Monitoring and Evaluation System Strengthening (MESS) Workshop

Findings and Recommendations from the National Workshop

(with Special Emphasis on MSM and Transgender Populations)

Sri Lanka

December 2014

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MULTI-COUNTRY SOUTH ASIA GLOBAL FUND HIV PROGRAMME

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with special emphasis on MSM and transgender populations.

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Thushara Ranasinghe
Executive Director,
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December 2014

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CCM	Country Coordination Mechanism
FPA	Family Planning Association
FPASL	Family Planning Association of Sri Lanka
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
INGO	International Non-Governmental Organizations
JPIU	Joint Programme Implementation Unit
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MESS	Monitoring and Evaluation System Strengthening
MESST	Monitoring and Evaluation System Strengthening Tool
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National AIDS Committee
NBTC	National Blood Transfusion Service
NGO	Non-Governmental Organization
NPTCCD	National Programme for Tuberculosis Control and Chest Disease
NSACP	National STD/AIDS Control Programme
SIM	Strategic Information Management
SIMU	Strategic Information Management Unit
STD	Sexually Transmitted Disease
TG	Transgender
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
WB	World Bank
WHO	World Health Organization

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Executive summary

Sri Lanka is an island country of 65,610 square kilometres located near the southern tip of India. It is a multi ethnic and multi lingual country with a population of 21.4 million (July 2012, estimation). The country has 9 provinces and 25 districts. There are basically two levels of governance, central government and the provincial councils or provincial governance.

HIV epidemic in Sri Lanka is at low level, HIV prevalence is less than 0.1% with an estimate of about 3,000 people living with HIV. As of end of 2013, 1845 HIV cases, 301 AIDS deaths and 71 cases of mother-to-child transmissions were reported to the National STD/AIDS Control Programme, Sri Lanka. Main mode of transmission is heterosexual. Proportion of homosexual and bisexual transmission is gradually increasing. In 2013 the homo/bisexual behaviours accounted 31% of the total transmissions showing an emerging epidemic among men who have sex with men.

In accordance with the three ones principle, Sri Lanka has one agreed HIV/AIDS action framework (national strategic plan 2013-2017), one national AIDS coordinating authority with broad-based multi sectoral mandate (National AIDS Committee), and one agreed country level monitoring and evaluation system (National HIV M&E plan 2013-2017).

International donors (GFATM, WB, UN, WHO, USAID etc) putting lot of pressure to show results in their monetary investments for health. Therefore, it is agreed among donors that national HIV M&E systems should follow the UNAIDS 12-component HIV M&E organizing framework (MESS tool) to show the HIV project and programme results as well as national outcome and impact results.

Monitoring and evaluation system strengthening tool was administered among 29 stakeholders of national HIV response in Sri Lanka with a special emphasis for MSM and TG populations. One-day MESS workshop was conducted on 12.12.2014 at Hotel Taj Samudra, Colombo as a self-assessment tool for stakeholders and the resulted MESS tool reflected the current status, suggestions and action points in relation to the national HIV M&E system. Assessment was conducted to gather information from the following three levels of organizational structures.

1. Ministry of health AIDS control programme (National STD/AIDS Control Programme)
2. HIV/AIDS umbrella organizations
3. Health facilities

National AIDS Control Programme: the National STD/AIDS control programme (NSACP) is the main government entity coordinating the national response to HIV in Sri Lanka. The Strategic Information Management (SIM) unit of the NSACP coordinates the national HIV M&E with the guidance of the multi-sectoral SIM subcommittee.

The MESS tool has identified strengths, weaknesses and key action points at the NSACP level for the improvement of the national HIV M&E system. In general, the system is in a level of acceptable standards. However, for further improvements following areas need to be considered.

Functional task analysis need to be carried out in order to review and develop the organizational structure with HIV M&E posts, job descriptions, and terms of references for reporting units.
Task force/TWG within the SIM subcommittee can be appointed to work on assessment of data needs, and the development of set of forms for other data reporting entities.
NSACP and the SIM subcommittee need to work on the development of the national HIV M&E work plan which is currently under the process of development (National HIV M&E plan, and

National HIV M&E work plan should be made available with the development of the time bound national strategic plan).
HIV M&E system assessment and HIV M&E plan reviews need to be carried out periodically.
Consultative training workshops for other partner entities should be planned and conducted as a capacity building process.
Efforts should be taken to conduct health facility surveys and condom availability and use surveys etc.

Umbrella organizations: Family Planning Association of Sri Lanka is the main organization among the umbrella organizations which is working with HIV related projects and programmes in the country especially as sexual health provider for most at risk populations (MARPs) under the grant of GFATM round 9 as the principle recipient (PR 02). In addition, there are number of other sub recipient (SR) organizations, such as Heart to Heart (H2H), Alcohol and Drugs Information Centre (ADIC), Sri Lanka Red Cross (SLRC), Community Strength Development Foundation (CSDF), Mithuro Mithuro Movement (MMM), Saviya Development Foundation are among other umbrella organizations. UN organizations (UNAIDS, UNDP, ILO, WHO), and some of INGOs (World Vision, Save the Children) are also having mandate for HIV related work. Government partners such as Family Health Bureau (FHB), Health Education Bureau (HEB), Department of Education, Department of Prison, and Department of Fisheries and Aquatic Resources are also having substantial contributions towards the national response to HIV.

The MESS tool has identified strengths, weaknesses and key action points at the level of umbrella organizations. In general, most of the entities are having project-based M&E systems without a clear mandate to contribute to the National HIV M&E system except for GFATM related activities. However, these entities provide data on demand basis to complement the national HIV M&E system. It is necessary to consider following areas for further improvement.

Some of the entities need appropriately skilled persons for HIV data management and reporting and they should be given clear mandate.
Need to provide consultative technical support to community based-organizations for HIV M&E capacity building.
Plan and develop national guidelines and tools for supportive supervision and data auditing mechanism for entities with relatively high HIV data loads.
Periodic data quality audits should be planned and conducted.
Conduct training programme for capacity limited entities.

Health facility level: In the health facility level, under the national STD/AIDS Control Programme there are 30 full time STD clinics out of which about 8 clinics function also as ART centres, Infectious disease hospital, Angoda also function as ART centre. In addition, Family Planning Association has 6 service delivery points and five mobile teams. Some of other community-based organizations have drop-in centres (DIC) where HIV counselling and condom promotion services are being carried out. In addition, private sector hospitals are also function as service delivery points.

The MESS tool has identified strengths, weaknesses and key action points at the health facility level. In general, almost all the government entities are having data recording and reporting system and contribute to the national HIV M&E system which is being managed by the SIM unit. However, there are no dedicated fulltime persons to carry out data management work at most of health facilities. Service delivery points of the FPA and private sector hospitals have their own data management process but there is no proper data reporting to complement the national HIV M&E system. It has been identified that the following areas need to be improved.

Health facilities should have at least one skilled person fulltime or part time, based on the work load, who can commit to HIV M&E needs. The infectious Disease Hospital needs a fulltime M&E person to carry out data recording and reporting activities.
Conduct M&E training workshops as a capacity building process for health facilities.
Include M&E responsibilities to the job description of persons handling data at facility level
Arrange incentive scheme for data mangers at the health facility level.
Private sector health facilities should be encouraged to provide data to the national HIV M&E system through private health service regulatory council of Sri Lanka.

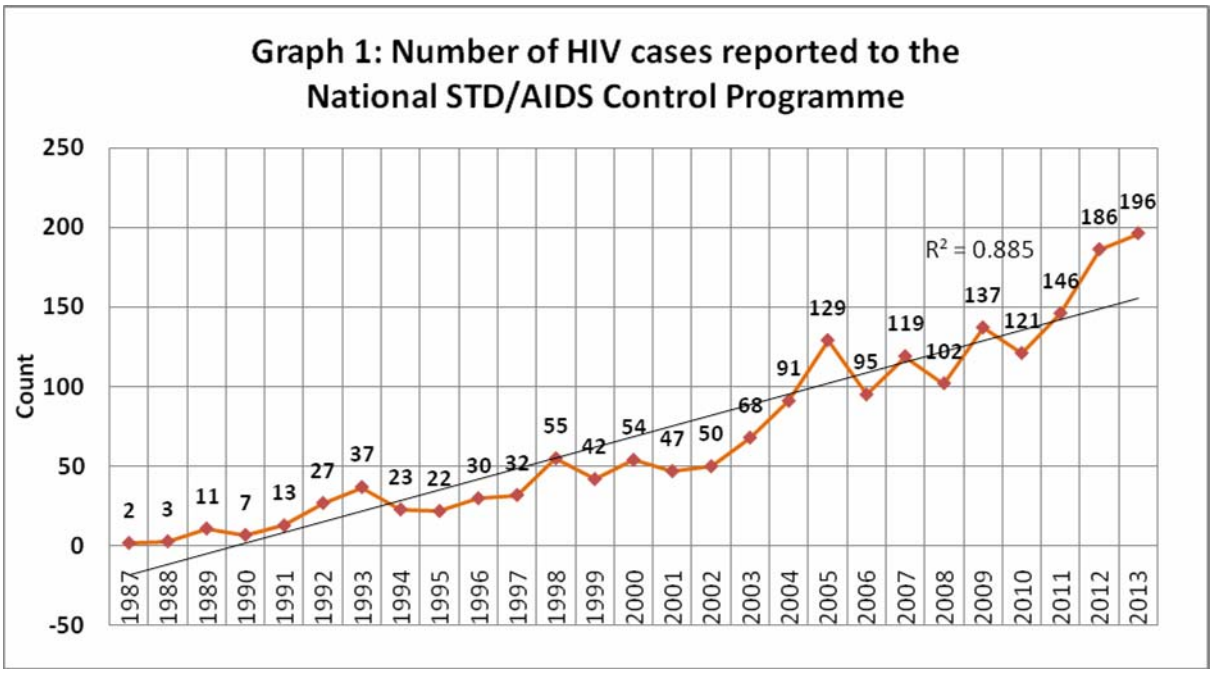
Background

Sri Lanka country profile

Sri Lanka is a Democratic Socialist Republic. It is an Island of 65,610 square kilometres situated near the Sothern tip of India. It has a population of 21.4 million (July 2012, estimation). Sinhala and Tamil are national languages while English has been recognized as the link language. For administrative purposes, Sri Lanka is divided into 9 provinces and 25 districts. Sri Lanka's Human Development Index (HDI) is 0.75, which gives the country a rank of 73 out of 187 countries with comparable data. (1)

HIV situation in Sri Lanka

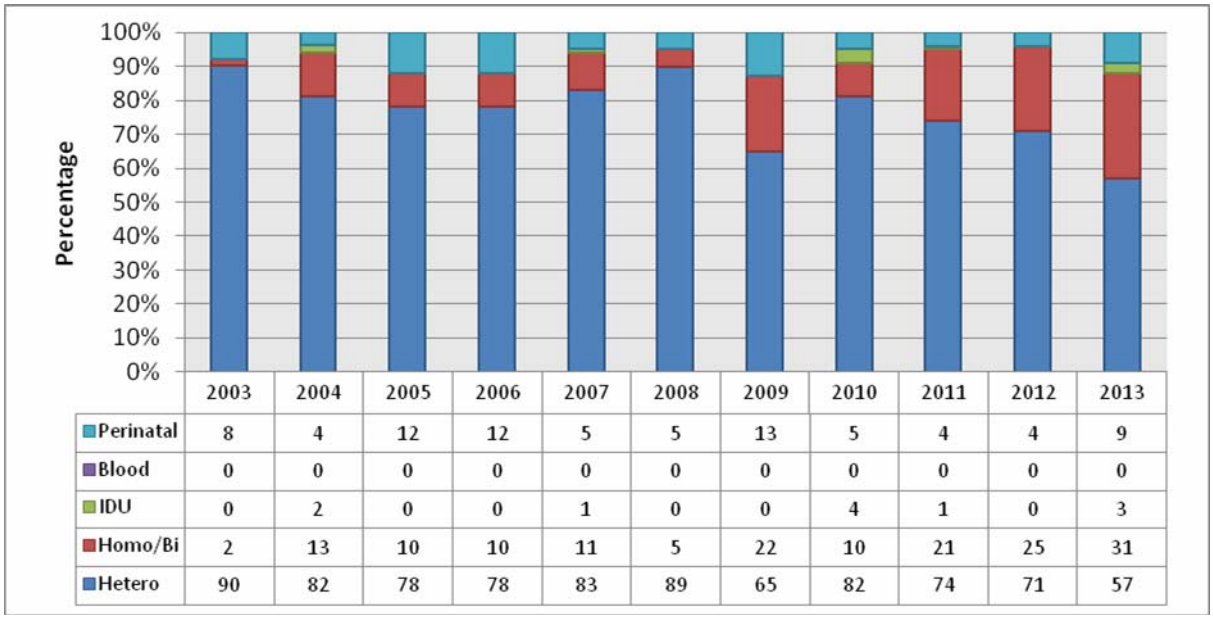
According to the global HIV epidemic classification, Sri Lanka is placed as a country with a low level HIV epidemic. As of end of 2013, 1845 HIV cases, 301 AIDS deaths and 71 cases of mother-to-child transmissions were reported to the National STD/AIDS Control Programme, Sri Lanka. (2) However, during the past 10 year period (2001-2011) there was a 10% rise in estimated number of new infections and 210% rise (graph 1) in reported number of HIV cases (47 cases in 2001 to 146 cases in 2011). This happened in the background of 33% reduction of new infections worldwide. (3)



Based on the available latest HIV estimates for Sri Lanka, it is estimated that there are 3000 (2000-5000) number of people living with HIV (estimated prevalence is 0.02%). (4) The estimated number of new HIV infections for the year 2012 was 277 (adults 258 and children 18) and there were total of 181 estimated AIDS deaths in 2012 while 75 children estimated to be infected with HIV in the same year. (4)

Number of HIV cases reported among the age group of 15-24 years over the last 5 year period from 2009 to 2013, has risen by 92% (from 13 cases in 2009 to 25 cases in 2013). In other words, youth are increasingly affected among reported new cases.

Analysis of the modes of transmission – Yearly analysis of the reported HIV cases by the probable mode of transmission over the past eleven years is shown in the graph-table below *(excluding cases where mode of transmission is not available/unknown).*



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Perinatal	8	4	12	12	5	5	13	5	4	4	9
Blood	0	0	0	0	0	0	0	0	0	0	0
IDU	0	2	0	0	1	0	0	4	1	0	3
Homo/Bi	2	13	10	10	11	5	22	10	21	25	31
Hetero	90	82	78	78	83	89	65	82	74	71	57

It is clear that, the heterosexual behaviour has been the main mode of transmission of HIV in Sri Lanka over the past years. The main drivers of this mode of transmission are female sex workers, clients of sex workers and other people with multiple concurrent sexual partners (MCP). The mapping and size estimation study carried out in 2013 shown an estimate of 15,000 accessible FSWs. (5) The trend of HIV transmissions through homo/bisexual behaviours is on the rise which warrants the targeted interventions for men who have sex with men (MSM), and male sex workers (MSW). Mapping and size estimation conducted in 2013 estimates that approximately 7,500 accessible MSM in the country. (5) Injecting drug use has not been a major mode of transmission in the country while transfusion related HIV cases not reported after 2003.

Furthermore, analysis of 2013 reported cases of HIV infections shows that out of 196 cases 31% of them were due to MSM or Bisexuals behaviours. (6) Among the incident cases (HIV cases in the age group of 15-24 years) 11 out of 16 were due to homosexual behaviours. The meaning of this is that there is an ongoing currently active epidemic exists among MSM (emerging MSM epidemic) in the country which needs to be addressed early. According to the latest sero-surveillance study, the HIV prevalence among MSM was 0.9%. (7)

Overview of the governance structure for the HIV response

Prevention and control of sexually transmitted diseases was carried out under the leadership of the Anti VD Campaign which was established in 1952 based on a British Model. In 1985, with the advent of AIDS, it was strengthened as the National STD/AIDS Control Programme (NSACP) under the ministry of health, Sri Lanka. (8)

National AIDS Committee

The first case of HIV/AIDS was detected in Sri Lanka in September 1986. The first AIDS Task Force was formed in February 1986 even before the first ever case of HIV/AIDS was identified in the country. In 1988, AIDS task force was expanded to form the National AIDS Committee (NAC) with multi sectoral representation under the ministry of health which is the high level policy making body in Sri Lanka. NAC meets twice a year to take HIV/AIDS related decisions in the country. According to the "three ones principal", NAC is the One national AIDS coordinating authority having broad-based multi-sectoral mandate.

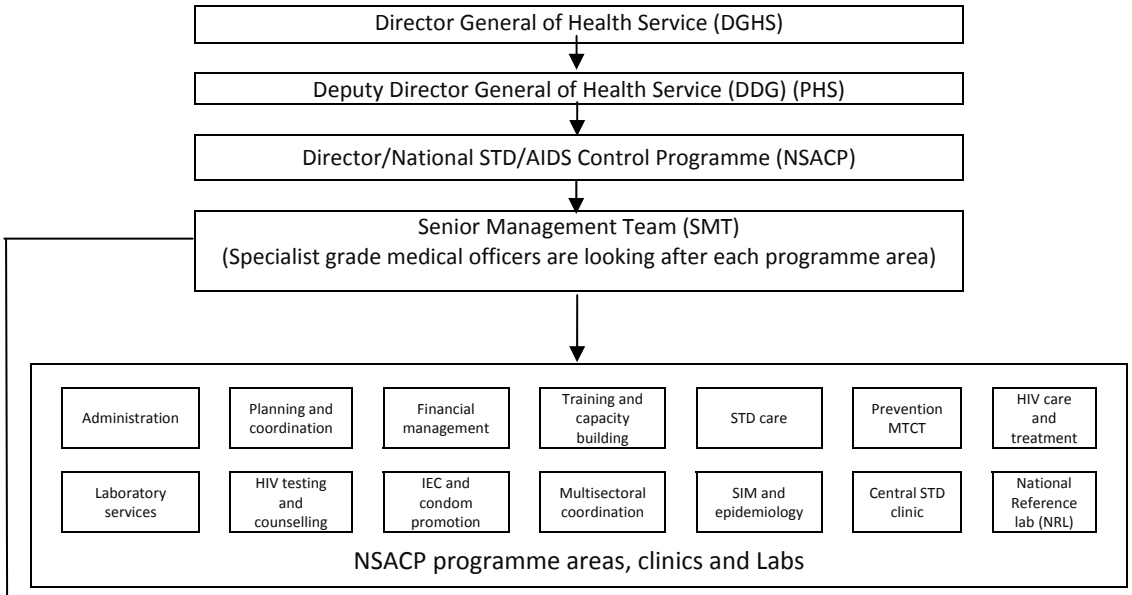
National STD/AIDS Control Programme (NSACP)

NSACP is the main government organization responsible for prevention and control of sexually transmitted diseases in Sri Lanka. It is currently a well organized disease control programme which has both curative and preventive components. The headquarters of the NSACP located in the Colombo city and it has 30 STD clinics in the network and some visiting clinics in the island. These clinics function as prevention and clinical care units at district level. The NSACP is acting as the main coordinating body for the national response to HIV/AIDS.

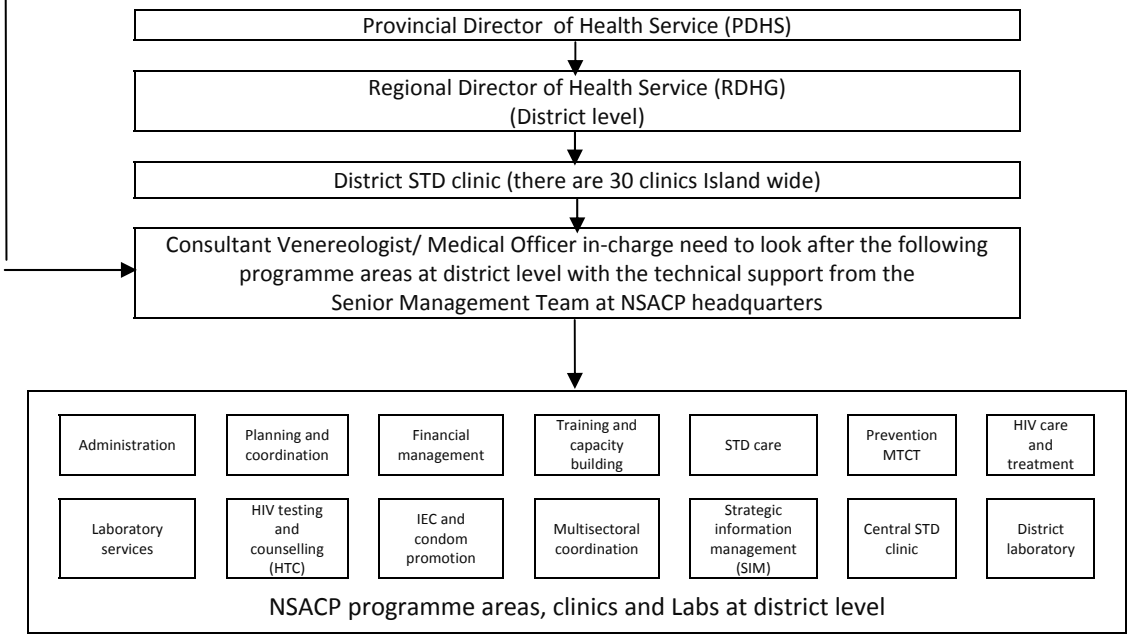
NSACP is a specialized public health programme that comes under the Deputy Director General of Health Service (Public Health Service 1) abbreviated as DDGHS (PHS 1) of the ministry of health. Director, NSACP in consultation with the senior management team (SMT) provides leadership and technical guidance to both preventive and curative services in the country. Senior management team (SMT) handles different programme areas of the NSACP which include 1. Administration, 2. Planning and coordination. 3. Laboratory services, 4. HIV testing and counselling, 5. Financial management, 6. IEC and condom promotion. 7. Training and capacity building, 8. Multisectoral coordination, 9. STD care, 10. HIV care, 11. Prevention of mother to child transmission, 12. Epidemiology, 13. Strategic information management. (8)

Peripheral STD clinic staff works under the technical guidance of the director and the programme area coordinators in the senior management team. However, administratively STD clinics are under provincial government. (8) The organizational structure of the central government level and provincial government level is outlined below.

The Organogram of the Headquarters of the NSACP under Central Government



The organogram of the Provincial Government (Provincial Councils)



Partnership and multi-sectoral coordination

Multi-sectoral coordination exists at different levels in the organizational structure of the national response to HIV.

Partnership at National AIDS committee/sub-committee level: all the stakeholders take part in HIV related activities and decisions at the national AIDS committee (NAC) level. Public, private, civil society organizations and development partners participate at different sub-committees of the NAC. Following are the main sub-committees operational at the national level.

1. Treatment, care and laboratory services subcommittee
2. Multisectoral coordination and prevention sub committee
3. Information education and communication sub committee
4. Legal and ethics sub-committee
5. Strategic information management sub-committee

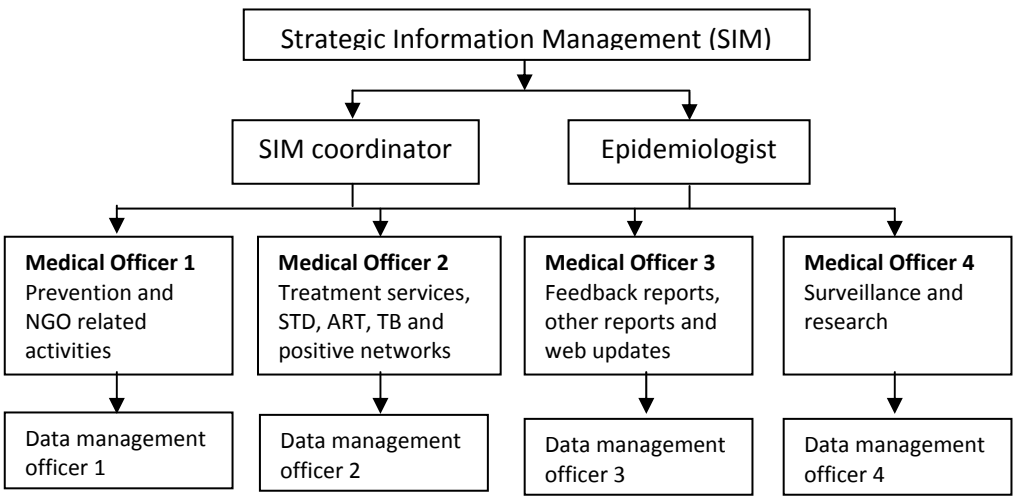
Multisectoral coordination: the Multisectoral coordination of the national STD/AIDS control programme is being carried out by the Multisectoral unit of the NSACP.

Partnership and coordination in Global fund context: multiple sectors are coordinated at country coordination mechanism (CCM) and at the Joint Programme Implementation unit (JPIU) where different partners are involved when implementing GFATM related activities.

Description of the national HIV M&E system

UNAIDS "three ones principal" endorsed in 2004, has given clear directions on the coordination of AIDS response in a country. One agreed country level monitoring and evaluation system is one of the important three principles. Strategic information management (SIM) subcommittee of the national AIDS committee with interrelated SIM unit is the main body of the national level monitoring and evaluation system. All other entities work as reporting units to the SIM unit. (9)

Organizational structure of the strategic information management unit of the National STD/AIDS control programme is outlined below.

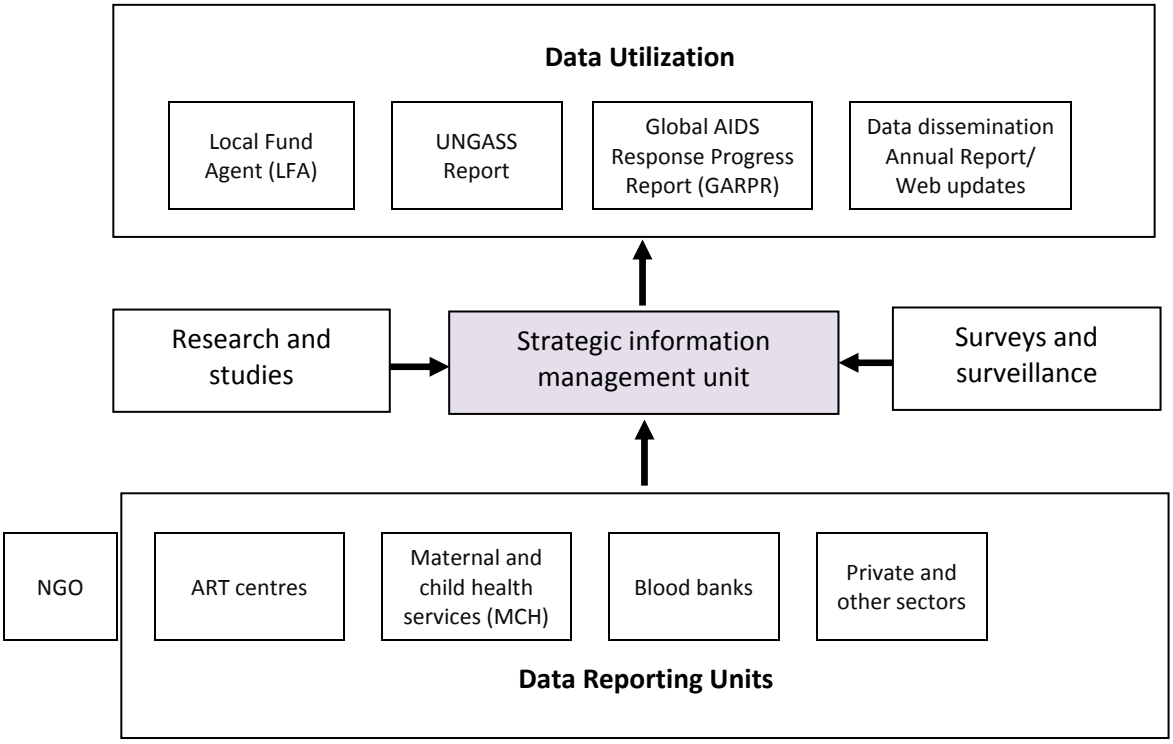


Coordination of HIV M&E partnerships

HIV M&E partnerships are strengthen through the collaborations of partners within the SIM subcommittee. In addition, coordination exists in the joint programme implementation unit (JPIU) which was mainly formed to discuss the GFATM related programme implementations.

In the HIV M&E system, most of the other entities are acting as data reporting units for the national HIV M&E system although they have their own M&E organizational structures for project-based M&E.

The SIM unit itself has wide array of data receiving and disseminating channels as outlined in the graph below. There are number of data reporting units that particularly report essential data for major indicators for the overall results-based M&E. Most of other data are used at the entity level for programme monitoring as per the M&E pipeline. (9)



Assessment methodology

12-component monitoring and evaluation system strengthening tool (MESST) was used to assess the national M&E system of Sri Lanka. MESST is a self assessment tool and participant themselves conduct the assessment with the support of a facilitator. MESST is an organizing framework to develop joint M&E systems. The tool has 12 components in 12 Excel sheets with M&E related statements where participants have to collectively grade the statements by considering the country context and experience. The tool has another Excel sheet as a check list for the national HIV M&E plan.

One day workshop was conducted in Colombo, on 12th of December 2014 at the Hotel Taj Samudra with the participation 29 multi-sectoral and multi level resource persons who were identified in the stakeholder analysis. Then the workshop facilitator has given a PowerPoint presentation on the MESS tool format and relevant instructions to complete this self assessment tool.

The 12-component assessment tool was administered among three mixed groups. Then each group was given 4 components (4 Excel sheets) to be completed during the activity. 12-component workbook opened in the format of "all stakeholder categories" using the relevant drop down option in the cover page of the tool. Three MESS tool categories (columns in the Excel sheet) were used for each component as mentioned in the table.

Level	Categories in MESS tool	Participant organizations
National level	Ministry of health, AIDS control programme	National STD/AIDS control programme, Ministry of health
National level	HIV/AIDS umbrella organizations	Family Health Bureau (FHB), Health Education Bureau (FHB), Family Planning Association, National Dangerous Drugs Control Board (NDDCB), Heart to Heart (SSR/MSM), Community strength development foundation (CSDF), Alcohol and Drug Information Centre (ADIC), Sri Lanka Red Cross (SSR/MSM), Population Services Lanka (PSL), UNAIDS, UNDP, Save the children, World Vision, Local Fund Agent (LFA)
Sub national level	Health facilities	STD clinics, ART centres, FPA service delivery points, Private sector health facilities

Groups were initially formed by 1, 2, 3 counting and then the composition was adjusted to have almost equal sectoral representation and power. Each group was named by a colour (as Purple group, Orange group and Yellow group). The purple group was given component 1, 2, 3, and 6 (relevant excel sheet-tabs were coloured in purple). The orange group was given components 4, 5, 7, 10 and the National M&E plan checklist sheet (sheet-tabs coloured in orange). The yellow group was given component 8, 9, 11, and 12 and corresponding sheet-tabs were coloured in yellow.

Each group reviewed their respective allocated components, and at the end, each group was given time to discuss the findings of the assessment before all the stakeholders. During the presentations, tool statements, relevant dashboard bars and action points were discussed and suggestions were noted down by the members of the respective smaller groups (colour groups). Then again a period

of time was given to re-grade the tool statements and also review the action points based on the discussions and suggestions. Then the facilitator consolidated the work sheets to the master workbook.

Assessment results

Component 1: Organizational structure with M&E

The overall objective of the implementation of this component among stakeholders is to establish and maintain an effective network of organisations responsible for HIV M&E at national, sub-national and service delivery levels. (10)

Assessment results
Strengths: National STD/AIDS control programme (NSACP), in the ministry of health has the inherent right to execute the main and pivotal role of the "three ones principal". Strategic information management unit (SIM Unit) of the NSACP coordinate the activities of M&E functions in liaison with the SIM sub-committee of the National AIDS Committee (NAC) which has a multi-sectoral and multi-level representation of stakeholders.
Weaknesses HIV M&E functions are not clearly mandated to other partner organizations and entities. However, the data are available on demand basis from other partner entities. Staff of the SIM unit is recruited under different grades in the ministry of health. However, separate M&E cadre has not been identified by the MOH to execute HIV M&E functions. Appropriately skilled HR is not available in most of the entities while some of the M&E positions are vacant.
Summary of key action points Review the strategies and organizational design and make necessary changes (functional task analysis). Identify and fill the vacant positions with appropriately skilled persons. Develop TORs/Job descriptions for SIM unit staff, umbrella organizations and at health facility. Develop a database format for electronic remote data entry.

Component 2: Human capacity for HIV M&E

The objective of the administration of this component of the tool is to ensure adequate skilled human resources at all levels of the M&E system in order to complete all activities defined in the costed, national HIV M&E work plan (10)

Assessment results
Strengths: SIM unit is co-headed by the SIM coordinator and Epidemiologist who are Doctorate level public health specialist trained in clinical and prevention medicine. Most of the M&E needs of the country can be fulfilled by the SIM unit with the partnership of the government and non-government entities.

Most of the national level government entities, umbrella organizations and health facility level have M&E positions either fulltime or partime.
On the job M&E training with supportive supervision is available as part of human capacity building process.

Weaknesses

National HIV M&E human capacity building plan is not available.
Some entities have M&E responsible persons but without proper work specialization.
National HIV M&E training curriculum is not available.

Summary of key action points

National M&E human capacity building plan need to be developed with the support of an international consultant including M&E related to MSM&TG.
Nationally endorsed M&E training curriculum (inclusive of MSM and TG) need to be developed.
National M&E human capacity building workshops need to be conducted.
Opportunities for regional and extra regional training on HIV M&E should be created.
Induction training programme should be developed for new recruits.

Component 3: HIV M&E partnerships

The objective of this component is to establish and maintain partnerships between internal units, external M&E entities and international stakeholders involved in planning and managing the National HIV M&E system (10)

Assessment results

Strengths:

Partnerships are better established within the SIM sub-committee of the national AIDS committee where most of the public, private, civil society organizations and development partners are involved.
SIM sub-committee working as the Technical Working Group (TWG) to makes decisions via a consensus building process.
Small country context and shared national HIV action framework of GFATM further strengthen partnership and collaboration.

Weaknesses

Some stakeholders are underrepresented in the SIM subcommittee especially sub-national level partners.
Some entities do not actively contribute in the SIM sub-committee because of their less capacity for HIV M&E functions.

Summary of key action points

SIM sub-committee TOR need to be reviewed and updated considering all aspects of M&E functions with special emphasis on MSM and TG.
Development of set of practical forms for data reporting should be done for the private sector and NGO sector.
Feedback system, need to be developed for private and NGO sector other than web updates and annual report.

Invite more M&E stakeholders in other sectors (private and NGOs) to SIM sub-committee.

Component 4: National HIV M&E plan

The objective of this component of the tool is to highlight the need of development and maintenance of a national M&E plan including identified data needs; national standardised indicators; data collection tools and procedures; and roles and responsibilities, in order to implement a functional national HIV M&E system. (10)

Assessment results
Strengths There is a multi-year, multi-sectoral and multi-level national HIV M&E plan for the period from 2013-2017 which coincide with the National strategic plan. National HIV M&E plan is well linked to the national strategic plan (NSP 2013-2017). HIV M&E plan had been developed with multi-entity participation.
Weaknesses All 12-components are not well described within the document there are gaps to be improved specially (a). Baseline values for indicators, (b). Midterm and end term targets, (c). M&E budget (d). Supportive supervision and data auditing procedures, (e). surveys and surveillance guidelines, protocols and governance. Sectoral HIV M&E plans or entity specific plans are not well linked to national M&E plan.
Summary of key action points NAC should have an M&E role with a proper mandate and TOR. Roles and responsibilities of each entity should be clearly defined. National M&E plan has to be improved to include all indicators related to MSM and TG in future versions.

Component 5: Costed HIV M&E work plan

This component of the tool does a self assessment of the stakeholders about the need of a multi-partner and multi-year M&E work plan as the basis for planning, prioritising, costing, resource mobilisation and funding of all HIV M&E activities. (10)

Assessment results
Strengths The need for the development of costed national M&E plan has been identified and currently it is under process of development.
Weaknesses Costed M&E plan is not available for implementation.
Summary of key action points Development of the national HIV M&E work plan.

Component 6: HIV M&E advocacy, communications and culture

The objective of this component assessment is to ensure knowledge of, and commitment to, HIV M&E and the HIV M&E system among policymakers, program managers, program staff, and other stakeholders. (10)

Assessment results
Strengths There are directors, mangers and people who strongly advocate for and support M&E within the entities and they request HIV-related information for reviews and planning. The need for strategic information has been clearly included in the national HIV policy. M&E heads are part of the management and planning team of the entities.
Weaknesses Project-based M&E culture is more established than overall result-based M&E. Vertical and lateral career movement of HIV M&E persons within the entities are limited.
Summary of key action points HIV M&E workshops need to be carried out for various sectors to improve the M&E culture within the government and other sectors with special emphasis on MSM and TG. M&E advocacy meetings for various sectors with the emphasis on MSM and TG should be planned and implemented.

Component 7: Routine programme monitoring

This component assesses the ability to produce timely and high quality data from routine data management efforts. (10)

Assessment results
Strengths Routine programme monitoring systems are well established as project-based M&E in all entities in order to show results for donors (GFATM etc). NSACP has routine monitoring of programme data through data reporting units (STD clinics, internal program units, national blood transfusion service (NBTC), National programme for TB control and chest disease (NPTCCD) etc). Data collection, recording and reporting system in the NSACP is well established with necessary disease definitions, and guidelines for maintenance of registers and reporting of data. Private sector HIV testing data is available to the NSACP. Outputs of the routine programme monitoring contribute mostly to the indicators of the national M&E plan. There are on the job training and in service training for routine programme monitoring needs.

Weaknesses

Routine monitoring data in most of other entities are for project-based M&E.

MSM and TG population data are usually considered as MSM data without a clear disaggregation.

Routine monitoring data are not linked to the SIM unit in some entities where ad hoc small grant implementation exist.

Other government sector data are not routinely sending to the SIM unit. However, they are available in on-demand basis.

Summary of key action points

Guidelines are to be developed for all programme areas which do not have guidelines both in health facility and community levels.

Adequate resources should be allocated to all the relevant entities for M&E.

Component 8: Surveys and surveillance

Surveys and surveillance component of the MESS tool assess the ability of stakeholders to produce timely and high-quality data from surveys and surveillance. (10)

Assessment results

Strengths

Surveys and surveillance conducted to date have contributed to most of indicators in the national M&E plan.

HIV sero-surevillance data are available from 1991 and had targeted appropriate populations and conducted every 1-2 years.

Mapping and size estimation data are available for key populations in 2010, 2012, and 2013.

First behavioural surveillance survey done in 2006/07, and integrated biological and behavioural survey has completed recently and awaiting results.

Demographic and health surveys are routinely conducted by the department of census and statistics (latest report was in 2006/07).

Regular HIV screening of donated blood is being carried out by the NBTS

Has a strong TB screening and surveillance system.

National HIV related surveys and surveillance reports are available in the NSACP website under downloads.

Weaknesses

Some surveys are not available at correct time frequency.

Still there are gaps in different HIV related indicators.

Surveys and surveillance studies done by some of other entities are not easily accessible.

Less effort for qualitative research.

MSM and TG disaggregation is not available in most of surveys. Both groups had been considered under MSM.

Summary of key action points

Surveys and surveillance inventory need to be developed.

Health facility surveys at HIV related service delivery points need to be planned and conducted.

National surveys on condom availability and use need to be planned and conducted.

Component 9: National and sub-national HIV databases

This component of the MESS tool assess the ability of entities to develop and maintain national and sub-national HIV databases that enable stakeholders to access relevant data for policy formulation, program management and improvement. (10)

Assessment results
Strengths In the SIM unit, Excel workbooks are used as data entering, editing and storage for routine programme monitoring. There is a Patient Information Management System (PIMS) for clinical data with data querying facilities and export facilities. However, system is in the process of revamping. FPASL has developed a total M&E system for the GFATM related data management. Most of other entities manage data using the spreadsheet facility of Ms Office.
Weaknesses No complete functioning database management system at national and sub-national level.
Summary of key action points Appoint a dedicated M&E person at sub-national level for data management and reporting. Need to develop and make available infrastructure, manpower positions including funds for reporting centres such as ART centre at IDH and some entities with high HIV data loads.

Component 10: Supportive supervision and data auditing

This component of the tool assesses ability of entities to monitor data quality periodically and address obstacles to producing high quality data (i.e. valid, reliable, comprehensive, and timely). (10)

Assessment results
Strengths Currently supportive supervision is provided when developing quarterly return of STD and ART at the NSACP. As implementers of GFATM grants both NSACP (PR1) and the FPA (PR2) provide supportive supervision, field visits and data verification to meet the demand of performance based funding. Ad hoc clinical audits are carried out by postgraduate students in the field of Venereology.
Weaknesses There are no national guideline and tools for supportive supervision on M&E and data auditing and feedback mechanism.
Summary of key action points Need to develop national guidelines and tools for supportive supervision on M&E. A protocol for data auditing should be developed.

Component 11: HIV research, evaluation and learning

Objective of this component of the MESS tool is to assess the ability to identify key evaluation and research questions and coordinate studies to meet the identified needs. (10)

Assessment results
Strengths

HIV research documents are available at the SIM unit and relevant documents in other entities.
SIM sub-committee or the Senior Management Team (SMT) or specially appointed Research and surveillance advisory committees take responsibilities in approving HIV research and evaluations.
HIV research and evaluation agenda which was agreed by the SIM sub-committee of the NAC exist.
Research and evaluation findings are used for policy formulations, planning and implementation of activities and projects.
Reviews of the HIV national response are conducted in each time before the development of NSP. Country level stakeholders, university academics, and international experts participate in national response reviews.
Research and evaluation findings are shared with stakeholders in the SIM sub-committee or progress review meetings, MO conferences (in NSACP).
There are national conferences or forum for dissemination and discussion of HIV research and evaluation findings.

Weaknesses

Inventory of research and evaluation articles or documents is available in an entity (AIDS foundation of Lanka). However, there are many limitations in the system.
No guidelines on evaluations, research standard and methods available. However, the responsible committees are examining these requirements.

Summary of key action points

Conduct a workshop to update the AIDS Foundation Lanka database structure (including research documents, reports, books etc), content and searching facilities.
HIV research and evaluation related activities should be mandated to the SIM subcommittee and SMT of the NSACP.

Component 12: Data dissemination and use

This component of the MESS tool assesses the ability to disseminate and use data from the M&E system to guide policy formulation and program planning and improvement. (10)

Assessment results
Strengths Information products are regularly disseminated to all the stakeholders by web updates and annual reports. Most of the stakeholder information need are met by the NSACP and partner organization. Information need assessment is done verbally at SIM sub-committee meetings. Standard data collection, tabulation and recording system has been developed as excel workbooks in NSACP.
Weaknesses Relatively less information generation than data descriptions. Difficulty in generalization of information due to survey or study limitations especially due to hidden nature of behaviours. Information products are not tailored to different segments of the audiences. Dissemination schedule is not known by most of the entities.

Summary of key action points

Development of, information need assessment mechanism in the SIM subcommittee.

Conduct workshop to improve the system of data analysis and data presentation and dissemination using the guidelines of WHO/UNAIDS.

Consultative workshop to develop Quarterly STI data dissemination sheets as available for HIV.

Prioritization of feasible next steps

Systematic administration of 12-component MESS tool in the national context facilitates the stakeholders to identify their own gaps in the M&E at organizational level. Furthermore, the tool provides valuable inputs to stakeholders who participate in the national HIV M&E system of the country. Sometimes it is not feasible to rectify all the deficits and gaps. Therefore, prioritization of feasible next steps is important to plan and implement high impact activities in the backdrop of resource limitations.

Priority areas

National AIDS Control Programme

Functional task analysis need to be carried out in order to review and develop the organizational structure with HIV M&E posts, job descriptions, and terms of references for reporting units.

Task force/TWG within the SIM subcommittee can be appointed to work on assessment of data needs, and the development of set of forms for other data reporting entities.

NSACP and the SIM subcommittee need to work on the development of the national HIV M&E work plan which is currently under the process of development (National HIV M&E plan, and National HIV M&E work plan should be made available with the development of the time bound national strategic plan).

HIV M&E system assessment and HIV M&E plan reviews need to be carried out periodically.

Consultative training workshops for other partner entities should be planned and conducted as a capacity building process.

Efforts should be taken to conduct health facility surveys and condom availability and use surveys etc.

Umbrella organizations

Some of the entities need appropriately skilled persons for HIV data management and reporting and they should be given clear mandate.

Need to provide consultative technical support to community based-organizations for HIV M&E capacity building.

Plan and develop national guidelines and tools for supportive supervision and data auditing mechanism for entities with relatively high HIV data loads.

Periodic data quality audits should be planned and conducted.

Conduct training programmes for capacity limited entities.

Health facility level

Health facilities should have at least one skilled person fulltime or part time, based on the work load, who can commit with HIV M&E needs. The infectious Disease Hospital needs a fulltime M&E person to carry out data recording and reporting activities.
Conduct M&E training workshops as a capacity building process for health facilities.
Include M&E responsibilities to the job description of persons handling data at facility level
Arrange incentive scheme for data mangers at the health facility level.
Private sector health facilities should be encouraged to provide data to the national HIV M&E system through private health service regulatory council of Sri Lanka.

List of recommendations

Component 1: Organizational structure with M&E
Recommendations
Review of the organizational design with the overall objectives of HIV M&E system (Functional Task Analysis). Mapping of HIV M&E entities and creation of new cadre positions where substantial amount of STD/HIV data are handled (e.g. STD clinics etc). Sub-national level (Provincial or District level) HIV M&E should be strengthen as part of decentralization of HIV M&E. Written HIV M&E mandate should be given to the reporting units and partners of M&E system Written and documented TOR/Job descriptions should be available at all entities in relation to the HIV M&E. HIV M&E vacancies should be filled with appropriately skilled persons. Fulltime IT specialist should be employed to SIM unit and the entities with high demand for HIV data.

Component 2: Human capacity for HIV M&E
Recommendations
Human capacity and capacity development should focus on individual level, organizational level and system level. National HIV M&E human capacity building plan and curricula should be developed to improve the M&E standards in all entities. Opportunities for regional and extra regional HIV M&E training workshops, meetings, and conferences should be created and provided. National databases should be made available on the HIV M&E trainers and related technical service providers as well as those who received training. HIV M&E training course can be initiated at national level for capacity building.

Component 3: HIV M&E partnerships

Recommendations
Task force should be created within the TWG (SIM sub-committee) to develop set of practical forms for routine reporting of data and also need to develop feedback mechanism for health data providers. Inventory of stakeholders for HIV M&E should be created, maintained and periodically updated. Invite new partners to SIM sub-committee based on stakeholder inventory updates.

Component 4: National HIV M&E plan
Recommendations
The national M&E plan should describe the implementation of all twelve components of a national HIV M&E plan. The national HIV M&E plan should adhere to international and national technical standard for HIV and AIDS M&E. National HIV M&E plan can be revised based on the findings of periodic M&E system assessments.

Component 5: Costed HIV M&E work plan
Recommendations
Costed, multi-year, multi-sectoral and multi-level HIV M&E work plan should be developed according to the international and national technical standards. All entities should commit to the national M&E work plan. Take measures to integrate HIV M&E work plan budget to the government budget.

Component 6: HIV M&E advocacy, communications and culture
Recommendations
Need to strengthen the knowledge and understanding of “M&E system concept” beyond the organizational M&E designs. HIV M&E communication and advocacy plan should be there either as a standalone document or integrated to national HIV communication strategy. HIV M&E advocacy programmes should be conducted to cover the provincial or district level managers.

Component 7: Routine programme monitoring
Recommendations
Creating a task force within the SIM sub-committee can work on the routine data gaps and take remedial measures. Mechanisms and procedures should be made to reconcile discrepancies in reports and data. Conduct in-service and on the job training covering all the entities.

Component 8: Surveys and surveillance
Recommendations

All protocols for surveys and surveillance should be based on international standards.
Qualitative studies should be planned and implemented among MSM and TG populations to understand the reality of their behavioural risk factors in order to plan effective interventions.
Operations research and innovations should also be considered for MARPs interventions.
Health Facility surveys and national surveys on condom availability and use should be encouraged.
Inventory of all HIV related surveys and surveillance conducted should be maintained with annual updates.

Component 9: National and sub-national HIV databases

Recommendations

High quality database management system should be developed for patient information management and for HIV M&E indicators and dashboard generation at the central level with remote data entry from other entities.
Appropriately skilled persons should be made available at data entry entities to the national system.

Component 10: Supportive supervision and data auditing

Recommendations

It is necessary to develop national guideline and tools for supportive supervision on M&E and data auditing mechanisms.
Routine supervision visits, data assessment and feedback should be carried out periodically.
Periodic data quality audits should be planned and performed.
Supervision reports and audit reports should be developed and made available for data reporting entities.

Component 11: HIV research, evaluation and learning

Recommendations

Develop an inventory of completed and on-going country specific HIV research and evaluation documents and articles.
Support the country-specific HIV related indexed database for easy searching and querying of articles and documents with links to the entity specific websites.
Encourage and promote research in the field by arranging research grants for postgraduate students and university academics.

Component 12: Data dissemination and use

Recommendations

Data use plan should be identified in the national HIV M&E plan.
Stakeholders, information need assessment, need to be conducted using a standard methodology.
Information products need to be tailored to the different segment of the audience.
Sub-national level information products should also be generated for decentralized actions

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Annex I – List of workshop participants

List of workshop participants		
1	Dr Sisira Liyange	Director, National STD/AIDS Control Programme, Ministry of Health.
2	Dr K A M Ariyaratne	Consultant Venereologist and Coordinator Strategic Information Management, National STD/AIDS Control Programme.
3	Dr Jayadarie Ranatunga	Consultant Venereologist and Coordinator MSM interventions under GFATM (R9/PII), National STD/AIDS Control Programme.
4	Dr Chinthaka Malavige	Medical officer, Strategic information management, NSACP.
5	Dr R Batuwantudawa	Consultant Community Physician and M&E coordinator, Health Education Bureau, Ministry of Health.
6	Ms K A D H Lakmini	Research officer, National Dangerous Drugs Control Board (NDDCB).
7	Dr Dayanath Ranatunga	Country Manger, UNAIDS, Sri Lanka.
8	Mr Chandana Jayalal	Programme Support officer, UNDP, Country office, Sri Lanka.
9	Ms Thushara Agus	Executive Director, Family Planning Association of Sri Lanka.
10	Ms Madusha Dissanayake	Director advocacy/HIV and focal point for Multi-country South Asia Global Fund programme, Family Planning Association of Sri Lanka.
11	Dr Thiloma Munasinghe	Consultant, 7-cities Multi-country study, Family Planning Association of Sri Lanka (FPASL).
12	Mr Asitha Punchihewa	Project Manager, GFATM (R9/PII) Principal recipient 2.
13	Mr Suchira Suranga	Director, M&E, Family Planning Association of Sri Lanka.
14	Ms Nadika Fernandopulle	Assistant Director HIV/AIDS and Project officer for DU & MSM component under GFATM (R9/PII), FPASL.
15	Mr S D Kalhara Senadhira	Manager M&E, Family Planning Association of Sri Lanka.
16	Mr Nishshanka Mudalige	Assistant M&E Officer (GFATM (R9/PII), Family Planning Association of Sri Lanka.
17	Ms Umanga Settinayake	Program Coordinator, Family Planning Association of Sri Lanka.
18	Dr Sujatha Samarakoon	Public Health Specialist, Local Fund Agent of GFATM, PwC
19	Mr H A Sudath Priyantha	M&E Officer, Community Strength Development Foundation
20	Mr Jude Fernando	Executive Director, Heart to Heart Lanka
21	Mr S Mohottiarachchi	Project Coordinator (GFATM R9/PII MSM component), Heart to Heart Lanka
22	Mr Amil Epa	Program Manager, Institute of Participatory Interaction in Development (IPID).

23	Mr Thushara Senanayake	Project Coordinator (GFATM R9/PII MSM/DU component), Saviya Development Foundation (SDF), Galle.
24	Mr K H C L Kasthuri Arachchi	Project coordinator (GFATM R9/P2 MSM component), Sri Lanka Red Cross, Anuradhapura
25	Mr V S Pothuwila	Field Supervisor (GFATM R9/P2 MSM component), Sri Lanka Red Cross, Anuradhapura.
26	Ms A R S Raheema	M&E Officer, Alcohol and Drugs Information Centre, Sub-recipient for GFATM R9/PII drug user component.
27	Ms Jeyaseely Francis	ZD and M&E Coordinator, World Vision Lanka
28	Ms Nanditha Katugampola	Project Manager, Population Services Lanka (PSL).
29	Mr K Ramaneish	Consultant, M&E.

Annex II – Costed HIV M&E work plan

Costed HIV M&E work plan based on the recommendations and suggestions made at the MESS tool workshop related to MSM, TG and HIV

Service delivery area	Ref: No	Activity title	Activity description	Responsibility	Estimated Cost	Potential source of funds	Technical Assistance (specify if needed)	Year 1				Year 2			
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Organizational structure with M&E (UNAIDS M&E component 1)	1.1	Functional task analysis (FTA) for the review and development of HIV M&E system	20-days consultancy with 4 stakeholder support meetings (30 participants each)	NSACP	25,300	GFATM	Need, 20-day consultancy service	X							
	1.2	Filling of HIV M&E vacant positions with appropriately skilled persons	2 persons in the NSACP, 3 persons in Umbrella organizations) for 2 years	NSACP	1,336	GFATM	No	X							
	1.3	Incentive payments for additional M&E work at entity level	Extra payments for handling HIV data in addition to their routine work (50 persons at a rate of 92 USD per month)	NSACP/ FPA	4,580	GFATM	No	X							
	1.4	Development of HIV M&E plans for selected 3 umbrella organizations	Consultancy 20-day consultancy service with 6 support meetings with 15 participants each (two meetings for each organization)	FPA	28,830	GFATM	Need, 20-day consultancy service		X						

Service delivery area	Ref: No	Activity title	Activity description	Responsibility	Estimated Cost	Potential source of funds	Technical Assistance (specify if needed)	Year 1				Year 2			
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.Human capacity for HIV M&E (UNAIDS M&E component 2)	2.1	Development of National HIV M&E human capacity building plan (including MSM and TG inputs)	Consultancy service for 10 days and two support meetings each with 40 participants	NSACP	20,000	GFATM	Need, 10-day consultancy service			X					
	2.2	Development of M&E training curriculum	10-day consultancy for the participatory development of the curriculum with 3 support meetings (30 participants each)	NSACP	21,380	GFATM	No				X				
	2.3	Conduction of HIV M&E human capacity building workshops	Conduction of three 2-day training workshops (30 participants each)	NSACP	21,750	GFATM	No					X	X	X	
	2.4	Regional and extra regional meetings	Regional and extra regional workshops or meeting attendance as a capacity building for HIV M&E high grade staff (6 persons/5 day programme)	NSACP/ FPA	22,500	GFATM	No	X	X	X	X	X	X	X	X
3. HIV M&E partnership (UNAIDS M&E component 3)	3.1	Conduction of consultative meetings to assess HIV M&E related data needs, data reporting forms, feedback system, stakeholder inventory	6 consultative meetings, each with 20 resource persons derived from SIM sub-committee	NSACP	14,650	GFATM	No		X						

Service delivery area	Ref: No	Activity title	Activity description	Responsibility	Estimated Cost	Potential source of funds	Technical Assistance (specify if needed)	Year 1				Year 2			
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4.HIV M&E advocacy, communication and culture (UNAIDS M&E component 6)	4.1	Development of HIV M&E advocacy and communication plan	10-day consultancy with 2 support meetings, 30 participants each	FPA	15,000	GFATM	Need, 10-day consultancy service			X					
	4.2	Conduction of HIV M&E advocacy meetings	Conduction of 6 advocacy meetings covering all provinces in order to improve the M&E culture and communication within and different entities	FPA	22,200	GFATM	No			X	X	X			
5. Routine programme monitoring (UNAIDS M&E component 7)	5.1	Development of HIV M&E operational Procedures (SOPs) for 3 selected organizations	30 days consultancy (TOR elements: desk review, study current procedures, gap analysis, data collection, recording and reporting formats, means of verifications, M&E product dissemination and use) with 6 consultative meetings	FPA	32,500	GFATM	Need, 30-day consultancy service			X					
	5.2	Training of M&E staff on the SOPs as capacity strengthening	Conduction of training workshops based on entity specific SOP (3 meetings each has 20 participants)	FPA	5,000	FPA	No					X	X	X	

Service delivery area	Ref: No	Activity title	Activity description	Responsibility	Estimated Cost	Potential source of funds	Technical Assistance (specify if needed)	Year 1				Year 2			
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6. Survey and surveillance (UNAIDS M&E component 8)	6.1	Health facility survey for HIV related services delivery points (multisector) consultancy	A survey to ascertain the availability of HIV related service delivery points and their facilities available (including all sectors)	NSACP	9,160	Government	No	X	X						
	6.2	Condom availability and use survey - Plan and conduct a national survey on condom availability and use (Survey consultancy)	A national survey on condom availability and use. No previous studies done on this even as baseline	FPA	15,200	GFATM	No	X	X						
	6.3	Qualitative/quantitative research grants for studies among MSM and TG populations (3 studies per year)	Qualitative research (in depth interviews / FGD to understand the realities of HIV prevention interventions among MARPs (MSM and TG)	NSACP/ FPA	22,900	GFATM	No	X	X	X	X	X	X	X	X
7. National and sub-national HIV databases (UNAIDS M&E component 9)	7.1	Development of a web-based Information Management System	A password protected interface is developed to the existing website of the NSACP for remote data entry by umbrella organizations	NSACP	11,500	GFATM	No			X					
	7.2	Development of Unique Identification Code (UIC) 5 day local consultancy	5-day local consultancy with two consultative workshop (40 participants each) to develop and recommend an Unique Identifier Coding (UIC) system for MARPs (MSM and TGs)	NSACP/ FPA	5,470	GFATM	No		X						
	7.3	infrastructure for M&E for reporting units	Computer and internet access (10 lap top computers with 10 dongles for internet facilities and maintenance cost)	NSACP/ FPA	18,200	GFATM	No	X							

Service delivery area	Ref: No	Activity title	Activity description	Responsibility	Estimated Cost	Potential source of funds	Technical Assistance (specify if needed)	Year 1				Year 2			
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
8. Supportive supervision and data auditing (UNAIDS M&E component 10)	8.1	Conduct supportive supervision visits	This include feedback and recommendations on HIV M&E (visits by 5 local supervisors to 20 selected units during a the period)	NSACP/ FPA	61,100	GFATM	No					X	X	X	X
9. HIV research, evaluation, and learning (UNAIDS M&E component 11)	9.1	Development of library database including article indexing, survey and surveillance inventory and document repository	Consultancy to update the database of the AIDS Foundation Lanka including article indexing, survey and surveillance inventory, document repository (consultancy for library format development by participatory approach with need assessment 2 meetings and consultancy payments for the maintenance	FPA	14,500	GFATM	No	X							

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