-Mar-2010	CO/M/561	None	40	M	45	15+	19-Mar-2015	OT1				Colombo
19	17	2010	Colombo	20-Mar-2010	CO/M/570	None	43	M	48	15+	20-Mar-2015	OT1				IDH
20	18	2010	Colombo	22-Mar-2010	CO/F/571	None	48	F	53	15+	22-Mar-2015	OT1				Colombo
21	19	2010	Colombo	24-Mar-2010	CO/M/574	None	41	M	46	15+	24-Mar-2015	OT1				Colombo
22	20	2010	Colombo	26-Mar-2010	CO/M/521	None	2.3	M	7.3	<15	26-Mar-2015	OT1				Colombo
23	21	2010	Colombo	31-Mar-2010	CO/M/558	None	40	M	45	15+	31-Mar-2015	D				Colombo
24	22	2010	Colombo	3-Apr-2010	CO/M/499	None	35	M	40	15+	3-Apr-2015	OT1				Kalubowila
25	23	2010	IDH	24-Apr-2010	CO/M/421	None	27	M	32	15+	24-Apr-2015	D				IDH
26	24	2010	Colombo	27-Apr-2010	CO/M/575	None	28	M	33	15+	27-Apr-2015	OT1				Colombo
27	25	2010	Colombo	27-Apr-2010	CO/M/304	None	44	M	49	15+	27-Apr-2015	OT1				Colombo
28	26	2010	IDH	5-May-2010	CO/F/576	None	24	F	29	15+	5-May-2015	OT1				IDH
29	27	2010	IDH	8-May-2010	CO/M/597	None	30	M	35	15+	8-May-2015	D				IDH

ANNEXURE 17 : STOCK REGISTER FORMAT

Stock Register						
Organization and Place of stock :-						
Item :-						
Date	Item Received		Item Issued		Balance in the stock	Signature
	Remarks	Quantity	Remarks	Quantity		

ANNEXURE 18. DISTRIBUTION REGISTER FORMAT

Item Distribution Register						
Name of the Item :-						
Name of the Peer educator :-						
Peer educator ID :-						
Date	Item Issued		Item Returned		Balance with PE**	Peer Educator's Signature
	Remarks	Quantity	Remarks	Quantity		

**** Without considering the items distributed by Peer educators to Peers.**

ANNEXURE 19: STOCK UPDATE AND DISTRIBUTION REPORT FORMAT

Template for Condom Distribution and Stock update at SSR level						
Reporting Period :-						
From:-				To:-		
Stock Balance						
A) Balance Stock as at <from date> :-						
B) No of Condoms Received :-						
C) No of condoms distributed among Peer Educators :-						
D) Balance stock as at <to date> :- (D= A + B - C)						
Distribution Details						
No	Peed Educator ID	Name of the PE	E) Blance stock in hand as at <from Date>	F) Number of condoms received by the PE during the period	G) Number of Condoms distributed among Peers	H) Balance Stock as at <to date> (H=E+F-G)
1	GF/GL/1/8					
Total			Σ E	Σ F	Σ G	Σ H
Approved by SSR						
Prepared by :-				Date:-		
Approved by :-				Date :-		
Approved by SR						
Approved by :-				Date :-		
Approved by PR2						
Approved by :-				Date :-		
Note :-						
Please check for followings						
1 D = A + B - C						
2 H = E + F - G in each and every raw						
3 Σ F = C						
4 Figures in the column G is tally with the figures in the system						
5 D = Physical stock in the stores as at <to date>						

ANNEXURE 20: FIELD VISIT REPORT

(Template for PR2/SR field visit reports of program implementation staff)

Family Planning Association of Sri Lanka

37/27, Bullers Lane, Colombo 07.



Section 01 – General Information

Name:-	Reporting Date:-	Period of the trip	
Designation:-		From:-	To:-
Places Visited (<i>Locations</i>)			
Date	Places Visited		
Report Distribution List (<i>Names and Designations to be provided</i>)			
PR2			
SR			
SSR			
Other			
Other accompanying persons (<i>Names and Designations to be provided</i>)			
PR1 (if any)			
PR2 (if any)			
SR (if any)			
Other (if any)			
Meetings / Discussions with stakeholders			

Staff members at SR/SSR level (Names and Designations to be provided)																													
Names of the ORWs/FSS meet during the visit																													
Names / ID numbers of Peer Educators meet																													
ID numbers of peers/clients meet																													
Other key persons meet during the visit (if any) (Names and Designations to be provided)																													
Level Visited / Observed:-	<table border="0"> <tr> <td>SR Office</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>SSR Office</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>SSR ORW</td> <td><input type="checkbox"/></td> <td>At the office <input type="checkbox"/></td> <td>At the field <input type="checkbox"/></td> </tr> <tr> <td>SSR Peer Educators</td> <td><input type="checkbox"/></td> <td>At the office <input type="checkbox"/></td> <td>At the field <input type="checkbox"/></td> </tr> <tr> <td>SSR Peers</td> <td><input type="checkbox"/></td> <td>At the office <input type="checkbox"/></td> <td>At the hotspot <input type="checkbox"/> other <input type="checkbox"/></td> </tr> <tr> <td>STI Clinics</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Other (please specify)</td> <td><input type="checkbox"/></td> <td colspan="2">.....</td> </tr> </table>	SR Office	<input type="checkbox"/>			SSR Office	<input type="checkbox"/>			SSR ORW	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the field <input type="checkbox"/>	SSR Peer Educators	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the field <input type="checkbox"/>	SSR Peers	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the hotspot <input type="checkbox"/> other <input type="checkbox"/>	STI Clinics	<input type="checkbox"/>			Other (please specify)	<input type="checkbox"/>	
SR Office	<input type="checkbox"/>																												
SSR Office	<input type="checkbox"/>																												
SSR ORW	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the field <input type="checkbox"/>																										
SSR Peer Educators	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the field <input type="checkbox"/>																										
SSR Peers	<input type="checkbox"/>	At the office <input type="checkbox"/>	At the hotspot <input type="checkbox"/> other <input type="checkbox"/>																										
STI Clinics	<input type="checkbox"/>																												
Other (please specify)	<input type="checkbox"/>																											
Documents Observed :-	<table border="0"> <tr> <td>Stock Registers</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> <tr> <td>Item distribution Lists</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> <tr> <td>Staff personal files</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> <tr> <td>Staff attendant sheets</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> <tr> <td>ORW advance programs</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> <tr> <td>Pocket meeting reports</td> <td><input type="checkbox"/> SR Level</td> <td><input type="checkbox"/> SSR Level</td> </tr> </table>	Stock Registers	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level	Item distribution Lists	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level	Staff personal files	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level	Staff attendant sheets	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level	ORW advance programs	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level	Pocket meeting reports	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level										
Stock Registers	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											
Item distribution Lists	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											
Staff personal files	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											
Staff attendant sheets	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											
ORW advance programs	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											
Pocket meeting reports	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level																											

	Progress meeting minutes	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level
	Peer Educator Daily Records	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level
	Other documents	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level
	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level
	<input type="checkbox"/> SR Level	<input type="checkbox"/> SSR Level
	<input type="checkbox"/> SR Level	SSR Level

Section 02 – Observations Recommendations, action points and plan for follow-up

	Observations (please provide in bullet points)	Recommendations based on the observations (If any)	Due date (Due date for follow up – if applicable)	Responsible person (Immediate action level responsible person at PR2/SR/SSR level for follow up)
01				
02				
03				
04				

ANNEXURE 21: HOTSPOT BASED SERVICE AND DATA QUALITY ASSESSMENT TOOL

Client Reg. No

--	--	--	--	--

Hotspot Based Service and data quality assessment tool

01. The client was identified using (Please use following one or more of information in the client registration form to identify the client. Pls do not record Personal details in the questionnaire)

	Criteria	Yes	NO	Remarks (If Any)
1.1	Clients' Name			
1.2	Other Name / Nick Name			
1.3	Permanent Address			
1.4	Current Address			
1.5	Age			
1.6	NIC number			
1.7	Telephone Number			
1.8	Marital Status			
1.9	Occupation			
1.10	Years of formal education			

02) Interaction with peer educator and field supervisor

	Criteria	Reported		Observed	
		Y e s			
	Client was able to mention the name of the peer educator				
	Client was able to mention the name of the field supervisor				
	What is the latest date that you had a meeting with PE?				
	How many times your peer educator met you during the last month?				
	Have you ever participated for a pocket meeting with other peers, peer educator and field supervisor?				

	Have you ever met the field supervisor?				
--	---	--	--	--	--

03) Uptake of services from the peer educators (Please use following questions to verify data recorded)

03. 1. Awareness on HIV/STI

Reported			
	Yes	No	Remarks (if any)
Awareness on HIV (H)			
Awareness on STI (S)			
Awareness by IEC materials			

	Criteria			
	Just after the HIV infection, the infected person becomes an AIDS patient			
	Can a healthy-looking person have HIV?			
	Can a person get HIV from mosquito bites?			
	Can a person get HIV by sharing food with someone who is infected?			

	Anal sex has higher risk than vaginal sex for HIV infection?			
	Can person reduce the risk of getting HIV by using a condom every time they have sex?			
	Sharing injecting equipment directly from person to person (without disinfection) has a risk of HIV transmission			

03.2) Condom Demonstration

Reported				
		Yes	No	Remarks
	Condom Demonstration (CD)			
Onsite Verification and observations		Yes	No	
3.2.1	Inspect the condom and expiry date.			
3.2.2	Tear the condom free edge of package and take out the condom. Ensure that the nails do not cause a tear in the condom			
3.2.3	To prevent the condom from bursting, squeeze the tip of the condom to take out the air.			
3.2.4	While holding onto the tip, unroll the condom down the shaft of the penis all the way to the base of penis.			
3.2.5	Slide off the condom from the penis ensuring that the semen collected at the tip does not spill or leak out.			
3.2.6	Dispose-off the condom in a safe place where it cannot be handled by another person.			
3.2.7	Wash hands to ensure that there is no potentially infected semen or vaginal secretions on the hand			
3.2.8	Use a tissue or a paper to remove the condom to prevent potential contact of vaginal secretions in the hand			

03.3) IEC Materials

Reported

	IEC materials (E)			
Onsite Verification and observations		Yes	No	
3.3.1	Have you received any IEC material or leaflet from the peer educator?			
3.3.2	Client correctly identified the IEC material received from the peer educator from a set of IEC materials.			
3.3.3	Have you ever read the above IEC material	Yes, Completely		
		Yes, Partially		
		No		

03.4) Condom Distribution

Onsite Verification and observations		Reported		Observed	
		Yes	No	Yes	No
3.4.1	Have you received condoms free of charge from the peer educator?				
3.4.2	Number of condoms that the client received from the peer educator during the last month (13 calendar days).				
3.4.3	Number of condoms received from peer educator is enough for me.				
3.4.4	If not, actual requirement per month (as an average)				
3.4.5	Did you use a condom during the last sex?				

03.5) Escorts to STD Clinics

Onsite Verification and observations		Reported		Observed	
		Yes	No	Yes	No
3.5.1	Did you visit to STD clinic during this year?				
3.5.2	If yes, date / month of the latest visit				
3.5.3	I went to STD clinic with my peer educator				
3.5.4	Do You know the result				

04) Tracking Duplication of clients

Onsite Verification and observations		Reported		Observed	
		Yes	No	Yes	No
4.1	Have you ever received condoms from another Peer Educator during this year?				
4.2	If, yes from whom?				
4.3	Have you ever received the same IEC material from another Peer Educator during this year?				
4.4	If, yes from whom?				

05) Meeting Selection Criteria

Observations	
Female Sex Workers	
5.1	Did you engage in consensual sex in return for money or payment in kind during the last month? If “yes” how many partners ?
5.2	If the answer is “No” for above question, latest date of sexual encounter with a non regular partner?
	Do you operate in a particular District (Yes/No)
Men Who Have Sex with Men	
5.3	Did you engage in sex (receptive or insertive)regularly or irregularly with male/s during the last month? If “yes” how many partners ?
5.4	If the answer is “No” for above question, latest date of sexual encounter with a male sexual partner?
	Do you operate in a particular District (Yes/No)
Beach Boys	
5.5	Did you engage in providing personalized services to male and/or female tourists such as sexual services, swimming assistance, boating, diving etc during the last month? If “yes” how many foreigners ?
5.6	If the answer is “No” for above question, latest date of sexual encounter with a foreign sexual partner?
	Do you operate in a particular District (Yes/No)

Drug Users	
5.7	Didi you use (<i>Inhaling/ injecting or any other form</i>) heroin, morphine, opium, oxycodone, hydrocodone, methadone, Suboxone, codeine, Percocet or Dilaudid. drugs during last week? If “yes” how many times ?
5.8	If the answer is “No” for above question, latest date that you used drugs?
	Do you operate in a particular District (Yes/No)

Name of the Interviewer : -

Interview

Date : -

Time : -

Place : -

.....

Interviewer (Signature)

ANNEXURE 22: PEER EDUCATOR CAPACITY ASSESSMENT TOOL

01. Identification

1.1	Peed Educator ID :-	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
1.2	Name of the Interviewer :-					
1.3	Date:-					

02. General Information

	Date joined with the project	
	Did you participate in a 2 or 3 or 5 day PE training? <i>(If no, please go to question 2.7)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, Number of days completed?	
	If less than planned days of PE training, why were you unable to complete?
	Number of days reported in the training completion report	
	Date/s of the training	
	Did You receive an on-the job training before starting work?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, under whom?	Field Supervisor <input type="checkbox"/> Project Coordinator <input type="checkbox"/> Other (Specify) <input type="checkbox"/>

03. Interaction with Field Supervisor and peers

3.1	Have you ever conducted a pocket meeting with the field supervisor and your peer group?	Yes <input type="text"/>	No <input type="text"/>
3.2	If yes, when did you conduct the last pocket meeting? (Please indicate the number of days before)	Number of days before	<input type="text"/>
3.3	When did you meet the field supervisor last time? (Please indicate the number of days before)	Number of days before	<input type="text"/>
3.31	How many peers currently under your purview (this is the denominator of the 3.4)		
3.4	Could you please mention the names of your peers? (Please indicate the number of names mentioned correctly by the peer educator)	Number of Names correctly mentioned	<input type="text"/>

04. Knowledge on HIV and STI

	Statement	Yes	No	Don't Know
4.1	Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?			
4.2	Can using condoms reduce the risk of HIV transmission?			
4.3	Can a healthy-looking person have HIV?			
4.4	Can a person get HIV from mosquito bites?			
4.5	Can a person get HIV by sharing a meal with someone who is infected?			
4.6	Can HIV transmit from infected mother to her unborn baby through blood?			

	Statement	True	False	Don't Know
4.7	Unprotected anal sex has a higher chance of HIV transmission than unprotected vaginal sex			
4.8	HIV antibody test is negative during the window period of the infection			
4.9	Giving ART (Antiretroviral Therapy) to HIV infected mothers can reduce HIV transmission to unborn baby			
4.10	Ability of HIV transmission is reduced when PLHIVs are on effective treatment regimens			

4.11	Name three sexually transmitted diseases you know <i>(Please do not read the options. Consider first three answers as correct answers and mark in the text box)</i>	1. Gonorrhoea 2. Chlamydia 3. Genital Herpes 4. Genital warts 5. Trichomonas 6. Syphilis 7. Other (Specify) 8. Do not know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.12	Name one sexually transmitted infections that can cause male urethral discharge <i>(Please do not read the options. Consider first answer as correct answer and mark in the text box)</i>	1. Gonorrhoea 2. Chlamydia 3. Genital Herpes 4. Genital warts 5. Trichomonas 6. Syphilis 7. Other (Specify) 8. Do not know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

05. Condom Demonstration

Please ask the peer educator to explain the steps of condom demonstration. Verify the answer by asking probing questions. Mark the steps that the respondent explains correctly. Please do not read the steps to the respondent.

		Yes	No	
5.1	Inspect the condom and expiry date.			
5.2	Tear the condom free edge of package and take out the condom. Ensure that the nails do not cause a tear in the condom			

5.3	To prevent the condom from bursting, squeeze the tip of the condom to take out the air.			
5.4	While holding onto the tip, unroll the condom down the shaft of the penis all the way to the base of penis.			
5.5	Slide off the condom from the penis ensuring that the semen collected at the tip does not spill or leak out.			
5.6	Dispose-off the condom in a safe place where it cannot be handled by another person.			
5.7	Wash hands to ensure that there is no potentially infected semen or vaginal secretions on the hand			
5.8	Use a tissue or a paper to remove the condom to prevent potential contact of vaginal secretions in the hand			

06. Data Quality and Consistency (Peer educator Diary – MEIMS)

6.1	Peer Educator could show his/her field dairy at the time of the interview	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.2	Completeness of the records	Highly Satisfactory	<input type="checkbox"/>
		Satisfactory	<input type="checkbox"/>
		Dissatisfactory	<input type="checkbox"/>
		Highly dissatisfactory	<input type="checkbox"/>
6.3	Completion of a sample peer calendar	Highly Satisfactory	<input type="checkbox"/>
		Satisfactory	<input type="checkbox"/>
		Dissatisfactory	<input type="checkbox"/>
		Highly dissatisfactory	<input type="checkbox"/>

Please do the following exercises for randomly selected date range (at least for 30 days)

Selected Date Range:-

From Date: - **To Date:** -

	Indicator	Number Recorded in the PE dairy	Number Reported as per the MEIMS
6.3	Number of Interactions		
6.4	Number of Condoms distributed		
6.5	Number of Escorts		

6.6	Number of awareness on HIV		
6.7	Number of awareness on STI		
6.8	Number of IEC/BCC materials		
6.9	Number of condom demonstration		

07. Behavior Change

7.1	Did you use a condom during the last sex?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7.2	Did you test for HIV during the past 12 months?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7.3	If Yes, do you know the result?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

08. Selection Criteria

8.1. Female Sex Workers			
		Yes	No
8.1.1	Engages in consensual sex in return for money or payment in kind		
8.1.2	Operating in the particular District		
8.1.3	Literate		
8.2. Men who have sex with Men			
8.2.1	<i>Male who engages in sex regularly or irregularly with male</i>		
8.2.2	Operating in the particular District		
8.2.3	Literate		
8.3. Beach Boys			
8.3.1	<i>Male who currently engages in providing personalized services to male and/or female tourists such as sexual services, swimming assistance, boating, diving etc</i>		
8.3.2	Operating in the particular District		
8.3.3	Literate		
8.4. Drug Users			
8.4.1	current <i>user of (Inhaling/ injecting or any other form)</i> heroin, morphine, opium, oxycodone, hydrocodone, methadone, Suboxone, codeine,		

	Percocet or Dilaudid. {Persons who do consume only cannabis (ganja) or its derivatives are not considered suitable}		
8.4.2	Operating in the particular District		
8.4.3	Literate		

Name of the Interviewer : -

Interview

Date : -

Time : -

Place : -

.....

Interviewer (Signature)

**ANNEXURE 23: REQUEST FOR HIV CONFIRMATORY TESTING FROM THE
REFERENCE LABORATORY OF THE NATIONAL STD/AIDS CONTROL PROGRAMME**

(VERSION: 7.4.2017)

<p>Instructions: To be completed by referring doctor/healthcare worker at the time of requesting HIV confirmatory test from the reference laboratory of the National STD/AIDS Control Programme, No. 29, De Saram Place, Colombo 10, Sri Lanka.</p> <p>Patient should be informed that all questions contained in this questionnaire are strictly confidential and will become part of their medical record)</p>	<p>Part I: TO BE FILLED BY THE REFERENCE LABORATORY</p> <p>Date of Receipt <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year</p> <p>Date of Confirmation <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year</p>			
PART II – TESTING DETAILS AND DEMOGRAPHIC INFORMATION				
PATIENT/CLIENT IDENTIFICATION INFORMATION If STD clinic patient fill A, otherwise fill B	<p>1A. STD Clinic Registration Number (For STD Clinic Clients)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Gender Sequential No Year Clinic Code</p>	<p>1B. Sample Details</p> <p>Institute/Hospital : _____</p> <p>Ward/ Clinic : _____</p> <p>BHT/ Clinic No : _____</p>		
HIV SCREENING TEST DETAILS	<p>2. Type of Screening Test</p> <p><input type="checkbox"/> a. ELISA Test</p> <p><input type="checkbox"/> b. Particle Agglutination Test</p> <p><input type="checkbox"/> c. Rapid Diagnostic Test</p> <p><input type="checkbox"/> d. Other _____</p>	<p>3. Date of Screening Test:</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year</p>		
HIV TESTING HISTORY	<p>4. Has patient/client ever been tested for HIV previously</p> <p><input type="checkbox"/> a. If Yes (date of last negative test) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Year Day Month <input type="checkbox"/> b. No <input type="checkbox"/> c. Not Known</p>			
DEMOGRAPHIC INFORMATION	<p>5. Name and address of Patient/Client</p> <p>Name : _____</p> <p>Address : _____</p> <p style="text-align: right;">F</p>		<p>6. Gender</p> <p><input type="checkbox"/> M <input type="checkbox"/></p> <p><input type="checkbox"/> Other</p>	<p>7. Date of Birth</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year</p>

8. Marital status <input type="checkbox"/> a. Single/Never Married <input type="checkbox"/> b. Currently Married <input type="checkbox"/> Living Together <input type="checkbox"/> c. Widow/Sep./Divor. & Living with spouse	
9. Occupation <input type="checkbox"/> a. Unemployed <input type="checkbox"/> b. Student <input type="checkbox"/> c. Employed as: _____ <input type="checkbox"/> d. NA	
10. District of Residence: _____	11 Nationality <input type="checkbox"/> a. Sri Lanka <input type="checkbox"/> b. Other (specify) _____
12. Ethnicity <input type="checkbox"/> a. Sinhalese <input type="checkbox"/> b. Tamil <input type="checkbox"/> c. Moore <input type="checkbox"/> d. Other (specify) _____ <input type="checkbox"/> e. Not Sri Lankan	

13. Reason for HIV Testing (:han one option possible)

<input type="checkbox"/> a. Voluntary Testing	<input type="checkbox"/> e. Accompanied by NGO outreach worker or peer	<input type="checkbox"/> i. Visa Screening	<input type="checkbox"/> m. Screening as part of a Survey
<input type="checkbox"/> b. STD Screening	<input type="checkbox"/> f. Partner/spouse or family member diagnosed	<input type="checkbox"/> j. Foreign Job Screening	<input type="checkbox"/> n. TB clinic screening
<input type="checkbox"/> c. Provider Initiated Testing (asymptomatic)	<input type="checkbox"/> g. Blood Donor Screening	<input type="checkbox"/> k. Screening for Legal/Insurance purposes	<input type="checkbox"/> o. Prison
<input type="checkbox"/> d. Clinical symptoms suggestive of HIV	<input type="checkbox"/> h. ANC Screening	<input type="checkbox"/> l. Screening before Medical/Surgical Procedure	<input type="checkbox"/> p. <u>Other (Specify):</u>

14. Clinical status at the time of diagnosis/testing <input type="checkbox"/> a. Asymptomatic <input type="checkbox"/> b. Symptomatic HIV <input type="checkbox"/> c. AIDS	
PART III: INFORMATION ON EXPOSURE TO HIV	
15. Sexual Exposure (Multiple Responses Possible) <input type="checkbox"/> a. Sexual Contact with Regular Partner of Opposite Sex <input type="checkbox"/> b. Sexual Contact with Non-Regular Partner of Opposite Sex <input type="checkbox"/> c. Sexual Contact with Person of Same Sex <input type="checkbox"/> d. Sexual Contact with Both Sexes <input type="checkbox"/> e. No Sexual Contact	16. Ever sold sex to clients <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No
17. Ever bought sex from a sex worker <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No	18. Ever gone abroad? <input type="checkbox"/> a. Yes, countries: _____ <input type="checkbox"/> b. No
19. Ever had sex with a foreigner? (In Sri Lanka or abroad) <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Not Applicable (Foreign Nationality)	20. History of Blood Exposure <input type="checkbox"/> a. No <input type="checkbox"/> b. Injecting Drug Use <input type="checkbox"/> c. Receipt of Blood/Tissue/Organ/Sperm Specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> d. Needle stick injury/mucosal splash Specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
21. Acquired from mother to child transmission <input type="checkbox"/> a. No <input type="checkbox"/> b. Yes <input type="checkbox"/> c. Not Known	

INFORMATION ABOUT SPOUSE/LIVE-IN PARTNER EXPOSURE TO HIV

22. HIV status of spouse

- a. Positive
- b. Negative
- c. Not Known
- d. Not Applicable

23. Has spouse ever gone abroad?

- a. Yes, countries _____
- b. No
- c. Not Known
- d. Not Applicable

24. Risk factors for HIV in spouse

- a. None b. MSM c. Sex Worker (now or former) d. Multiple Sex Partners
- e. Injecting drug user (now or former) f. Not Known g. Not Applicable

DETAILS OF THE REFEREING DOCTOR/HEALTHCARE WORKER

A. Name : _____
B. Signature : _____
C. Designation : _____

D. Institution : _____
E. Telephone No.: _____
F. Date : _____

ANNEXURE 24: DATA QUALITY ASSURANCE CHECKLIST

NSACP/SIMU/2017/5/27

National STD/AIDS Control programme, Sri Lanka

Name of the clinic : _____

STD clinic

ART center

Date of visit : _____

Supportive supervising team	
Name	Designation
1.	
2.	
3.	

Summary of important findings and recommendations (To be filled at the end of visit):

M&E STRUCTURES, FUNCTIONS AND CAPABILITIES

A. Recording formats/registers:		Persons responsible for maintaining	Adequately Trained? Y/N	Remarks
a. STD clinic				
i.	Main Register			
ii.	Subsequent visit register			
iii.	Outpatient blood testing register			
iv.	HIV testing and counselling register			
v.	IEC/BCC awareness programme register			
vi.	Microscopy laboratory daily recording register			
vii.	Female sex worker register			
viii.	Interview and contact tracing register			
ix.	Antenatal of syphilis and HIV register (EMTCT)			
x.	Syphilis register (STD clinic attendees)			
xi.	Outreach programme register			
xii.	MRRP register for (CSW, MSM, TG, BB, PWDU/ID, Prisoners)			
xiii.	Condom/ Lubricants distribution register			

xiv.	Pre-employment/ Visa screen register			
xv.	Training register			
xvi.	Defaulter register			
xvii.	Other			
b. HIV clinic/ART center				
i.	Pre ART register			
ii.	ART register			
iii.	ART drug dispensing register			
iv.	Register for children living with HIV			
v.	HIV TB register			
vi.				
vii.				

B. Reporting formats/returns		Persons responsible for completing	Adequately Trained? Y/N	Remarks
a. Quarterly returns				
i.	Quarterly STD returns			
ii.	Quarterly ART returns:			
b. Excel worksheets				
i.	Quarterly cross sectional ART and Pre ART databases			
ii.	Annual Cohort ART database			
iii.	EMTCT HIV and syphilis databases			

II. Knowledge, understanding on the key definitions/concepts

	Key definitions/concepts:	Y/N
STD Clinic Main Register:	a. Correct understanding of the term 'episode' is reflected in the entries of the Main Register (i.e. does not enter subsequent visits as a new row if for the same episode, and should enter multiple diagnoses for the same episode in a single row)	
	b. Only patients who come to STD clinics for the first time receive a Master number (or if patients' previous Master number cannot be retrieved)	
	c. Members of key population are classified according to self-disclosure (including accompaniment by NGO staff)	

ART Register:	d. Both, patients who are started on ART for the first time and the patients who are transferred while on ART are entered in to the register	
	e. A single row is dedicated for a one patient (i.e. when a patient who is lost to follow up after commencing ART and re-enters for care, the same row which was dedicated for that person at the first time he registered is updated without allocating a new row).	
EMTCT Register:	f. Pregnant women who know they are HIV positive prior to their ANC visit are counted as “tested positive or know their status”	

Data collection and reporting forms and tools

	Key Criteria	Good	Satisfactory	Need Attention
STD clinic	a. Last STD quarterly returns was complete			
	b. Last STD quarterly returns was on time			
	c. Registers are legible, organized by gender, and use standard codes as per guidelines (Main, Outpatient Blood testing, etc.)			
	d. Registers are stored in a manner consistent with data security guidelines			
	e. Electronic files are secured according to guidelines (e.g. password protected, access only given to designated persons, Back up of files are up to date, patient identifiers are not included in electronic files)			
	f. STD Patient forms are maintained in good order and kept securely			

HIV clinic	g. Last ART quarterly returns was complete			
	h. Last ART quarterly returns are was on time			
	i. Registers are legible, organized by gender, and use standard codes as per guidelines			
	j. Registers are stored in a manner consistent with adequate data security			
	k. Electronic files are secured according to guidelines (e.g. password protected, access only given to designated persons, Back up of files are up to date, patient identifiers are not included in electronic files)			
	l. ART patient forms are maintained in good order and kept securely			

Cross check of data elements:

	Reported	Verified
a. Number of newly registered female patients in the last quarter		
b. Number of new episodes among MSM patients in the last quarter		
c. Number of FSW received an HIV test in the last quarter		
d. Spot check one patient episode in Main register against STD patient form	N/A	

Data Management Process: What were the action steps identified at the last data quality monitoring visit for this site?

- a. What are the current areas of concern for maintaining/improving data quality as identified by the site manager?
- c. Are the areas of concern consistent with the current assessment of data quality? Y / N _____
- d. What actions has the manager of the site taken since the last data quality monitoring visit?
- e. What are the next steps planned for addressing data quality at this site?

FOR MORE INFORMATION, CONTACT;

**NATIONAL STD/AIDS CONTROL PROGRAMME,
29, DE SARAJ PLACE, COLOMBO 10.**

SRI LANKA.

E-MAIL: info@aidcontrol.gov.lk

WEB : <http://www.aidcontrol.gov.lk>