Community-led Monitoring for HIV Services in Sri Lanka

Report of the pilot project 2023

fpa SRI LANKA enriching relationships

SK PA·2

National STD/AIDS Control Programme SRI LANKA

Lanka Plus Towards Positive Living

Acknowledgments:
Community-led Monitoring (CLM) is a community-owned and community-led intervention for service optimisation, introduced for the improvement of HIV services in Sri Lanka as a pilot project in June 2023. The CLM tool was developed by Health Equity Matters (formerly Australian Federation of AIDS Organisations - AFAO) and partner organisations with financial assistance from the Global Fund, for the sustainability of HIV services for key populations in Asia (SKPA). The SKPA-2 toolkit was developed based on the experiences of the first SKPA-1 programme with the support and involvement of Health Equity Matters, Asia-Pacific Coalition on Male Sexual Health (APCOM), the Asia-Pacific Transgender Network (APTN), the Asia-Pacific Network of People living with HIV (APN+), the Asia-Pacific Network of Sex Workers, and the Philippine NGO Pinoy +.

The following SKPA-1 sub recipients are also acknowledged: Save the Children Bhutan, the Family Planning Association in Sri Lanka, the Community Health and Inclusion Association in the Lao People's Democratic Republic, Youth for Health Center in Mongolia, Burnet Institute in Papua New Guinea, Love Yourself in the Philippines, Estrella+ in Timor-Leste, and the Malaysian AIDS Council. We also thank the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the Global Fund for their significant contributions.

National consultant, CLM Pilot Sri Lanka
Dr Ajith Karawita, MBBS, PGDV, MD, FSLCoSHH

Report Authors
Dr Ajith Karawita, MBBS, PGDV, MD, FSLCoSHH & F. Zahrah Rizwan

Lead organisation
Family Planning Association of Sri Lanka

FPA and SKPA programme staff
Mr. Jake Oorloff. Programmeme Officer- SKPA2, The Family Planning Association of Sri Lanka
Mr. Ranaka Siriwardana. Project Officer- SKPA2, The Family Planning Association of Sri Lanka
Ms. Sonali Gunasekara, Director, Advocacy, The Family Planning Association of Sri Lanka.

Technical working group
Mr. Palitha Wijayabandara (Chair), Dr. Ariyaratne Manathunga and Dr. Sathya Herath, Mr. Lakshan Fernando, Ms. Nadika Fernandopulle, Mr. Amal Bandara, Mr. Mahesh Nissanka, Mrs. Imasha Perera Kumarawadu, Mr. Manju Prasanna Hemal, Mr. SPI Niroshan, Mr. Singhe S Wickrmsinghe, Mr. Ranjith Liyanage, Mrs. Januka Thilakaratne, Ms. Kanthi Abeykoon.

Research staff: Mr. SPI Niroshan Senadheera, Mr. Tiran Peiris, Ms. Delusha Perera, Mr. PW Chamara Pushpakumara, Mr. DA Inodha Thathsarana, Mr. D Hirusha Shean, Mr. ALAS Dilshan Abeygoda, Mr. AA Abeynayake.

Electronic version of document: accessed at www.fpasrilanka.org

Suggested citation: Family Planning Association of Sri Lanka, 2023. Community-led Monitoring of HIV Services in Sri Lanka; Report of the pilot project 2023, Colombo.

Published by: Family Planning Association of Sri Lanka, No 37/27, Bullers Lane, Colombo 07, Sri Lanka.

30th June 2023

Community-led Monitoring for HIV Services in Sri Lanka

Report of the pilot project 2023

Executive Summary

Ending AIDS as a public health threat by 2030 is a global target to save millions of people around the world from HIV infection. Sri Lanka aims for HIV diagnosis, treatment, and viral suppression rates to be 95%-95%-95% by 2025 on its path to end AIDS by 2030, in line with the 2030 agenda of the United Nations Sustainable Development Goals (UN-SDG).

Although Sri Lanka is considered a low prevalent country, with the HIV prevalence rate estimated below 0.1%, the country's diagnosis, treatment, and viral suppression rates were at 86%-80%-87% as of 2022. Achieving the 95% target requires high quality HIV services to be provided to key populations that need it most.

Currently HIV and STI services in Sri Lanka are provided mainly by the National STD/AIDS Control Programme (NSACP) under the Ministry of Health through a network of 41 STD clinics island wide. In addition, there are community health systems that provide HIV services mainly in the Colombo and Gampaha district. The national estimate for People Living with HIV (PLHIV) is 4,100 (2022), while 2,992 PLHIV are receiving HIV treatment and care services. Government STD clinics are annually reached by 51,240 (2021) people for HIV and STI related services.

This community-led monitoring (CLM) pilot project was introduced as a method to receive feedback on HIV services by the service users themselves, whose input would be valuable in improving the services offered to high risk, key populations in Sri Lanka. The standard set of indicators monitored were Availability, Accessibility, Acceptability, Quality (AAAQ), as well as Satisfaction and prevalence of Serious Incidents.

The CLM pilot project evaluated responses of 133 men, belonging to the Men who have Sex with Men category, who attended four selected HIV service facilities. Below is a summary of CLM results from the pilot study with the average score per indicator across all facilities. These values need to be interpreted with an understanding of the operationalisation of the indicator.

The satisfaction score is an overall independent mark assigned by the participant and is not dependent on any other criteria. The serious incidents captured in this report are not limited to the men who have sex with men (MSM) sample, so as to give a more comprehensive assessment of serious incidents reported at these facilities.

Your Guide to Navigating the Report

This report provides an overview of the CLM pilot conducted in four selected clinics in Sri Lanka. The reader can gain insights into the functionality of the CLM pilot in Sri Lanka and the feedback received for each clinic. The information presented in this report under the indicators of Availability, Accessibility, Acceptability and Quality helps identify areas of intervention required at each clinic. However, it is important to note that the CLM pilot is not a research study aimed at exploring the broader landscape of HIV service providers in Sri Lanka and should not be regarded as such. Given the variations in geographic location, available resources, and the scope of services provided by each clinic, using this tool to draw direct comparisons between them would not yield accurate results.

Here are some important things to keep in mind when looking at the results:

How the scores are calculated: The scores are based on a method that considers only the forms where all the questions were answered with a "yes." Forms where a question about a particular indicator was left unanswered or answered "no" was not considered in the score calculation for that indicator.

The AAAQ indicator scores: The score for each indicator is determined by the specific set of sub indicators assigned to each of it. For example, the overall score for Accessibility is determined by responses to all the three aspects of location safety, opening hours, and affordability.

Sample size matters: The number of forms filled out varied between clinics. Colombo STD Clinic and Community Clinic had more forms than Gampaha STD Clinic and Colombo HIV Clinic, so it is important to keep that in mind when interpreting the results.

Table of Contents

List of Acronyms and Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
AEM	Asian epidemic model
AFAO	Australian Federation of AIDS Organisations
APCOM	Asia Pacific coalition on male sexual health
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community based organisation
CLM	Community-led monitoring
CoC	Code of conduct
CSO	Civil society organisation
FPA	Family Planning Association
FPASL	Family Planning Association of Sri Lanka
FSW	Female sex workers
GDP	Gross domestic product
H2H	Heart 2 heart
HCW	Healthcare worker
HIV	Human immunodeficiency virus
ICWAP	International community of women living with HIV Asia & Pacific
KP	Key population
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSACP	National STD/AIDS control programme
PLHIV	People living with HIV
PrEP	Pre exposure prophylaxis
PWID	People who inject drugs
RA	Research assistants
SAQ	Self-administered questionnaire
SI	Serious incidents
SKPA	Sustainability of HIV services for key populations in Asia
SOP	Standard operating procedure
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
TG	Transgender
TWG	Technical working group
UIC	Universal identification code
UNAIDS	United Nations programme for AIDS
USD	United States Dollar

1. Introduction

1.1 Setting the context

Sri Lanka is a tropical island located off the Southern coast of India. The island has a rich multi-ethnic population of 22.1 million people, speaking Sinhala, Tamil and English as their primary languages. Sri Lanka has an average life expectancy of 77 years and a Human Development Index of 0.782 (2019 figures). In 2021, the country's GDP amounted to 88.9 billion USD, with a per capita GDP of 4,014 USD (Central Bank of Sri Lanka). In 2020, the average literacy rate was 93% and as of 2021, computer literacy stood at 34.3%, while digital literacy was estimated at 57.2% (Department of Census and Statistics, 2021).

HIV Status

Sri Lanka's HIV prevalence is less than 0.1% in the general population and less than 5% in any of the key populations, making it a low–level epidemic country. As of 2022, the estimated number of people living with HIV was 4,100 with new HIV infections <200, AIDS deaths <100 and the adult HIV incident rate <0.01%.

The data indicates the estimated number of PLHIV stabilised during 2000-2022 while new HIV infections for the same period showed a declining trend (NSACP, 2022).

The 95-95-95 (%) target

In line with UN SDG standards, Sri Lanka aims to achieve a 95%-95%-95% rate for HIV diagnosis, treatment, and viral suppression by 2025. As of 2022, these figures were 86%-80%-87% (NSACP, 2022). Of the 4,100 PLHIV, the number of prevented deaths was 1,491, with 2,992 persons receiving HIV treatment and care services (2022). Of these PLHIV, 2,947 were on antiretroviral (ART), and 2,391 reported viral suppression.

Key Populations

Key Populations (KP) of interest in the National Strategic Plan of Sri Lanka (2023-2027) are Men having Sex with Men, Female Sex Workers, Transgenders, People Who Inject Drugs, Beach Boys[1] (community preferred term is tourism service providers) and People in closed settings (Prison inmates). KP interventions in Sri Lanka are mainly carried out by the Ministry of Health on collaborative projects and programs with NGOs and CBOs.

1 It is important to note that the term 'beach boys' is used in this report to align with the National Programme's use of the term. Communities have called for the use of de-stigmatizing language and we support the community's call for the term Tourism Service Providers, to be used instead.

In 2019, of the 3,550 people living with HIV;

31% were low risk males, 26% men who have sex with men, 25% low risk females, 14% clients of female sex workers, and 4% female sex workers. The percentage of male people who inject drugs is estimated to be almost zero.

Annual new infections of key populations as per the results of the Asian Epidemic Model (AEM), is at an estimate of 137 new infections in 2019.

Of these, 53% were recorded among men who have sex with men, 21% among clients of female sex workers, 15% among low risk women, 5% among male people who inject drugs, 4% among female sex workers, and 2% among low risk males. The percentages of new infections among men who have sex with men are increasing over time (SLCoSHH, 2020).

1.2. About SKPA-2

The SKPA-2[2] Programme (July 2022- June 2025) is funded by the Global Fund to fight AIDS, Tuberculosis, and Malaria in Bhutan, Mongolia, The Philippines, and Sri Lanka. It also promotes the sustainability of high-quality, priority HIV services in these countries. The grant was built on the SKPA-1 Programme, existing Global Fund-supported programmes in the country and multi-country grants for key populations, all with the aim to provide the strategic, programmatic, and financial environment for countries under transition from Global Fund support.

The SKPA-2 Programme has four objectives:

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

The SKPA-2 Programme works with multiple partners to achieve these objectives, through a three-year, USD12.5 million programme financed by the Global Fund, for the period 1 July 2022 to 30 June 2025.

2 Sustainability of HIV Services for Key Populations in Asia – 2

1.3. Why Community-led Monitoring (CLM)?

The CLM method helps meet the aim and objectives of SKPA-2 in several ways. Participant centric feedback ensures that the data gathered on HIV services is based on evidence and real experiences. The feedback helps highlight priority services, identify which services require improvement as well as any existing barriers to service access etc., in order to make meaningful improvements. By empowering key populations to play a role in improving HIV services that they directly access, the CLM method could encourage continued monitoring and follow ups.

1.4. Objectives

General objective

The objective of the pilot project is to assess the feasibility of Community-Led Monitoring (CLM) to improve HIV services offered to key populations in Sri Lanka.

Specific objectives

1. To determine the availability of HIV services sought by key populations
2. To determine the accessibility of HIV services by key populations
3. To determine the acceptability of HIV services by key populations
4. To describe the quality of HIV services as reported by key populations
5. To understand the level of satisfaction of HIV services as felt by key populations
6. To study the prevalence and follow up actions of serious incidents faced by key populations

2. CLM Pilot Overview

2.1. The Framework

This pilot project gathered data from those seeking or receiving services at selected HIV/STD clinics. 138 individuals participated in the study. Given that Sri Lanka's highest number of new infections are recorded among men having sex with men (MSM), the pilot focused only on MSMs who sought HIV related services during the month of June 2023. Of the total participants, **133** belonged to the selected MSM Key Population category.

Three government clinics and one community clinic were selected for the pilot:

Government clinics:

1. STD Clinic, Colombo
2. STD Clinic, Gampaha
3. HIV Clinic Colombo

Community clinic:

1. Heart 2 Heart (H2H) Clinic, Colombo

2.2. Data collection

Tools

The data collection tool in the SKPA -2 toolkit was used to implement the CLM pilot study. The toolkit included generic tools which were adjusted to the Sri Lankan context.

a. **CLM Client Form:** The main Self-Administered Questionnaire (SAQ) used to receive the feedback
b. **CLM Follow up Form:** To record further details from those who reported a serious incident while seeking/ receiving services
c. **Consent Form:** Provided participants with details about the project to obtain their informed consent
d. **Code of Conduct (CoC):** Ethical guidelines that all those involved (including the research team) agreed upon.

The above documents were translated into Sinhala by professional language translators. The translations were reviewed by the CLM Technical Working Group (TWG) and amended where necessary for clarity or to match the content accurately.

Approach

The research assistants (RA) identified men who have sex with men by using networks of known clients, those already registered and receiving services through KP projects and those who attend clinics for PrEP.

The potential participants were invited to the study and informed about the project. Consecutive clients were requested to provide feedback on services offered by the clinics on selected days. Questionnaires were shared with them after their consent was obtained.

The **CLM Client Form** was completed in different settings such as;
a. Within a space provided by the service facility
b. Outside the facility as an exit interview
c. In community sites after receiving services at selected facilities
d. Responses were also obtained via a telephone conversation by the research assistant[3]

CLM Follow Up Form is to be completed by the 'Case Manager' appointed for the study. Case Managers are required to scrutinise the completed CLM Client Forms and check for any serious incidents that may have been recorded. If any of the serious incidents were marked and follow up was marked as yes, and if the participant is willing to go ahead with the complaint, the Case Manager is expected to take necessary action based on the Standard Operational Procedures (SoP) of the Case Management (See Annex VIII).

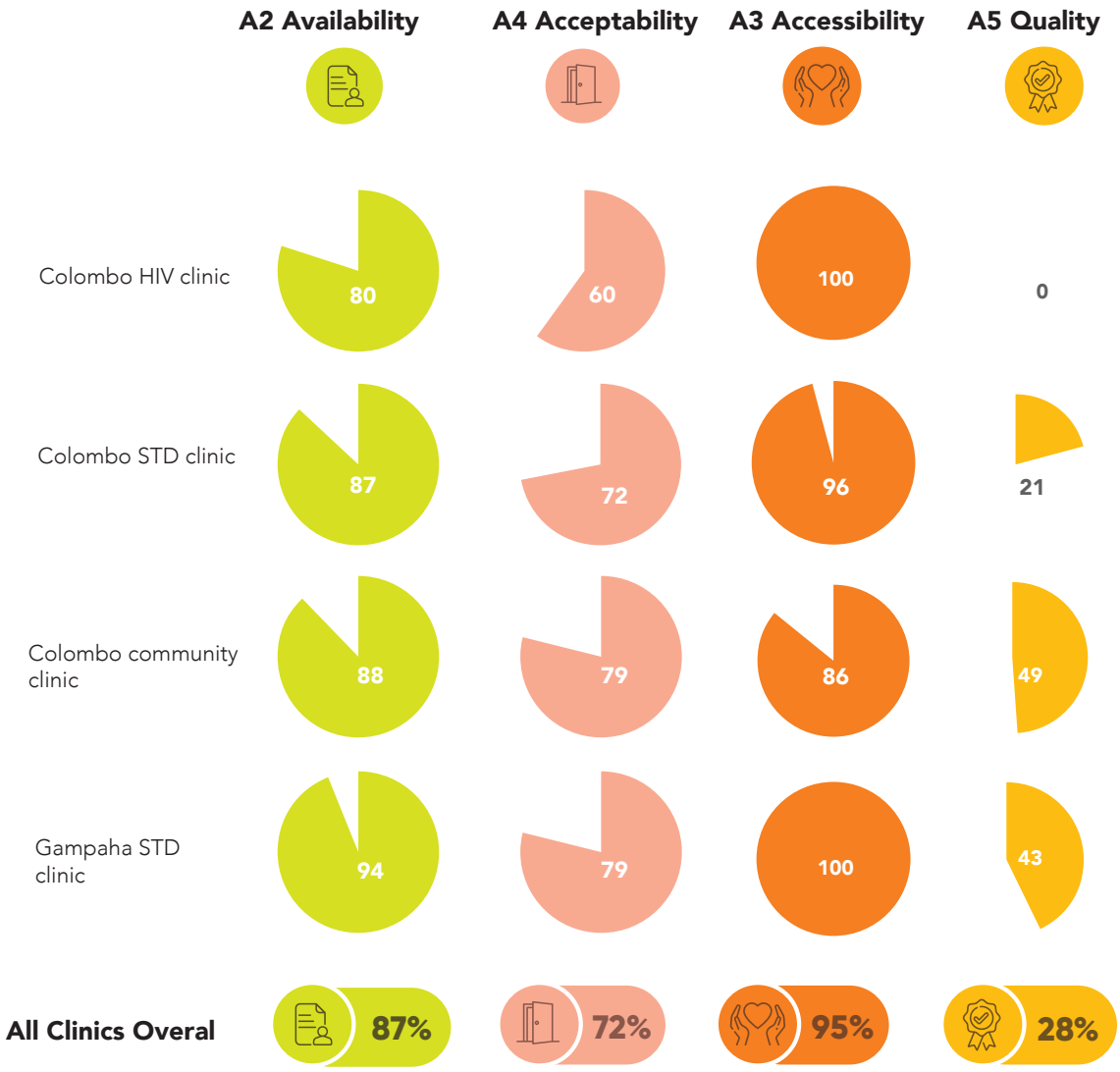
3 Informed consent was obtained over the phone in this instance.

2.3. Making sense of the data

Data was analysed on an Excel workbook with dedicated sheets for instructions, data entry, CLM indicators and the dashboard. A serial number and a Unique Identification Code (UIC)[4] was used for identification purposes. All possible outcomes (categorical variables) were entered under drop-down menus. Quantitative data was entered as measures (in number values). Excel formulas were used to count responses for the calculation of the CLM indicators.

The standard set of indicators provided in the SKPA-2 toolkit were used to assess HIV related services at each facility. The indicators and their method of calculation are elaborated in Annex VI (SKPA2, 2022).

Below is a breakdown of the CLM indicators with the overall AAAQ score as a percentage across all facilities.



4 The UIC was formed with a reproducible syntax (two letters of first two names/two-digit birth month/two-digit birth date/two English letter postal code of the district of birth/one letter for assigned biological sex at birth (M-male, F-female, I-inter sex).

The satisfaction score is an overall independent mark assigned by the participant and is not dependent on any other criteria. The serious incidents captured in this report are not limited to the men who have sex with men (MSM) sample, so as to give a more comprehensive assessment of serious incidents reported at these facilities.

2.4. Quantifying the responses

Availability indicator:

The number of responses filled in as all sought HIV services received
—Divided by—
The number of responses with any HIV service sought

Accessibility indicator:

The number of responses filled in as satisfied with all three questions
(related to 1. location safety, 2. opening hours, 3. affordability)
—Divided by—
The number of responses with all three questions answered

Acceptability indicator:

The number of responses filled in as satisfied with all three questions
(related to 1. respectful treatment, 2. consent, 3. privacy/confidentiality)
—Divided by—
The number of responses with all three questions answered

Quality:

The number of responses filled in as satisfied with all three questions
(related to 1. items received, 2. information received, 3. waiting time)
—Divided by—
The number of responses with all three questions answered

Satisfaction:

Average of the decile rank given in the feedback form about overall satisfaction;

Serious incidents prevalence:

Number of responses filled in as experienced a serious incident
(1. stigma and discrimination, 2. violence, 3. harassment, 4.breach of privacy/ confidentiality, 5. service refusal. 6. pain/distress)
—Divided by—
The number of responses having at least one HIV service sought and received.

2.5 Ethical Considerations

Community-led monitoring (CLM) is considered as a programme activity and not a research. Therefore, an ethical approval from an ethical review committee for CLM was not obtained. Instead, institutional approvals were obtained from the Ministry of Health and the National STD/AIDS Control Programme, and the community-based health facility included in the pilot project. The CLM activity carried out in Sri Lanka was a pilot study involving participants from 4 selected sites. The following ethical principles have been applied to all CLM activities:

Voluntary participation: The participation in the CLM activity is completely voluntary. Participants were allowed to withdraw at any time from the survey without giving a reason. Their right to receive services from a health facility was not related in any way to their participation or non-participation in CLM activities.

Informed consent: All participants were fully informed about the pilot project before obtaining their consent. The pilot was conducted after obtaining informed consent from all participants.

Confidentiality: Any identifying information was not made available to anyone except with the express consent of the participants. Identifying information, such as telephone numbers in the case of serious incident reporting, have been stored securely and will only be used for service follow-up and referral purposes.

Anonymity: The anonymity of individuals participating in CLM was protected using a UIC.

Privacy: All data collected during CLM was managed in a way that protects the privacy of participants (visual and auditory privacy) and the confidentiality of the information they provide, so that feedback cannot be linked to the individual who provided it.

Do No Harm: Everything has been done to ensure that individuals involved in CLM are protected from psychological or physical harm that could result from their participation.

Code of Conduct: A Code of Conduct (CoC) was signed by all individuals involved in carrying out the CLM activity.

These ethical principles were also included in the training for those involved in CLM including data collection, management, and analysis.

3. Results

CLM Indicators Overview

A1 CLM Participation	133
A2 HIV Service Availability	87%
A3 HIV Service Accessibility	72%
A4 HIV Service Acceptability	95%
A5 HIV Service Quality	28%
A6 HIV Service Satisfaction	9.2
A7 Prevalence of Serious Incident	3% (4)
A8 Prevalence of Stigma & Discrimination	1.5% (2)

Serious Incident Follow-up Mechanisms

50%
B1 Serious Incident Follow-up Attempts

50%
B2 Successful client follow- up of serious incidents

100%
B3 Accurate reporting of serious incidents

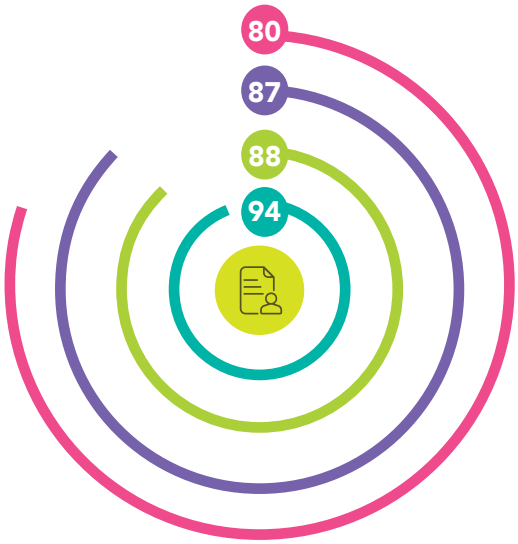
0
B4 Referrals to services following a serious incident

100%
B5 Successful and timely resolution of serious incidents

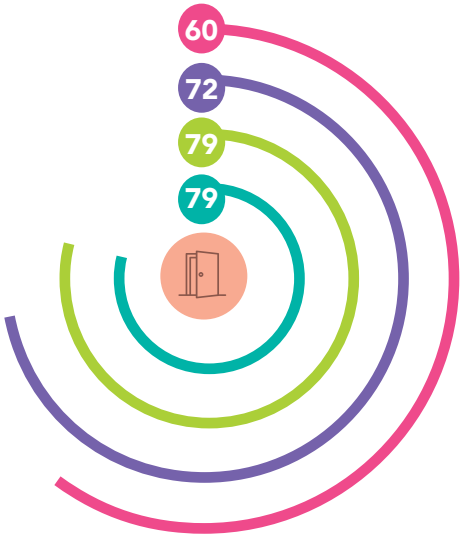
Sri Lanka CLM AAAQ Inidicators by Clinic Location

Colombo HIV clinic | Colombo STD clinic | Colombo community clinic | Gampaha STD clinic

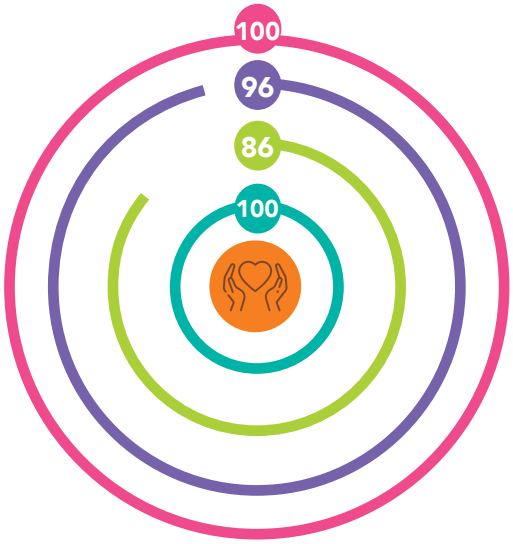
A2 Availability



A3 Accessibility



A4 Acceptability



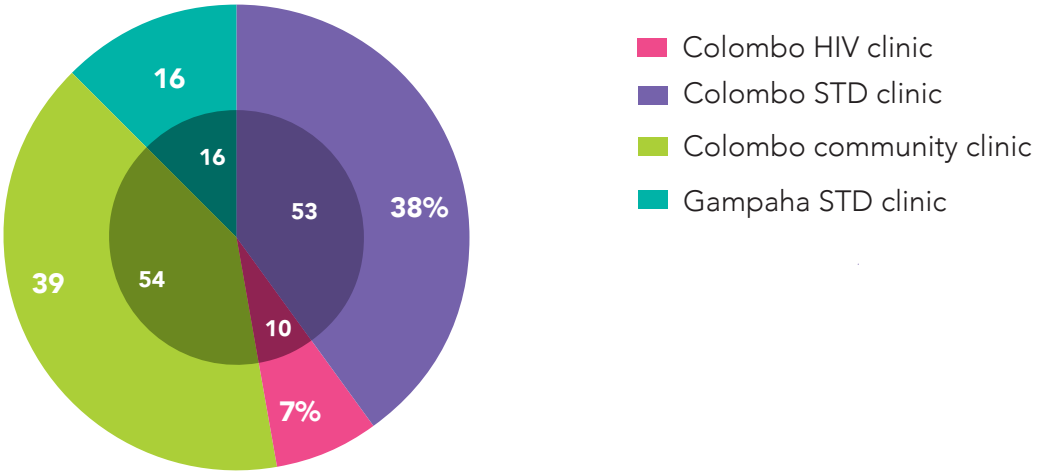
A5 Quality

All Clinics Overall

87% | 72% | 95% | 28%

3.1. CLM participation

A total of 133 men having sex with men KP participants shared their feedback and no one filled more than one CLM form. The representations below show CLM participation by the type of health facility, age category and risk behaviour.



CLM Participation Rate

Research assistants invited potential participants to fill in the CLM Client Form. However, on average 1-3 persons out of 10 refused to participate in the pilot. The main reason for their refusal was the lack of time. Some noted that the CLM Client Form was too long, and that they had doubts about confidentiality. Responses from clinic attendees of the Colombo HIV clinic were the lowest. The reason for the low participation being the restrictions imposed by the head of the facility (due to not having been adequately informed previously about the CLM survey). Therefore, research assistants resorted to other ways of getting responses from HIV clinic attendees such as completing CLM forms as they walked out of the clinic, subsequent meetings at community clinics, and telephone conversations with members of the People Living with HIV organisation. The Gampaha STD clinic also had low number responses due to the low number of client attendance and limited time available for data collection.

CLM participation by age category indicated that over two-third of feedback were from men who have sex with men above 25 years of age[5].

5 Although the total no. of MSM participants were 133, two of them had not marked their age category. Therefore, the above breakdown is for 131 MSMs. This applies to the age-wise breakdown of figures across the report.

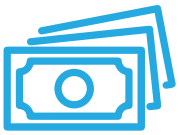
Other behaviour recorded by MSM participants

Of the 133, men who have sex with men participants, 23% engaged in sex with women and 14% used recreational drugs, 5% engaged in commercial sex work and 2% engaged in injecting recreational drugs. These behaviour types are not exclusive and could be overlapping for some MSM participants.

23%

Male-to-female sex
31 participants

05%



Money/goods in exchange for sex (CSW)
6 participants

14%

Use of recreational drugs (PWUD)
18 participants

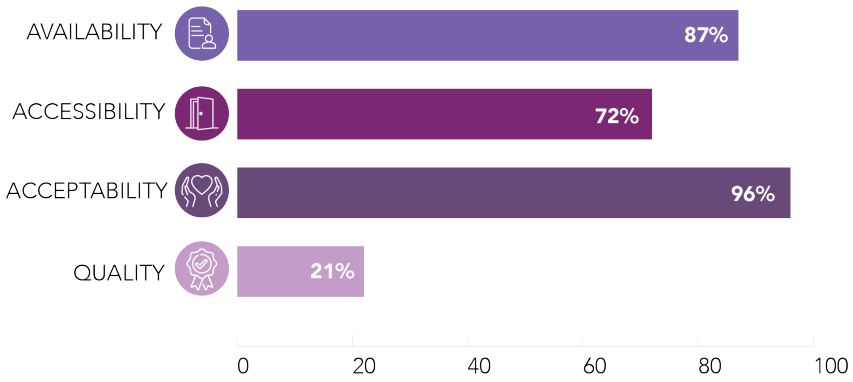
02%

Injected recreational drugs (PWID)
3 participants

3.2. Assessment of the Colombo STD Clinic

A total of **53 men having sex with men KP participants** responded to the CLM form at the Colombo STD Clinic.[6]

Colombo STD Clinic AAAQ



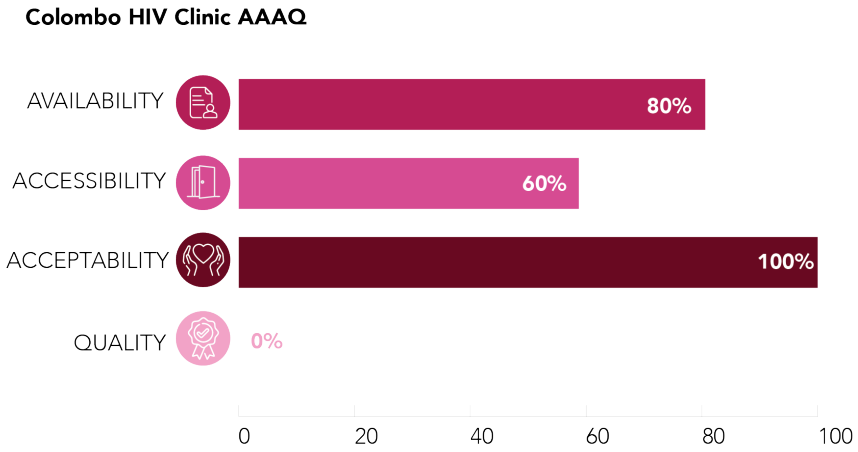
The Colombo STD Clinic (CSC) scored well for **Acceptability** and **Availability,** in that order. However, the score for accessibility was relatively lower (72%) and the facility scored the lowest (21%) on quality. **Accessibility** in the pilot study was measured on location safety, opening hours, and affordability. The lowest scoring sub-indicator of the three was affordability. 24% of those who rated affordability said the clinic was not affordable. **Quality** of services was measured based on items received, information received and waiting time. The lowest scoring sub-indicators for quality were waiting time and items received. 68% said they had to wait too long to see the health care provider and 20% said they did not receive the items they needed.

> **"It would have been better if they provided a quicker service. Displaying the clinic number on a screen instead of calling out names and numbers would be an improvement."**

6 Although the total no. of MSM participants were 133, two of them had not marked their age category. Therefore, the above breakdown is for 131 MSMs. This applies to the age-wise breakdown of figures across the report.

3.3. Assessment of the Colombo HIV Clinic

A total of **10 men having sex with men KP participants** responded to the CLM form at the Colombo HIV Clinic.



The Colombo HIV Clinic (CHC) scored well for **Acceptability** and **Availability.** The score for accessibility was relatively lower at 60% and the facility received a zero on the Quality score.

The 100% score for Acceptability, indicates that all participants were treated respectfully, the staff seeked their consent and maintained privacy and confidentiality. In terms of Accessibility, all participants said the location was safe and the opening hours were suitable. However, affordability had the lowest score. 40% (four out of ten participants) said the clinic was not affordable.

Since none of the participants at the Colombo HIV clinic were satisfied with all three sub-indicators, namely items received, waiting time, and information received, the clinic has a collective score of zero for **Quality**[7]. 30% said they did not receive the items they needed, 20% said they had to wait too long to see the health care provider, and 10% said they did not receive the information they needed.

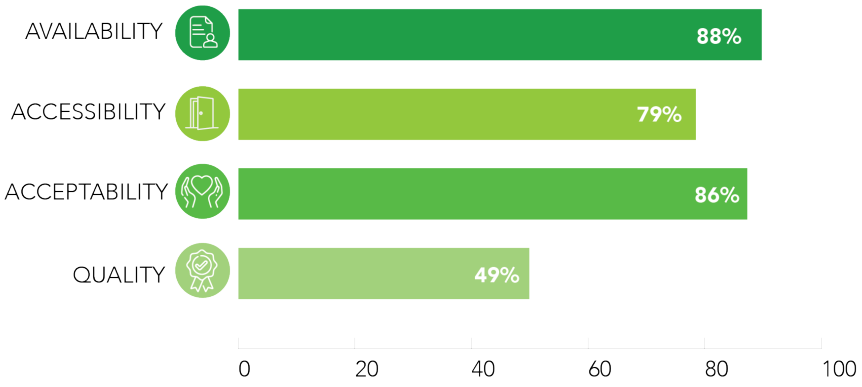
> **Administer enough medicines of proper quality in the prescribed dosages and ensure there is an uninterrupted supply. In the future, make sure actions are taken to avoid situations that leads to people having to take expired medication.**

7 The zero score on quality should be understood in context of the scoring and calculation method of the study. To get a score above zero, at least one participant must find all the quality criteria acceptable. If every participant scores even one of the sub-indicators negatively, this would result in a collective score of zero as no one has been wholly satisfied with the quality of the facility (based on the criteria provided).

3.4. Assessment of the Colombo Community Clinic

A total of **54 men having sex with men KP participants** responded to the CLM form at the Colombo Community Clinic.

Colombo Community Clinic AAAQ



The Colombo Community Clinic (CCC) recorded high scores for **Acceptability** and **Availability.**in that order. The facility scored relatively lower on accessibility and lowest on the Quality indicator (49%).

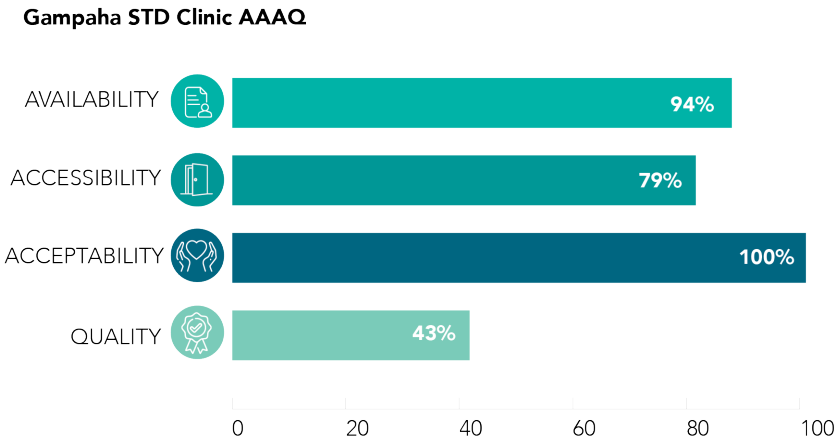
For the **Quality** indicator, waiting time had the lowest score followed by items received. 41% said they had to wait too long to see the healthcare provider and 12% said they did not receive the items they needed.

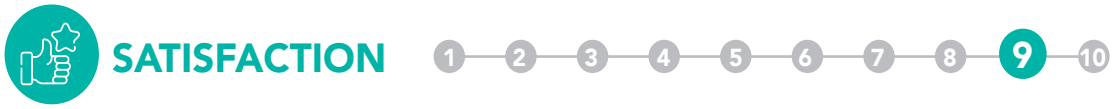
It is important to note the occurrence of four serious incidents reported at the CCC. More details in Section 3.6.

> **"The location and the service of the staff are both commendable."**

3.5. Assessment of the Gampaha STD Clinic

Total of **16 men having sex with men KP participants** responded to the CLM form at the Gampaha STD Clinic.





The Gampaha STD Clinic (GSC) recorded a 95% rating for Acceptability and 84% for Availability. The quality indicator was scored lowest at 43%.

The 95% score for **Acceptability,** indicates that most participants were treated respectfully, the staff seeked their consent and maintained privacy and confidentiality. In terms of **Accessibility**, a key point to note is that 13% (two out of sixteen) of participants found that the location was not safe.

Of the sub-indicators for the Quality indicator, the worst performing sub indicator was waiting time. 47% said they had to wait too long to see the healthcare provider.

> **"It would be an improvement if the areas for blood collection and the administration of ART or other medications were established indoors"**

3.6. Serious incidents

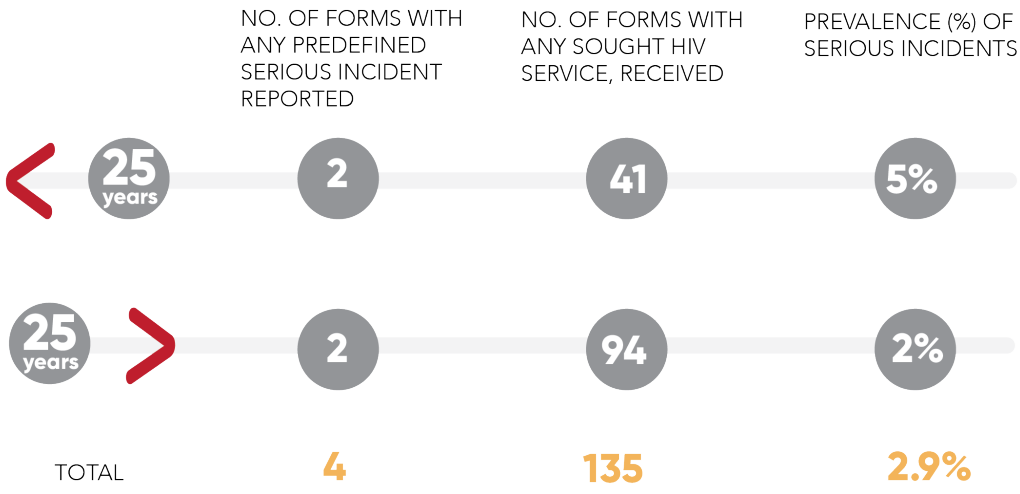
Serious incidents refer to an experience of:

- Stigma and discrimination
- Violence due to visiting the clinic
- Harassment (including sexual) from the service staff or other clients
- Breach of privacy or confidentiality
- Refused service because of gender, identity, race, risk behaviour or other
- Pain or distress
- Or any other reason (to be specified)

Participants were able to mark more than one serious incident on their feedback form and could provide further details if they opted to. The number of serious incidents refers to the number of individual incidents a participant faced even if that single incident touched on more than one of the above sub indicators. For example, the refusal of service due to a participant's gender may have also caused pain and distress. However, this would be considered one serious incident.

Overall, four serious incidents were recorded by four individuals.[8]

The breakdown of serious incidents reported by age groups shows that the prevalence of serious incidents was slightly higher among men who have sex with men who were below 25 years (4.7%) compared to those over 25 years 2.2%). However, the interpretation of data is difficult with a low number of reported cases.



8 The serious incidents captured in this report are not limited to the men who have sex with men (MSM) sample, so as to give a more comprehensive assessment of serious incidents reported at these facilities. The other individual (cisgender male) did not mark their key population category/ risk behaviour.

3.6.1. Serious Incident Breakdown

Serious Incident: Case Number 1

Clinic: Colombo HIV Clinic

Type of incident as reported in the client form:

- Stigma and discrimination
- Violence due to visiting the clinic
- Breach of privacy or confidentiality

Report:

An employee at the NSACP clinic had told people in the participant's neighbourhood that he had attended a medical examination at the clinic. The participant also stated that the doctors had made negative comments about the participant.

Follow up action:

- Successful Contact was made based on the contact information provided in Client Form.
    - The Case Manager provided the complainant with information on what CLM is and how the information provided will be handled, including the protocol that will be followed in maintaining privacy and confidentiality of the complainant.
- The complaint was documented via the Serious Incident Follow Up Form after the complainant provided consent to proceed.
- The Case Manager requested consent to escalate the complaint to the Serious Incident Management Committee.
    - The complainant did not provide consent/chose not to escalate the incident to the SIM Committee.
    - The Case Manager provided Dr. Karawita's phone number for further conversations if required[9]. The complainant discussed with Dr. Karawita and chose not to escalate the matter to the SIM Committee.

9 Dr. Ajith Karawita (Consultant Venereologist, Teaching Hospital, Anuradhapura and Head of the Institution, Provincial Health Training Centre, Anuradhapura) for the purpose of the pilot study advocated for the CLM.

- **Reasons provided:** Client feared reprisals from the accused if any action was taken. Given that the client and the accused live in the same locality the potential of him tracing the complaint back to the client was high. He feared that any action would further jeopardise his physical safety and privacy.

Serious Incident: Case Number 2

Clinic: Colombo Community Clinic

Type of incident as reported in the client form:

- Stigma and discrimination
- Violence due to visiting the clinic
- Harassment (including sexual) from the service staff or other clients

Report:

The participant reported that the doctor asked him multiple questions about the participant's role/ positions when engaging in sex and persistently asked personal questions about the complainant's sexual partners.

Follow up action:

- Successful Contact was made based on contact information provided in Client Form.
    - The Case Manager provided the complainant with information on what CLM is and how the information provided will be handled, including the protocol that will be followed in maintaining the privacy and confidentiality of the complainant.
- The complaint was documented via the Serious Incident Follow Up Form after the complainant provided consent to proceed.
- The Case Manager requested consent to escalate the complaint to the Serious Incident Management Committee.
- The complainant did not provide consent/chose not to escalate the incident to the SIM Committee.
- The Case Manager provided Dr. Karawita's phone number for further conversations if required.
    - The complainant discussed with Dr. Karawita and chose not to escalate the matter to the SIM Committee.
    - **Reasons provided:** The client chose not to escalate the incident due to concerns that returning to the same clinic might lead to an uncomfortable situation or embarrassment, particularly if the matter was escalated. There was a fear of encountering the same doctor after lodging the complaint. He reported that he will return to the same clinic even after the complaint was made but also requested to be able to choose between speaking to a male or female doctor.

Serious Incident: Case Number 3

Clinic: Colombo Community Clinic

Type of incident as reported in the client form:

- Violence due to visiting the clinic
- Harassment (including sexual) from the service staff or other clients

Report:

- No further comments/ details were added.
- Follow up action: No contact details were provided by the participant for follow up. Therefore, this incident is not included in the follow-up ratings below.

Serious Incident: Case Number 4

Clinic: Colombo Community Clinic

Type of incident as reported in the client form:

- Breach of privacy and confidentiality

Report:

- No further comments/ details were added.
- Follow up action: No contact details were provided by the participant for follow up. Therefore, this incident is not included in the follow-up ratings below.

3.6.2. Follow up of serious incidents

Process of follow up and incident resolution:

- The participant was contacted by the case manager to follow up on the initial complaint and to document the case via the CLM Follow Up Form.
- The client was given the option of proceeding with the complaint to the Serious Incident Management (SIM) Committee and/or accessing pro bono counselling and/ or legal services by a peer or trained professional (not belonging to the same clinic where the incident was reported)

All four (4) clients who reported a serious incident during this pilot, declined escalating the case to the Serious Incident Management Committee, due to fear of further stigma and discrimination.

The number and percentage of serious incident reports followed up is also an important way of measuring the initial action taken when a serious incident has been reported by a client. Albeit this does not capture how the serious incident has been resolved. The indicator is calculated by dividing the number of CLM follow up forms with one or more attempts made to contact the clients by the number of CLM client forms filled in with one or more incidents reported.

No of CLM Follow-Up Forms with one or more attempts made to contact the client	No of CLM Client Forms with serious incidents reported	Rate of serious incidents followed up for further details (percent)
2	**4**	**50**

3.6.3. Successful contact of serious incidents

The number and percentage of serious incident reports where a successful contact was made is used as an indicator and is calculated by dividing the number of follow-up forms with successful attempts; by number of follow-up forms with one or more attempts were made. All attempts made were successful.

Successful contact is an important indication of meaningful engagement with key populations in addressing their concerns and reports. Where successful contact is not made, the reporting of serious incidents falls short in being a meaningful feedback method and could lead to community mistrust in CLM.

No of follow-up forms with successful attempts	No of follow-up forms with one or more attempts were made	Rate of successful attempts (percent)
2	2	100

3.6.4. Correctly reported serious incidents

The number and percentage of serious incidents correctly recorded is an indicator to identify the correct reporting of serious incidents by the clients. The indicator is calculated by dividing the number of follow-up forms with correct reporting of a serious incident (true serious incidents) by the number of follow-up forms with yes or no to serious incidents.

No of follow-up forms with true serious incidents	No of follow-up forms with "yes" or "no" to serious incidents	Rate of correctly reported serious incidents (percent)
2	2	100

3.6.5. Referral of incidents to relevant support services

The number and percentage of serious incidents referred to services (such as health services, social services and legal services) is an indicator to understand the referral rate. The indicator is calculated by dividing the number of follow-up forms filled in as referred to a service by the number of follow-up forms with true serious incidents.

No of follow-up forms filled in as referred to a service	No of follow-up forms with plausible/probable serious incidents	Rate of referral to servicers (percent)
0	2	0

3.6.6. Resolution of serious incidents within 30 days

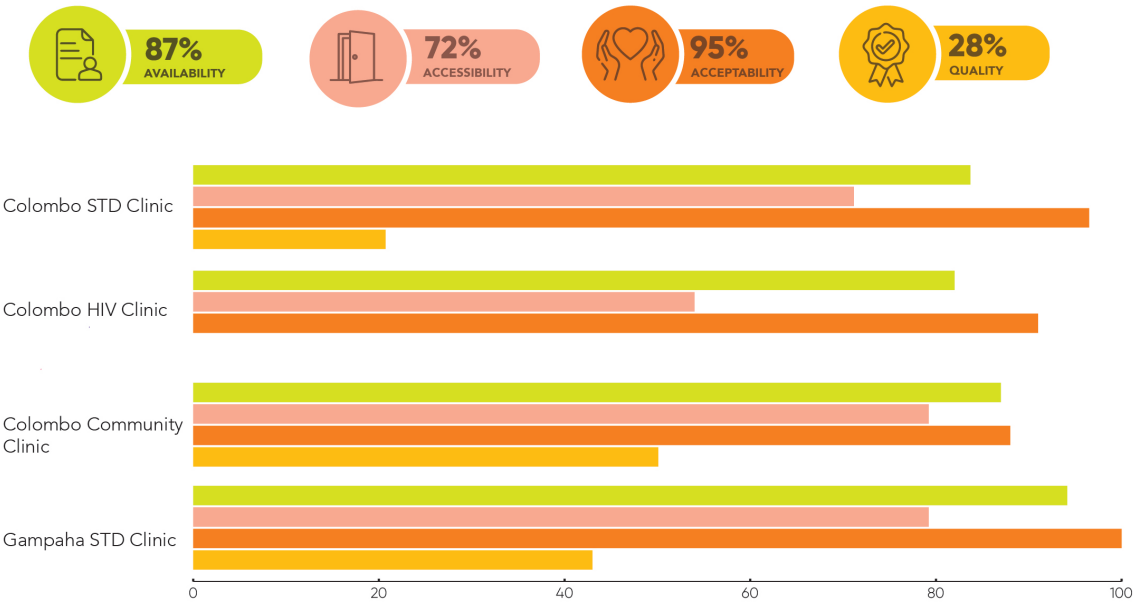
For the purpose of this CLM Pilot, the definition of 'successfully resolved within 30 days' means the following:

1. The complaint has been accurately documented in a CLM Follow Up Form by the Case Manager
2. The Case Manager can immediately support the client by offering clarification if a situation arises from misunderstanding of process or procedure and provides assistance or takes action to remedy/ resolve the incident in consultation with Dr. Karawita. The case is documented along with actions taken for review by the SIM Committee.
3. If the Case Manager deems the incident requires escalation and has the consent of the client – then the case is escalated to the SIM Committee for further action.
4. The SIM Committee deliberates and recommends action
5. The Serious Incident Management Committee shares suggested next steps with the facility manager and /or made referrals for the client to be able to remedy the situation.
6. Case Manager reports back to the client on actions taken to resolve the complaint, within 30 days of the serious incident being first reported.
7. Case Manager prepares brief of Serious Incidents and suggested follow up action and shares the same with community organisation coordinating the CLM for further advocacy.

4. Discussion

This section provides an overview of the key outcomes from the CLM pilot conducted in Sri Lanka along with an understanding of the CLM pilot process. The summary table below presents the overall scores of the four clinics, under each indicator for a closer comparison. **Acceptability, Availability, and Accessibility scores are at 95%, 87% and 72% respectively. However, the overall average Quality score is at 28%.**

Summary Table



The data indicates the facilities performed well in terms of Availability and Acceptability. However, performance in the Accessibility category is relatively lower, and the Quality score remains the lowest.

Acceptability

The overall score for acceptability is the highest among all indicators at 95%. Most participants have reported being treated with respect, consent being taken for procedures and privacy and confidentiality maintained in all clinics. However, two respondents from the Colombo Community clinic have reported breach of privacy and confidentiality, three have reported not having taken consent and lack of respectful treatment at the above clinic. Two participants from the Colombo STD clinic have reported not having taken consent during procedures.

Availability

The overall score for Availability is at a high value of 87% because services (such as HIV screening, confirmation and counselling; STI testing/diagnosis and treatment; Post-exposure prophylaxis (PEP); Pre-exposure prophylaxis (PrEP); Antiretroviral therapy (ART) initiation, refill and counselling) were received by all respondents who sought it.

The services that were sought but not received by a few respondents were condom and lubricant supply (three respondents from the Colombo STD clinic; one of the respondents from the Gampaha STD clinic reported "NO"). One respondent each from the Colombo HIV and Gampaha STD clinics reported not having received ART refill, while one respondent each from the Colombo HIV and Colombo STD clinics reported not having received viral load testing. Insufficient ART supplies exacerbated by post-COVID challenges and the economic crisis in Sri Lanka, causing uncertainty among PLHIV clients, may have had an impact on these scores. The scores also drop as a result of participants not having responded to all the types of services.

Accessibility

The overall score for accessibility is 75%. From the three components that determine the accessibility scores: *location safety, opening hours and affordability*, most service providers scored low in relation to affordability. 40% of respondents of the Colombo HIV Clinic and 24% of respondents of the Colombo STD clinic found the services unaffordable.

Service quality

The Colombo STD Clinic and the Colombo HIV Clinic have received significantly low quality scores, with ratings of 21% and 0%, respectively.

The quality score is determined solely by the positive responses received for all the three sub-indicators: the receipt of items such as medicine and condoms, the provision of necessary information, and the waiting time. None of the respondents at the Colombo HIV Clinic reported complete satisfaction with all the mentioned factors, while only 23% of the respondents at the Colombo STD Clinic expressed satisfaction with all the aforementioned aspects. This significantly contributes to the overall quality score being lowered.

It is essential to delve deeper into the specific sub-indicators, to identify which component requires interventions. In this case, interventions are needed to address the more prominent issue of prolonged **waiting time** in service delivery. 80% of respondents of the Colombo HIV clinic and approximately 70% of the respondents of the Colombo STD Clinic have experienced a long waiting time to see the health care provider.

Long waiting times can occur due to staff shortages, distinct procedures for STD consultations that

can impact STD clinics, contributing to lower service quality scores. Sample collection, lab processing, and report return times are usually longer in STD clinics, leading to crowding and extended doctor wait times.

When analysing the feedback, it is important to consider that the Colombo Community Clinic and the Colombo STD Clinic had a comparatively larger number of forms filled, 54 and 53 respectively for MSM respondents, whereas the Gampaha STD clinic and the Colombo HIV clinic had a small sample of participants, 16 and 10 MSM respondents respectively. The reader also needs to avoid the inclination to generalise the results or gauge an overview of the entire clinic based on the indicator scores provided.

Serious incidents

Four serious incident cases were reported in the pilot process. Three of them were reported by respondents who fell into the key population group of MSMs, while the key population category was not marked by the fourth person. It is important to stress that each case reported is to be tended to with the utmost attention and appropriate action as per the case management SOP should be taken in the follow-up and resolution process.

Satisfaction scores

All the clinics have received a high average satisfaction score of 9 out of 10 despite the varying responses provided to the other indicators. It is possible that this score was based on the overall experience and health service of the facility, rather than feedback based on the specific visit made or of a selected service. While it is encouraging that all the clinics received a high average satisfaction score of 9 out of 10 from participants, it is important to emphasise that these high scores should not overshadow the existence of service-related issues that demand improvement and corrective action within each clinic. These areas may not have been adequately reflected in the satisfaction scores and addressing them remains a top priority to ensure a consistently good level of service for all patients.

5. Observations/Challenges – Pilot Process

The following aspects were reported via the CLM Pilot Staff Feedback form and the Technical Working Group discussions:

- **Refusal to participate:** 3 out of 10 participants declined to participate in the survey and the reasons for this are as follows: time taken to fill the questionnaire, hesitance to share personal information with doubts in confidentiality management; inability to comprehend technical terms in the form.
- **Low interest/inability to self-administer the survey:** Aversion to a self-administered survey was expressed due to the following reasons: inability to read or write; lack of time to read and comprehend questions; ill-health.
- **Data collection tool:** Participants have found it difficult to mark questions related to Availability. This could have been due to the exhaustive list of all services mentioned in the form and because clients may not quite know how to distinguish between services based on their names. Further, questions on the CLM form related to the HIV status, KP screening and gender question were among those that participants were hesitant to respond to (according to the online feedback provided by the enumerators).
- **Accessibility to clinics:** Permission to proceed with the study was initially granted by the Director General of Health Service (DGHS) and the Director of the National STD/AIDS Control Programme (D/NSACP). However, resistance was shown by government clinics as sectional heads were not well-formed about the feedback system. Concerns raised include: the absence of ethics clearance, privacy, and confidentiality breaches (surveys collecting data on sexual orientation and HIV status for instance), and the rationale behind the selection of the men who have sex with men sample was raised.
- **Lack of infrastructure & services:** Inadequate clinic space limits privacy and confidentiality, which can discourage clients from providing feedback. For example, the Gampaha STD clinic is a container clinic located on the hospital grounds.
- **Short time frame:** To meet project completion deadlines, the pilot was conducted within a short time frame. This had an impact on the coordination and data collection process.
- **Selective sampling:** Since the pilot study was conducted only among men who have sex with men, the enumerators used the approach of identifying potential participants at PrEP clinics based on their networks.
- **Variation in the No. of participants across clinics:** The initial design aimed to include 50 participants from each facility, however the participants for each clinic vary. This variation was a result of the low number of patients present at the Gampaha STD clinic during the study period and an inability to conduct onsite data collection at the Colombo HIV clinic.

6. Limitations of the Report

When interpreting the results presented in this report, it is important to take into consideration the limitations given below. Additionally, it is crucial that the report is read keeping in mind that the pilot conducted for CLM in Sri Lanka was not intended as a research study but rather as a programme activity aimed at assessing the feasibility of its implementation in the Sri Lankan context.

- **Assessment solely dependent on the feedback tool:** Community-led monitoring of HIV is conducted through a form filled out by service users. Therefore, it is important to note that not all service users will always provide feedback, and a single service user may provide multiple feedback.
- **Generalisability:** The statistics derived from CLM indicators are reliant on feedback from participants who filled out the CLM form. These values may not accurately reflect the entire population of clinic visitors unless there is a substantial response rate to the CLM forms.
- **Calculation of scores:** The indicator scores in this report are calculated exclusively based on forms that responded affirmatively to all associated questions. For instance, the accessibility score has been computed based on forms that gave positive responses to all aspects, including safety and convenience of location, opening hours, and affordability. Nevertheless, there may be cases where participants answered positively to the first two questions but negatively to the last one, and these scenarios are not represented in the scores. Consequently, it can be challenging for clinics to identify which aspect of Accessibility requires intervention solely relying on these scores.

7. Conclusion and Recommendations

In conclusion, the pilot study in Sri Lanka successfully identified key issues in HIV service delivery for key populations. Its objective was to assess the feasibility of implementing community-led monitoring (CLM) in four health facilities. Implementing CLM is crucial to sustain HIV services for key populations and all service users. These results also serve as valuable advocacy tools for improving HIV services in the country.

Following are recommendations for the successful implementation of the CLM in Sri Lanka.

- CLM reporting needs to present results highlighting individual clinic performance based on the indicators and the data can be stratified based on age, sex/gender, subgroups of key populations. Further examination of the contributing factors within each indicator (taking guidance from the CLM toolkit) can be presented to identify specific issues that require interventions in the clinics.
- The following recommendations are for the CLM client form.
    - The language needs to be simplified so it is easy to understand for a general audience. Questions related to HIV status and KP screening may need to be amended for future implementation to reduce refusal rates.
    - The form needs to be made available in the Tamil language as well.
    - It is best if the questions for all the sub-indicators under a key indicator follow an affirmative flow. For example, under Accessibility in the current CLM form the questions for receipt of items and information are presented in an affirmative form, but the question on waiting time is designed in a negative form. The question for waiting time can be refined as: *Did you meet with the health care provider within the expected waiting time?*
    - In instances where indicators such as waiting time can differ from one clinic to another (given the nature of procedures and services sought), the form can perhaps mention a waiting period that is considered acceptable as perceptions of waiting time are subjective. On the other hand, as a practice, service providers can keep clients informed about the time that is required for procedures in order to manage client expectations when they come to receive services.
    - Each type/ category of serious incident could carry a description indicating how it differs from one to another to facilitate accurate understanding and reporting of the incidents. Without such an understanding the types of serious incidents may overlap one another and be confusing to the participants reporting an incident.
- Ethical clearance for a non-research determination from a local ethics review committee and institutional permissions need to be taken before the activity and well communicated with facility staff.

- Two additional questions have been proposed to be included in the CLM Follow Up Form (see annex III) to ensure that the Case Manager can accurately capture how the case was dealt with and resolved, and if not resolved why this was so. The suggested questions in the CLM Follow Up Form are also linked to the SOP for the Serious Incidents Management Committee. These two questions will also provide a more nuanced narrative in the CLM Report in terms of how a case relating to a serious incident was resolved.
- The socio-political and economic context in which the data is received needs to be taken into consideration since it can have a large impact on the data gathered. For instance, the issues that arise with HIV service provision during crisis moments (such as the economic crisis in Sri Lanka) can be unique to that period.
- Standard operating procedures (SOP) need to be developed for preliminary activities before the implementation of the CLM. The SOP should include a plan or strategy of communication for different levels of administration at the facility staff level and to key populations.
- Series of dialogue, lobbying and advocacy programs need to be carried out before starting the CLM among stakeholders.
- CLM sensitization and social marketing among key populations and facility staff should be done with multi language IEC materials such as introductory brochures, flyers, and booklets as well as an introductory workshop or orientation with facility staff and key population community members.

Beyond the CLM Pilot Study – Action Plan

Lanka Plus, the coordinating CSO for the CLM Pilot Study provided feedback to the four selected clinics. An action plan was developed based on the feedback.

In developing the action plan, the focus was kept on Section 5 - General Feedback and follow-up questions 25 and 26. (Question 25: "What was the best part of your experience at this HIV service?", Question 26: "Do you have any advice, recommendations, or requests for this HIV service?") [10]

Meetings were arranged with the four clinics. The clinic Consultant (who leads administrative work at the clinics) was the key point of contact. At these meetings:

- The action plan was shared with the clinics for recording purposes and service improvement.
- The CLM coordinator shared the information gathered in the pilot and engaged in discussion on the findings.
- The responses from the consultant and other clinic staff attending the meeting were documented.
- Lanka Plus shared the outcomes of these meetings with KP led CSOs.

The action plan is categorised into three phases: immediate action, medium-term, and long-term in consultation with the consultant/facility manager.

The progress of these actioned interventions to better service experience at the clinics will be reviewed quarterly for progress updates.

10 These sections were selected as they offered direct feedback from clients on the services. The complete dataset was not used for action planning as it would have been an overreach of the pilot.

8. References

Ariyaratna N, A. C. (2020). Risk factors for viral hepatitis; A infection to Gampaha District, Sri Lankan unmatched case control study. BMC Public Health.

Central Bank of Sri Lanka. (2020). Economic and social statistics of Sri Lanka. Colombo: Central Bank.

Department of census and statistics. (2021). Annual Bulletin. Colombo: Department of census and statistics.

Family Planning Association. (2023, 06 24). skpa-2-programme-july-2022-june-2025. Retrieved from fpasrilanka: https://www.fpasrilanka.org/content/skpa-2-programme-july-2022-june-2025

Health Equity Matters. (2023, 06 24). International program. Retrieved from https://healthequitymatters.org.au/our-work/international-program/

NSACP. (2022). Annual Report 2021. Colombo: National STD/AIDS Control Programme.

SKPA2. (2022). Sustainable community-led monitoring of HIV servicers: A toolkit for key populations. AFAO.

SLCoSHH. (2020). Technical report on HIV estimation Sri Lanka 2019. Colombo: National STD/AIDS control programme.

Annexes

Annex I. Sub-Indicator Results

Annex 1.1: AVAILABILITY SUB-INDICATOR RESULTS

Sought Service	Cmb STD n=54			Sought Service	Cmb HIV n=10			Sought Service	Cmb Community n=53			Sought Service	Gampaha STD n=16		
	Received	Not	Overall (%)		Received	Not	Overall (%)		Received	Not	Overall (%)		Received	Not	Overall (%)
59	57	N/A	**97**	**10**	10	N/A	**100**	**91**	89	N/A	**98**	**88**	88	N/A	**100**
26	26	0	**100**	**10**	10	N/A	**100**	**68**	66	N/A	**97**	**75**	75	N/A	**100**
70	70	0	**100**	**80**	80	N/A	**100**	**75**	72	N/A	**95**	**100**	100	N/A	**100**
22	15	6	**67**	**10**	10	N/A	**100**	**49**	45	2	**92**	**50**	44	1	**88**
22	15	6	**67**	**10**	10	N/A	**100**	**40**	38	2	**95**	**44**	44	N/A	**100**
7	6	N/A	**75**	N/A	N/A	N/A	**N/A**	**19**	19	N/A	**100**	**6**	6	N/A	**100**
24	22	0	**92**	**20**	20	N/A	**100**	**60**	60	N/A	**100**	**44**	44	N/A	**100**
46	44	N/A	**96**	**10**	10	N/A	**100**	**49**	47	N/A	**96**	**75**	75	N/A	**100**
9	7	N/A	**80**	**20**	20	N/A	**100**	**28**	28	N/A	**100**	**25**	25	N/A	**100**
26	26	0	**100**	**60**	50	1	**83**	**13**	13	N/A	**100**	**31**	25	1	**80**
9	9	0	**100**	**10**	10	N/A	**100**	**36**	36	N/A	**100**	**25**	25	N/A	**100**
6	2	2	**33**	**20**	10	1	**50**	**21**	21	N/A	**100**	**13**	13	N/A	**100**
9	7	N/A	**80**	**10**	10	N/A	**100**	**9**	8	N/A	**80**	**13**	13	N/A	**100**
2	2	0	**100**	**10**	10	N/A	**100**	**4**	4	N/A	**100**	**13**	13	N/A	**100**
4	2	N/A	**50**	**10**	10	N/A	**100**	**6**	6	N/A	**100**	**6**	6	N/A	**100**
19	19	0	**100**	**40**	40	N/A	**100**	**2**	N/A	N/A	**N/A**	**19**	19	N/A	**100**

Annex 1.2: ACCESSIBILITY SUB-INDICATOR RESULTS

Indicator: Acessibility	Cmb STD n=53			Cmb HIV n=10			Cmb Community n=54			Gampaha STD n=16		
	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)
Location Safety (AT)	53	0	100	10	0	100	51	4	94	14	13	88
Opening Hours (AU)	50	6	94	10	0	100	53	0	98	16	0	100
Affordability (AV)	35	21	66	6	40	60	39	15	72	13	6	81

Annex 1.3: ACCEPTABILITY SUB-INDICATOR RESULTS

Indicator: Acceptability	Cmb STD n=53			Cmb HIV n=10			Cmb Community n=54			Gampaha STD n=16		
	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)
Respectful Treatment (AY)	53	0	100	10	0	100	49	6	91	16	0	100
Consent (AZ)	50	4	94	10	0	100	45	6	83	15	0	94
Privacy / Confidentiality (BL)	0	100	0	0	100	0	2	85	4	0	100	0

Annex 1.4: QUALITY SUB-INDICATOR RESULTS

Indicator: Quality	Cmb STD			Cmb HIV			Cmb Community			Gampaha STD		
	n=53			n=10			n=54			n=16		
	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)	Yes	No	Overall (%)
11. Did you receive the items (medicine, condoms, information, lubricant etc) you need? (BC)	38	19	72	7	30	70	45	11	83	13	6	81
12. Did you have to wait too long to see the health care provider? (BD)	36	32	68	8	20	80	22	57	41	7	50	44
13. Did you receive all the information you need and were all your questions answered? (BE)	50	4	94	9	10	90	53	2	98	15	0	94

Annex II. CLM Client Form

CLM Client Form

CLM Form No
(For office use only) ☐

Answer the questions given below

Section 1: HIV/Health Service and Visit Date

1 Today's date Year ☐ Month ☐ Day ☐
(Mention the date the form is filled out)

2 Name of the facility ☐
(Name of the institution visited for service)

3 Address of the facility ☐

4 Date of your visit Date ☐ Time ☐

Section 2. Feedback on the Service

Availability

5 Which of the following services you sought by visiting the facility today?
(Mark the service you required with a tick (√) in the first cage and in the second cage mark whether you received the service or not, with a tick)

	Sought Service	Did you receive it?
5a. HIV screening test	☐	Yes ☐ No ☐
5b. HIV confirmation test	☐	Yes ☐ No ☐
5c.HIV counseling	☐	Yes ☐ No ☐
5d. Condom and lubricant supply	☐	Yes ☐ No ☐
5e. Post-exposure prophylaxis (PEP)	☐	Yes ☐ No ☐
5f. Pre-exposure prophylaxis (PrEP)	☐	Yes ☐ No ☐
5g. Sexually Transmitted Disease (STD) testing/diagnosis and treatment	☐	Yes ☐ No ☐
5h. Anti-retroviral therapy (ART) initiation	☐	Yes ☐ No ☐
5i. Anti-retroviral therapy (ART) refill 5j. Anti-retroviral therapy counseling	☐	Yes ☐ No ☐
5k. Viral load testing	☐	Yes ☐ No ☐
5l. Other HIV case management	☐	Yes ☐ No ☐
5m. TB services	☐	Yes ☐ No ☐
5n. Management and medicine for opportunistic infections caused by HIV lack of immunity	☐	Yes ☐ No ☐
5o. Other service (specify)	.....	

Accessibility

6.1	Was the HIV service location safe and convenient for you?	Yes ☐	No ☐
6.2	Was the HIV service location convenient for you?	Yes ☐	No ☐
7	Are the opening hours suitable for you?	Yes ☐	No ☐
8	Was the service affordable for you?	Yes ☐	No ☐

Acceptability

9	Were you treated respectfully by the staff? (Regardless of your gender, sexual orientation, age or religion)	Yes ☐	No ☐
10	Did the staff seek your consent for any procedures (Inquiring the history of sex, examinations and obtaining samples)?	Yes ☐	No ☐

Quality

11	Did you get an adequate quantity of the items you required (medicine, condoms, information, lubricant etc.) ?	Yes ☐	No ☐
12	Did you have to wait too long to see the health care provider?	Yes ☐	No ☐
13	Did you receive all the information you need and were all your questions answered?	Yes ☐	No ☐

Satisfiability

14	Please give a score out of 10 for how satisfied you were with the service (where 1 is for lowest and 10 is for highest satisfaction)	/ 10 ☐

Section 3. Reports of any "Serious Incidents" experienced

15. Did you experience any serious incident when visiting the facility for services or when receiving service?
(If so, identify your experience under the categories mentioned in 15a to 15g and mark in the appropriate cage with a tick (√))

15a.	Were the staff discriminatory toward you or did they treat you with contempt?	Yes ☐	No ☐
15b.	Did you experience physical or verbal harassment as a result of visiting the facility for service?	Yes ☐	No ☐
15c.	Did you experience sexual or other harassment from the staff or other service recipients who were at the facility?	Yes ☐	No ☐
15d.	Did you experience breach of privacy or confidentiality?	Yes ☐	No ☐
15e.	Were you refused of service because of gender, identity, race, risk behaviour or other reasons?	Yes ☐	No ☐
15f.	Did you undergo excessive physical or mental pain or distress?	Yes ☐	No ☐
15g.	Other	Yes ☐	No ☐

.....

16 Please provide some more details about the serious incident you experienced in the cage below to assist our follow-up.

17 Do you consent to having a trained staff member or volunteer contact you to help resolve this? Yes ☐ No ☐

18 If yes, please provide your preferred mode of contact and details

First name or nickname

Phone number

Email address

Whatsapp/lima/other social media

Section 4. Client profile

19 When did you last complete this form?

Never	Less than 12 months ago	More than 12 months ago
☐	☐	☐

20 What is your age? (Age as at last birthday) Age in Years

21 What is your gender? (tick box)

Cisgender Male	Cisgender Female	Transgender Male	Transgender Female
Other / Do not want to Disclose			

22 In the past 12 months have you engaged in any of the behaviours listed here? (tick all that apply, there can be more than one answer)

22a. Male to male sex Yes ☐ No ☐

22b. Male to female sex Yes ☐ No ☐

22c. Received money or goods in exchange for sex Yes ☐ No ☐

22d. Use of recreational drugs Yes ☐ No ☐

22e. Injected recreational drugs Yes ☐ No ☐

22f. None of the above Yes ☐

22g. Do not want to disclose Yes ☐

23 Do you have a unique identifier code (anonymous client code) that you are willing to share?

Here it is ☐ No or unsure ☐

Please provide the new number generated through the CLM Project in the space below. (Generating a new number: First two characters of the name as in the identity card/ birth month/birth district/ biological sex assigned at birth. Eg. DA/06/AD/M)

☐

24 What is your current HIV status? (tick box)

Negative ☐ Positive ☐

Unsure ☐ Do not want to disclose ☐

Do not know ☐ Never tested ☐

Section 5. General Feedback and follow-up

25 What was the best part of your experience at this HIV service?

☐

26 Do you have any advice, recommendations or requests for this HIV service?

☐

Thank you for taking the time to provide feedback on your HIV service experience.
Your feedback is important!

Annex III. CLM follow-up form

Section 1: Follow-up details

1 CLM form number

2 Name of the facility

3 Location of the facility

District	DSD	GS division	Village

4 Date of the CLM report Day Month Year

5 Date of this follow-up Day Month Year

6 Details of individual following up report

Name

Designation (position) e.g. Outreach worker

Organization

Contact details

7 Client age (age at last birthday) Age in years

8 Client gender (tick box)

Cisgender male	Cisgender female	Transgender male	Transgender female	Other / do not want to disclose

9 Client Unique identifier code (if known)

Yes, here it is

No or unsure

10 Client risk behaviours in last 12 months (tick all that apply)

10a. Male to male sex	Yes	No
10b. Female to female sex	Yes	No
10c. Received money or goods in exchange for sex	Yes	No
10d. Use of recreational drugs	Yes	No
10e. Injected recreational drugs	Yes	No
10f. None of the above/did not disclose	Yes	No

11 Did client consent to having a trained staff member or volunteer contact them for more information on this? Yes No

If no, then go to **section 5** and enter 'client refuses to continue the case' under final result
If yes, please continue, using the client's preferred mode of contact and details on their CLM form

Section 2. Follow-up attempts

12 Is this the first contact related to this complaint or a follow-up?

First ☐ Follow-up ☐

13 How are you following up the client?

Phone call/ Whatsapp/etc. ☐ Email ☐ Face-to-face ☐

Other, please specify ☐

14 Did you reach the client?

Attempt 1		Attempt 2		Attempt 3	
Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

If you were not able to reach the client after 3 attempts, skip to section 6 and enter 'could not reach client'

Section 3. Recap of serious incident(s) to be followed up

15 What was the serious incident they reported experiencing at the service?

15a. Stigma and discrimination	Yes ☐	No ☐
15b. Violence linked to visiting the service	Yes ☐	No ☐
15c. Sexual harassment from the service staff or other clients	Yes ☐	No ☐
15d. Breach of privacy or confidentiality	Yes ☐	No ☐
15e. Refused service because of gender, identity, race, risk behavior or other	Yes ☐	No ☐
15f. Pain or distress	Yes ☐	No ☐
15g. Other, explain	☐	

16 After discussing with the client, was this a serious incident as above? Yes ☐ No

Enter any more relevant details here to assist understanding or resolution of the issue

Section 4. Information following successful contact with client

17 Did you refer the client to any of the following services? (tick box)

17a. HIV or health services	Yes ☐	No ☐
If yes, which health facility?	Yes ☐	No ☐
17b. Counseling services	Yes ☐	No ☐
17c. Legal services including police	Yes ☐	No ☐
17d. Social welfare services	Yes ☐	No ☐
17e. Other, please specify		

Section 5. Final result from this follow-up attempt

18 Is the case still ongoing or is it now resolved/closed?

18a. Ongoing Yes ☐ No ☐

18b. Case resolved or closed because

Could not reach client ☐ Successful resolution accepted by client ☐ Client refuses to continue the case ☐ Could not successfully resolve the case ☐

Other situation, please specify

19 Please explain in a few words the nature of the follow-up contact and the result

Thank you for taking the time to provide feedback on your HIV service experience. Your feedback is important!

Annex IV. Consent Form

Obtaining informed consent (Informed Consent Form)

As part of a community-led monitoring project, you will be invited to report on the quality of a facility where you last visited for HIV services.

This feedback is done by the Lanka Plus organization with the knowledge of the Ministry of Health and with the support of the Family Organization Association. Obtaining this information (feedback) will take about 10 minutes to complete.

- Your participation in this is voluntary.
- Apart from indirectly developing the service standards of the organization by participating in this survey, you will not receive any direct advantage.
- There is no personal risk associated with participating in this survey apart from the discomfort or anxiety of having to re-live an unpleasant an event or experience.
- All data and information gathered from you will be codified and storied anonymously and will not be shared with others.
- You are not required to provide any identifying information about yourself; your response will remain anonymous.
- Only if you identify a serious problem that requires follow-up you will be requested to provide contact details (phone, email or social media). In such an event, a manager will contact you directly to learn more about the problem and discuss future follow-up procedures, will your responses will be no longer anonymous to us.
- Your responses to this survey will remain confidential. Any submissions based on the data provided will not include names or identifying information.

If you have any question or problem you may contact our Organization from Monday through to Friday from 8:00 a.m. to 4:00 p.m.

Mr. S. P. I. Niroshan, Chairman, Lanka Plus Organization, 46A, Daham Mawatha, Moratuwa. 077-086666, 0114901692, Email: lankaplus2001@gmail.com

You can print a copy of your consent form or take a screenshot. Indicate below whether you agree to participate in the survey or not:

- ☐ You have read and understood the above facts
- ☐ You are 18 years old or older
- ☐ You agree to participate in voluntarily

☐ I agree ☐ I don't agree

Annex V. CLM code of conduct

Code of Conduct for People involved with CLM Activities

I, undersigned, certify that I will comply with the following principles during the preparation and implementation of any of the CLM activities in [name city, country]. This code of conduct must be signed by any individual (employee, volunteer or consultant) involved in CLM activities before they commence.

The principles of this code of conduct are:

All individuals, regardless of their age, ethnicity, religion, gender or sexual orientation, involved in CLM activities should be treated with respect and without a discriminatory or judgmental attitude. Individuals involved in CLM activities refers to individuals who are conducting interviews or client follow-up; those interviewed as part of CLM; those contacted by the team but not eligible as per the criteria established; individuals who refuse to participate, or who refuse to answer some of the questions; including healthcare providers and other members of the team.

- Informed consent should be obtained from every participant prior to collecting information from them.
- The only identifier that should collected is a first name or nickname, telephone number, email, or social media username, only if the key population service user wishes to initiate a follow-up contact after reporting a serious issue, and this information is collected only after obtaining consent. No other identifiers such as full name, date of birth, or address will be collected from any participants.
- The confidentiality of all individuals approached or involved in CLM activities must be respected, and efforts should be ensured to keep data in a safe place, including during travel or breaks.
- Data must never be fabricated or altered to replace missing data (i.e., questions not answered by the participant) or to suit a desired outcome.
- No collected or transcribed data (e.g., field notes, transcripts, questionnaires, recorded tape, dataset) should ever be shared with outside persons who are not involved in data collection or analysis, without prior approval of the CLM coordinator.

I have read and understood the above principles and agree to abide by them

Name and Surname:……

Organization:……

Position:……...

Date: Place:……..

Signature:……..

[2 copies: 1 for the staff/volunteer and one kept in the CLM file of the organization]

Annex VI. Independent Contractor Agreement

This agreement made and entered into between T**he Family Planning Association of Sri Lanka** (hereinafter referred to as the 'Client'), having its registered office at 37/27, Bullers Lane Colombo 7, Sri Lanka, and S P I Niroshan (NIC No: xxxxxxxxxxxx), **President of the Lanka Plus Organization** (Hereinafter referred to as the 'Independent Contractor') having the registered office at xxxxxxxxxxxxxxxxxxxxx.

Whereas the Client has agreed to engage the services of the 'Independent Contractor' for 'Client', and the 'Independent Contractor' has agreed to make available to the 'Client' the knowledge and experience in the capacity of Technical Assistance for the **CLM Pilot Project Coordination.**

Nature of Service
The 'Independent Contractor' will provide the 'Client' with the service detailed in the Terms of Reference stipulated in Article 6 (Six), including changes that may be required from time to time.

1. Duration of this Agreement
This agreement shall commence from 19th May 2023 to 30th June 2023 and will be renewed at the total discretion of the management of FPA Sri Lanka.

2. Duty Station of FPA Sri Lanka
Remote or as required to carry out duties and responsibilities as set out in section 5 of this agreement.

3. Rights and Obligations of the 'Independent Contractor'
The rights and obligations of the 'Independent Contractor' are limited to the terms and conditions of this agreement. Accordingly, the 'Independent Contractor 'shall not be entitled to any benefit, payments, subsidy, compensation or entitlement except as expressly provided in this Agreement.

4. Duties and Responsibilities of the 'Independent Contractor'

Recruitment, Training, and Administration

- Advertise, recruit, organise training and manage 1 coordinator for a period of six weeks in the month of May and June; four Enumerators for two weeks in the month of June and 1 Case Manager for two weeks in the month of June 2023 to pilot CLM as per the approved ToRs.
- Ensure that recruited Enumerators and the Case Manager identify as Gay, bisexual, or queer and understand the behaviours of men who have sex with men.
- Ensure that Enumerators who are hired have had no prior involvement in service provision under the National HIV Prevention Programme under the Ministry of Health and NSACP to minimise bias or conflict of interest incidents.
- The Independent Contractor will organise staff training that the CLM National Consultant will facilitate.
- All staff will sign a code of conduct prepared for the CLM activities.
- The Independent Contractor will make connections and harmonise outreach and testing of MSM clients in the National HIV Prevention Programme and the data-gathering activities of CLM. Conduct meetings with Heart to Heart Lanka Organisation and the Strategic Alliance for Research and Development (SARD) to ensure cooperation.
- Together with the National Consultant, introduce and secure buy-in at testing clinics.

- Work closely and liaise between project staff and the facility staff and be able to troubleshoot issues that may arise at clinics.
- The Independent Contractor will adhere to a high standard of ethics when administering project activities in line with FPA standards.

Data gathering

- The Independent Contractor will ensure data collection is conducted using the data collection form (CLM client form), which has 26 variables. The data collection forms and training will be provided by the Family Planning Association, along with guidelines on data collection by the National Consultant for CLM.
- The Independent Contractor will ensure that Enumerators recruit and secure consent from a minimum of 30 and a maximum of 50 self-identifying MSM persons from the four HIV service provision sites to make up a maximum of 200, a minimum of 120 respondents as part of the Pilot. CLM client forms will be provided for each potential participant and, if required, will be supported by the enumerator to fill the form out.
- The data collectors will maintain the confidentiality of the data and ensure that the data gathered is of high quality, accurate and complete.
- Enumerators will generate a Unique Identification Code (UIC) for each client. A handwritten note with said UIC will be provided to each client, which CLM will use to identify the number of visits and the number of persons who have been engaged with CLM.
- Data will need to be secured or password protected, and/or encrypted.
- The Independent Contractor will ensure that the data is uploaded accurately and in a timely manner to the Google Forms by the Enumerators for analysis.

Serious incidents reporting and management.

- The Independent Contractor will ensure that Case Manager will work with Enumerators in a situation where a serious incident has been reported.
- The Independent Contractor will supervise and ensure that Case Manager carries out duties as per the ToR, including work filling in Serious Incident Follow-up Form, liaising with Serious Incident Management Mechanism and reporting back to the client in an ethical and professional manner.

5. Terms of Reference

Activity	
1. Signing of the contract	3rd week May
2. Submission of the Work plan	4th week May
3. Meetings with CSOs working in outreach in the national programme (Heart to Heart Lanka Organization, Strategic Alliance for Research and Development)	4th week May
3. Recruitment and Training of Enumerators/data collectors	1st week of June
4. Data gathering (Subject to confirmation by CLM National Consultant)	2nd week of June
3. Submission of completed data sheets	By 3rd week of June
4. Focus group discussion (FGD) with the CSO and the Enumerators /data collectors	3rd week June

6. Payment of Fees

Breakdown of remuneration and deliverables

The 'Independent Contractor' will be remunerated a total of XXXXXXX only (LKRXXXXXXX) and will correspond with the deliverables as set out in the table printed below.

Cost	**Number of positions**	**Total**
Coordinator fee, inclusive of transport and communication.	1	XXXXX
Case manager	1	XXXXX
Enumerators	4	XXXXX
Administrative fee, inclusive of all incidental costs.		XXXXX
Total		XXXXXX

AND
Remuneration will be released in five separate instalments when deliverables have been met.

Key deliverables	**Instalment**	**Tranches of payment**	**Deliverables**
1. Signing of the contract	First	15%	Signed contract
2. Submission of the Work plan	Second	15%	Approved work plan, including Plans and dates for recruiting all staff positions and tentative plan of meetings with CSOs working in the National HIV Prevention Programme in Colombo and Gampaha.
3. Recruitment of all staff positions and training schedule	Third	20%	CVs of successful candidates, along with copies of the signed contract and training schedule.
4. Submission of all data sheets	Fourth	40%	A final agreed set of data sheets
5. Focus group discussion (FGD)	Fifth	10%	Successful completion of the FGD with data collectors and the CSO staff

7. Considerations

- 1st instalment - Upon signing of the contract, 15% (LKR XXXXXXX) of the total contract value will be paid for the commencement of work.
- 2nd instalment - Upon submission of work plan along with dates and plans and procedures for recruitment, training schedule, payment plans, and dates for Enumerators, Case Manager and Coordinator and approval by Programme Officer- SKPA2 15% (LKR XXXXXXX) out of the total contract value will be paid.
- 3rd instalment - Upon successful recruitment of all staff positions and submission of CVs of successful candidates. 20% (LKR XXXXXXX) of the total contract value will be paid.
- 4th instalment - Upon submission/uploading of all data sheets and confirmation by the CLM National Coordinator, 40% (LKR XXXXXXX) out of the total contract value will be paid.
- 5th instalment - Upon completion of Focus Group Discussion and email confirming by CLM National Coordinator, 10% (LKR XXXXXXX) out of the total contract value will be paid.

Each instalment will be paid upon the confirmation by the Programme Officer SKPA-2 or, where stated, by the CLM National Consultant that the work has been completed from the previous instalment.

8. FPA Sri Lanka is committed to creating a safe environment for children to protect them from all forms of abuse, neglect, violence and exploitation and include them in decisions that affect them. FPA Sri Lanka expects that all its employees and others who work with FPA Sri Lanka have children's best interests at the heart of their involvement with the organisation.

As a signatory to this contract with FPA Sri Lanka, you will ensure 100% compliance with the organisation's Code of Conduct for the Protection of Children, Young People & Vulnerable Adults. Any breach of this code of conduct will result in disciplinary action, and any serious breaches may result in action leading to termination of service.

9. Termination of Agreement

The Family Planning Association and the Lanka Plus Organization enter this Memorandum of Understanding in good faith and commit to all conditions and clauses set out herein. The contract may be terminated by either party if said conditions are breached. Failure to fulfil any and all conditions within a week of a lapsed deadline will be seen as a breach of contract and result in automatic termination of said contract unless and otherwise a request for extensions has been formally made and agreed to by both parties as an amendment to this document.

Actions will be taken towards any programmatic or financial discrepancy and/or misconduct as per the internal protocols of FPA Sri Lanka and/or the law of Sri Lanka.

The terms of this MOU shall be for a period of 6 weeks (May 2023 to 30th June 2023.)

a. This independent agreement is only for the period stipulated in Article 2 (Two). No discontinuation of service unless otherwise ordered by the Executive Director of the 'Client'
b. In the event the 'Independent Contractor' has violated or has been deemed to have violated any one or more of the terms & conditions given under Article 5 (Five) and Article 6 (Six), the 'Client '**will** take necessary action to annul this agreement **with immediate effect.**

The 'Independent Contractor' may terminate this contract after a notice period of 20 working days, which shall be given to the 'Client' in writing.

10. Consent
I, **S P I Niroshan** NIC No:XXXXXXXIndependent Contractor), am willing to undertake to provide the services under this agreement for the period commencing **19th May 2023 to 30th June 2023.**

AND

I also agree to abide by the terms given above and am also aware that this agreement will cease to be in effect, as per the provisions in Article 2 (Two) and Article 9 (Nine)

IN WITNESS WHEREOF this Agreement has been entered into the day & year set out below.

The 'Client'

The 'Independent Contractor'

.....
Thushara Agus
Executive Director
The Family Planning Association of Sri Lanka

.....
S P I Niroshan
Independent Contractor
President
Lanka Plus Organisation

Annex VII. CLM monitoring process

1. Introduction to the Community-Led Monitoring (CLM)

Community-Led Monitoring (CLM) is a method of service optimisation by gathering feedback from service users. CLM has been introduced to HIV services in Sri Lanka for the first time in June 2023.

This CLM method is a simple approach to measuring the availability, accessibility, acceptability, and quality (AAAQ) of HIV services for key populations from the perspective of service users. This CLM method is developed by Health Equity Matters (formerly known as AFAO) and its partners under the Sustainability of HIV Services for Key Populations in Asia (SKPA) programme, which is funded by the Global Fund.

2. CLM Feedback System

CLM feedback system has two data recording forms. The system was implemented completely by a manual system for the pilot study which will later be converted to an electronic system.

<table>
<tr>
<td>1</td>
<td>CLM Client Form</td>
<td>

This is the feedback form filled by client or the service user of a health institution or a facility.
The Client Form includes 26 questions to be answered by consented respondents after having received HIV services from a health facility.
CLM client form is a self-administered questionnaire (SAQ). However, research assistants may need to provide support to some respondents to complete the feedback.
The CLM Client Form has fifteen (15) service availability questions, three (3) accessibility questions, three (3) acceptability questions and three (3) quality related questions.
Most importantly, there is section for clients to report about Serious Incidents (SI) that they had to face while receiving services, These SIs are recorded under following seven (7) categories.

<table>
<tr><td colspan="2">Serious incidents (SI)</td></tr>
<tr><td>a</td><td>Stigma and discrimination</td></tr>
<tr><td>b</td><td>Violence because you visited the service</td></tr>
<tr><td>c</td><td>Harassment (including sexual) from the service staff or other clients.</td></tr>
<tr><td>d</td><td>Breach of privacy or confidentiality</td></tr>
<tr><td>e</td><td>Refused service because of gender identity, race, risk behaviour etc.</td></tr>
<tr><td>f</td><td>Pain or distress</td></tr>
<tr><td>g</td><td>Other</td></tr>
</table>
</td>
</tr>
</table>

2	**CLM Follow Up Form**	• This form is a 'Follow Up Form' completed by the 'Case Manager' of the CLM project. • The CLM Follow Up Form has 19 variables to be completed by the Case Manager. • CLM follow up form is used for those who have experienced a serious incident (SI) and are willing to further investigate the injustice the client had to face.

3. CLM Indicators Explained

	A: Key Population CLM Indicator	
Indicator Number	Indicator Long Name **(Short Name)**	Definition / Computation
A1	Number of key population CLM client forms received ***(CLM Participation)***	The number of CLM forms received from key population HIV service users within a certain period of time (e.g. month, quarter) where a defined HIV service was marked as sought or 'yes' or 'no' in Q5
A2	Number and percentage of HIV service visits where the services were rated as available ***(availability rate of all sought HIV services)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to every service sought (Q5a - Q5n)
		Denominator: The number of CLM forms filled in with one or more boxes checked under the service sought column (Q5a-Q5n)
A3	Number and percentage of HIV service visits where the services were rated as accessible ***(accessibility rate)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to every accessibility related question on the client form (Q6, Q7, Q8).
		Denominator: The number of CLM forms filled in with an entry in the yes or no column for every accessibility-related question on the client form (Q6, Q7, Q8).
A4	Number and percentage of HIV service visits where the services were rated as acceptable ***(acceptability rate)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to every acceptability-related question on the client form (Q9 and Q10) and a 'no' checked for breach of privacy or confidentiality (Q15d).
		Denominator: The number of CLM forms filled in with an entry in the yes or no column for every acceptability-related question on the client form (Q9, Q10 and Q15d)
A5	Number and percentage of HIV service visits where the services were rated as good quality ***(service quality rate)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to every quality-related question on the client form (Q11, Q12 and Q13).
		Denominator: The number of CLM forms filled in with an entry in the yes or no column for every quality related question on the client form (Q11, 12 and 13)

A6	Mean (average) overall satisfaction score ***(mean satisfaction score)***	The mean (average) of scores on all CLM client forms entered in Q14
A7	Number and percentage of key population service visits where a serious incident (SI) is reported ***(prevalence of serious incidents)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to one or more of the serious incident predefined categories on the client form (Q15, a-g).
		Denominator: The number of CLM forms received from key population HIV service recipients within a certain period of time (e.g. month, quarter) where a defined HIV service was received (Q5a-5n) as indicated through a 'yes' box being checked in Q5 on the client form.
A8	Number and percentage of key population HIV service visits where stigma and discrimination was reported ***(prevalence of stigma and discrimination)***	*Numerator:* The number of CLM forms filled in by key populations where there is a 'yes' checked next to stigma and discrimination in the serious incident section of the client form (Q15a.).
		Denominator: The number of CLM forms received from key population HIV service recipients within a certain period of time (e.g. month, quarter) where a defined HIV service was received (Q5a-5n) as indicated through a 'yes' box being checked in section 2 on the client form.

	B. Key population CLM serious incident follow-up indicators	
B1	Number and percentage of serious incident reports followed up ***(follow up rate of serious incidents)***	*Numerator:* The number of CLM follow-up forms filled in with one or more attempts made to contact the client (a 'yes' or 'no' checked in Q14 on the follow-up form).
		Denominator: The number of CLM client forms filled in with one or more serious incidents indicated (Q15a-g) .
B2	Number and percentage of serious incident reports where a successful contact with a key population HIV service client was made for follow up ***(successful client follow-up of serious incidents)***	*Numerator:* The number of CLM follow-up forms where the individual making the follow-up attempt successfully contacted the key population HIV service user reporting a serious incident (a 'yes' checked in Q14 of the follow-up form)
		Denominator: The number of CLM follow-up forms with a serious incident indicated and one or more attempts were made to contact the client (a 'yes' or 'no' checked in Q14 on the follow-up form)
B3	Number and percentage of serious incidents correctly recorded ***(rate of true serious incidents)***	*Numerator:* The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?').
		Denominator: The number of CLM follow-up forms with a 'yes' OR 'no' next to Q16 on the follow-up form ('was this a serious incident?').

B4	Number and percentage of serious incidents referred to services ***(referral rate of serious incidents)***	*Numerator:* The number of CLM follow-up forms with the 'yes' box ticked under one or more of the services listed in Q17 referrals (Q17a-e).
		Denominator: The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?).
B5	Number and percentage of serious incidents resolved within 30 days ***(resolution rate of serious incidents within 30 days)***	*Numerator:* The number of serious incidents successfully resolved within 30 days from reporting the incident (Q18b). The time taken to resolve the incident can be calculated by counting the number of days in between Q4 (date of the CLM report) and Q5 (date of this follow-up) on the client follow-up form.
		Denominator: The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?').

Annex VIII. Standard operating procedure of the serious incident management committee.

Community-ed Monitoring (CLM)

for HIV services, Sri Lanka

Standard Operating Procedures

for

2023

1. Introduction to the Community-Led Monitoring (CLM)

Community-Led Monitoring (CLM) is a method of service optimisation by gathering feedback from service users. CLM has been introduced to HIV services in Sri Lanka for the first time in June 2023.

This CLM method is a simple approach to measuring the Availability, Accessibility, Acceptability, and Quality (AAAQ) of HIV services for key populations from the perspective of service users. This CLM method is developed by the Australian Federation of AIDS Organisations (AFAO, now known as Health Equity Matters) and its partners under the Sustainability of HIV Services for Key Populations in Asia (SKPA) programme, which is funded by the Global Fund.

2. CLM Feedback System

The CLM feedback system has two data recording forms:

<table>
<tr>
<td>1</td>
<td>CLM Client Form</td>
<td>

This is the feedback form filled by a client or the service user of a health institution or a facility.
The Client Form includes 26 questions to be answered by consenting respondents after having sought and / or received HIV services from a health facility.
The CLM Client Form is a self-administered questionnaire (SAQ), available in Sinhala, Tamil and English. However, research assistants may need to provide support to some respondents to complete the feedback form.
The CLM Client Form has fifteen (15) service availability questions, three (3) accessibility questions, three (3) acceptability questions and three (3) quality related questions.
Most importantly, there is a section for clients to report any Serious Incidents (SI) that they experienced while seeking and / or receiving services, These SIs are recorded under the following seven (7) categories, which may often overlap:

<table>
<tr><th colspan="2">Serious Incidents[1] (SI)</th></tr>
<tr><td>a</td><td>Stigma and discrimination</td></tr>
<tr><td>b</td><td>Violence because you visited the service</td></tr>
<tr><td>c</td><td>Harassment (including sexual) from the service staff and / or other clients</td></tr>
<tr><td>d</td><td>Breach of privacy or confidentiality</td></tr>
<tr><td>e</td><td>Refused service because of gender identity, race, risk behaviour etc.</td></tr>
<tr><td>f</td><td>Pain or distress</td></tr>
<tr><td>g</td><td>Other (Please specify)</td></tr>
</table>
Clients were able to mark more than one serious incident on the CLM Client Form and could provide further details if they opted to. The number of serious incidents refers to the number of individual incidents a participant faced even if that single incident touched on more than one of the above sub indicators. For example, the refusal of service due to a participant's gender may have also caused pain and distress. However, this would be considered as one serious incident.
</td>
</tr>
<tr>
<td>2</td>
<td>CLM Follow Up Form</td>
<td>

This form is a 'Follow Up Form' completed by the 'Case Manager' of the CLM project.
The CLM Follow Up Form has 19 variables to be completed by the Case Manager.
CLM Follow Up Form is used for those who have experienced a Serious Incident (SI) and are willing to share more information on the injustice they (the client) faced while seeking or accessing an HIV service.

</td>
</tr>
</table>

3. Serious Incident Management Protocol

3.1. Objectives

The overall objective of the management of serious incidents is to create an enabling environment for key populations to access HIV services, free from all forms of stigma, discrimination and / or violence and harassment.

Specific Objectives

- To manage and address serious incidents reported by clients accessing HIV services;
- To advocate for a community-friendly environment with facility managers and staff;
- To provide pro-bono legal assistance, psychosocial support, guidance and recommendations to affected individuals;
- To provide strategic information for evidence-based improvement of health facilities and institutions.

3.2. Definitions

The following table provides broad definitions for each of the serious incidents. The Serious Incidents Case Managers and members of the Serious Incident Management (SIM) Committee need to study the following areas for necessary actions:

	Serious Incidents	Definition of the Serious Incident
1	Stigma and discrimination	Stigma includes a range of stigmatising experiences such as avoidance behaviours, gossip, verbal abuse and social rejection (eg: blaming, insulting, ignoring, not talking, etc) on the basis of a person's sex, gender identity, sexual orientation, drug use, sex work and HIV status. Discrimination can include the above stigmatising behaviours where they affect the enjoyment of rights, as well as physical abuse, denial of health or social services, denial or loss of employment or education opportunities or even arrest. People may experience intersectional discrimination or stigma on several grounds, including race, disability and/or socioeconomic status.[2] Although stigma and discrimination cause violence, in their most aggressive forms, they may also be acts of violence.
2	Violence (experienced while seeking and / or obtaining a service) from the staff and / or other clients	Violence includes the sexual and / or physical actions that causes a client to suffer sexual, physical or/and psychological (emotional) violence when they access the facility for services. In this instance the violence is experienced when the client is seeking and / or receiving services from a health facility or clinic. However, in some cases, unethical and / or unprofessional actions of health facility staff or other clients can result in violence experienced by clients when they have left the health facility (ie: if a staff member or another client has breached privacy and confidentiality of a client, they can be subjected to violence (and / or harassment) while on the street, at the workplace or at home).

3	Harassment (including sexual, experienced while seeking and / or obtaining a service) from the service staff and / or other clients	Harassment includes all forms of physical, sexual, psychological (emotional), verbal, gestural and / or other forms of harassment faced by clients, at the facility, either from the staff or other clients. In this instance the harassment is experienced when the client is seeking and / or receiving services from a health facility or clinic. However, in some cases, unethical and / or unprofessional actions of health facility staff or other clients can result in harassment (and also violence) being experienced by clients when they have left the health facility (ie: if a staff member or another client has breached privacy and confidentiality of a client, they can be subjected to harassment (and / or violence) while on the street, at the workplace or at home).
4	Breach of privacy and / or confidentiality	Privacy here is defined as visual and auditory privacy when the client is sharing sensitive information (sexual history) with the healthcare worker. Confidentiality is defined here to denote that the recording and storing of the client's personal data and information is not accessible to a third party and is securely stored under lock and key and / or password protected. In instances where a client has just tested positive for HIV, and where the health facility staff is required to inform the NSACP in order to ensure the client has access to services, this information needs to be shared with the client so they are aware of the protocol that is followed.
5	Refused service because of gender, identity, race, behaviour or other,	This category includes clients who were refused services that they were supposed to receive from the facility, because of their sex, gender identity, sexual orientation, sexual behaviour, drug use, HIV status, race, class and / or other such factors.
6	Pain or distress	This category includes clients who have faced uncomfortable and undue pain and distress while receiving services from the facility (e.g. multiple punctures to take blood, painful insertions of the speculum and undue pain while taking urethral samples or rectal samples etc.)
7	Other	This category is used for any other form of serious incidents (SI) recorded by the client. All responses in this category must be specified.

3.3. Serious Incident Management Process

All Serious Incidents reported through the CLM Client Form will be reviewed, managed and resolved through a two-step process:

1) Case Manager/s

a. The Case Manager/s will be the first point of contact responsible to review, manage and where possible resolve all Serious Incidents in a manner that centres the needs of the person/s affected.

b. The Case Manager/s will be appointed by the SKPA-2 Project Manager, for a 1-year term, extendable as required.

c. The number of Case Managers appointed will be determined by the number of serious incidents being reported and the geographical regions they are being reported in.

2) Serious Incident Management (SIM) Committee:

a. If the Case Manager is unable to resolve a case, it will be handed over to the SIM Committee, who will then be responsible to review and resolve the case, in a manner that centres the needs of the person/s affected.

b. The SIM Committee will be appointed for a 2-year term, extendable as required.

3.4. Roles and Responsibilities of the Case Manager/s

1) Regularly review all Serious Incidents which have been reported in the CLM Client Forms. For this, the case manager is required to follow up with the organisation that is conducting the CLM during that period and the organisation too is obligated to bring reported serious incidents to the attention of the case manager.

2) If the client has consented to providing follow up information about the Serious Incident, conduct a follow up interview using the CLM Follow Up Form, to gather more details about the incident.

3) After more details have been gathered through the CLM Follow Up Form, check the details for accuracy.

4) If the Case Manager is able to provide a remedy for resolution, this should be done. Details of proposed method of resolution must be documented in the CLM Follow Up Form.

5) If required, the Case Manager should refer the client to the following services for follow up / further action:
    a. HIV and / or health services
    b. Pro bono counselling services
    c. Pro bono legal services and / or police
    d. Peer / other support services
    e. Other support services

6) If the Case Manager is unable to resolve the serious incident, the case should be referred to the Serious Incident Management Committee via email. The following details must be included when a case is being referred to the SIM Committee:
    a. Date emailed to SIM Committee
    b. Name & Email of SIM Committee member receiving the case
    c. Name & Email of Case Manager referring the case
    d. Suggested Next Steps
    e. Client has been updated on actions to date (Yes/No – Date: xxxx)

7) The Case Manager must liaise with the SIM Committee to ensure that the proposed next steps / follow up action to resolve the SIM Committee has been implemented.

8) The Case Manager is responsible to report back to the client on actions taken to resolve complaint as soon as possible but no later than 30 days of the serious incident being first reported.

9) Case Manager prepares Monthly Brief including details of Serious Incidents and suggested follow up action, and shares the same with the community organisation coordinating the CLM for further advocacy.

10) Case Manager must ensure that all CLM Follow Up Forms must be stored securely in a manner that protects the confidentiality of the person affected by the Serious Incident. Hard copies must be converted into digital copies and all CLM Follow Up Forms must be password protect-

ed and backed up on an external hard drive provided by SKPA-2 Project Manager.

11) The Case Manager shall support the CLM Management Staff to calculate the following CLM Indicators:

    a. Prevalence of serious incidents: Number and percentage of key population service visits where a serious incident (SI) was reported;

    b. Prevalence of stigma and discrimination: Number and percentage of key population HIV service visits where stigma and discrimination was reported;

    c. Serious Incidents rate of follow up contact for further details: Number and percentage of serious incident reports followed up for further details;

    d. Successful contact rate: Number and percentage of serious incident reports where a successful contact was made to gather further information;

    e. Accurately recorded Serious Incident Rate: Number and percentage of serious incidents accurately recorded;

    f. Serious Incident Referral rate: Number and percentage of serious incidents referred to services;

    g. Resolution of Serious Incident within 30 days: Narrative description of serious incident and if it was resolved, how it was resolved; if not resolved, why it was not resolved.

3.5 Desired Profile of the Case Manager

1) Bachelor's Degree [or SLQF Level 5 qualification or above] in Social Sciences, Humanities, Sociology, Gender Studies, Psychology, Public Health or related field, and at least 2-3 years of work experience in a related field.

2) Knowledge and sensitivity to current socio-political trends in Sri Lanka and a strong commitment to social justice and human rights principles.

3) Knowledge and familiarity with the issue of gender-based violence in Sri Lanka is desirable, along with awareness and understanding of broader issues relating to gender, sexuality, diversity and inclusion.

4) Fluency in Sinhala and/or Tamil language skills, both written and spoken is required.

5) Excellent knowledge of MS Office, Google Workspace and other relevant computer skills.

3.6 Roles and Responsibilities of the Serious Incident Management (SIM) Committee

1) The SIM Committee is expected to play the following overarching roles:

    a. Advisory role

    b. Facilitate discussions & dialogues with relevant state authorities

    c. Advocacy role

2) Closely analyse the Serious Incidents and determine whether any legal, policy or ethical standards (refer to the table below for a few examples) have been violated by the service provider. The SIM Committee is expected to take necessary action on a case-by-case basis through dialogue, discussion and advocating with relevant authorities.

Laws, Policies and International Conventions	
Constitution of Sri Lanka (Fundamental Rights Chapter)	International Covenant on Civil and Political Rights (ICCPR)
Penal Code of Sri Lanka	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
Universal Declaration of Human Rights	International Covenant on Economic, Social and Cultural Rights (ICESCR)
Relevant laws and policies relating to Right to Health	National STI/HIV Strategic Plan of Sri Lanka 2023-2027

3) The SIM Committee is expected to make collective decisions on follow up action that would mitigate the Serious Incident and sensitively resolve the issue in a manner that centres the needs of the affected person/s. A few examples of follow up actions are as follows:

    a. Inform the facility manager/s by sending a letter with details of how relevant sections of the laws and policies have been violated and persuade the health authorities to take constructive decisions to create an enabling environment for key populations seeking services.

    b. Advice the relevant healthcare worker concerned in writing. Extreme care must be taken not to divulge the name and other identifying details of the person who reported the serious incident as this could lead to a breach of confidentiality, and result in further violence and / or harassment against the client.

    c. Request for a letter of explanation from the healthcare worker asking them to respond to the serious incident. Extreme care must be taken not to divulge the name and other identifying details of the person who reported the serious incident as this could lead to a breach of confidentiality, and result in further violence and / or harassment against the client.

    d. Recommend departmental disciplinary actions according to the establishment code (E-code) or relevant circulars

    e. Task shifting at health facility.

    f. Recommend training and capacity building on human rights, diversity and inclusion for those who are not competent in carrying out their duties in a professional manner.

    g. If the person affected by the Serious Incident is willing to take legal action, provide the necessary support and guidance for them to do this.

4) All follow up actions suggested and followed through by the SIM Committee must be documented in writing, and periodically shared with SKPA-2 Project Manager.

3.7 Desired composition of Members of the SIM Committee

1) The SIM Committee shall comprise of 3-5 experts with post graduate qualifications and at least 3-5 years of experience in the field of human rights, law, sociology, public administration, health, gender studies, psychology or related field.

2) The SIM Committee shall include the following members:

    a. Senior representative from the Human Rights Commission of Sri Lanka

b. Senior representative from the Ministry of Health

c. Senior representative from the Legal Aid Commission OR an attorney-at-law nominated by the SKPA-2 Project Manager.

d. Two representatives from civil society (including one who has experience advocating for the rights of key populations)

3) Knowledge and sensitivity to current socio-political trends in Sri Lanka and a strong commitment to social justice and human rights principles.

4) Knowledge and familiarity with the issue of gender-based violence in Sri Lanka is desirable, along with awareness and understanding of broader issues relating to gender, sexuality, diversity and inclusion.

3.8 Referral List[1]

A	Health Services (such as treatment of injuries, HIV testing, PrEP, emergency contraception, STI screening and treatment, and mental health screening)	
1	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
2	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
3	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
B	Social Services (such as crisis counselling and support groups, financial aid, community-based organizations that may provide accompaniment)	
1	**Name of Organization / Facility**	

1 Adapted from: Available online here.

	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
2	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
3	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
C	Justice / Legal Services (such as legal information, assistance with arrest/detention, and contact information of trained law enforcement officers when they can be safely engaged)	
1	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
2	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	
3	**Name of Organisation / Facility**	
	Hours:	
	Location:	
	Phone:	
	Contact Person:	
	Services Available:	

Annex IX. Serious Incident Management

4.1. Objectives of the SI Management

The overall objective of the management of serious incidents is to create an enabling environment for key populations to access for HIV services.

Specific objectives

- To manage serious incidents reported by clients
- To advocate facility mangers and staff to have community friendly environment for key populations
- To provide legal assistance, guidance and recommendations for affected individuals
- To provide strategic information for evidence-informed improvement of institutions

4.2. Definition of the serious incidents

The following table details the definition of the serious incidents in general terms. The members of the SIM committee and case managers need to study following areas for necessary actions

	Serious incidents	**Definition of the serious incident**
1	Stigma and discrimination	**Definition:** Stigma and discrimination is the devaluation of people by adding discredits to them. If the stigma terns in to an action it is called an enacted stigma, there can be minor forms of enacted stigma (e.g. blaming, insulting, ignoring, not talking etc) and also a server forms of enacted stigma also called discrimination (unlawful actions).
2	Violence because you visited the service	**Definition:** This category includes the physical or verbal (spoken or written) actions that causes a client to be suffered physical or/and psychological (mental) violence against clients when they access the facility for services. Violence is more about the physical harm rather than the psychological harm. Here, the violence is said to be risen due to the visit of the facility or the clinic
3	Harassment (including sexual) from the service staff or other clients	**Definition:** This category includes all sort of physical, psychological (emotional) or sexual harassment faced by clients at the facility either from the staff or other clients. The main purpose of the harassment is to do a psychological harm rather than physical harm.
4	Breach of privacy or confidentiality	**Definition:** This category includes clients who faced a breach of privacy and confidentiality. **Privacy** here is defined as visual and auditory privacy when the client is sharing the sensitive information (sexual history) with the healthcare worker. **Confidentiality** is defined here to denote that the recording and storing of personal data and information have no access to others and all are kept under lock and key or password protected.

5	Refused service because of gender, identity, race, risk behaviour or other,	**Definition:** This category include clients who were refused from services which were supposed to be received from the facility.
6	Pain or distress	**Definition:** This category include clients who have to face some uncomfortable and undue pain and distress while receiving services from the facility (e.g. multiple punctures to take blood, painful insertions of the speculum and undue pain while taking urethral samples or rectal samples etc.)
7	Other	**Definition:** This category is used for any other form of serious incidents (SI) recorded by the client. If the answer is to be categorised under the "other" and it has to be specified.

4.3. Responsibility of the serious incident management

In the CLM process, the serious incidents are primarily managed by the "Case manager" appointed by the project management. The next responsible body of the serious incident management is the serious incident management committee (SIM committee).

1. Case manager: who should have SLQF level 5 or above (Bachelor's degree in a field relevant to the work)
2. SIM committee: Include group of experts in the area of law, sociology, Public administration, health, gender studies, human rights and experienced people in the field relevant to the work. Number of committee members should be three or five

4.4. Roles and responsibilities of the Case manager

CLM process need to employ Case managers (CM) based on the work load and the geographical areas to be covered. The main roles and responsibilities of the case manager are outlined below

Receive all the responded client feedback forms with serious incidents recorded

Serious incidents (SI) reported by clients in the client form need to be followed up by the CM if the client has given consent to do so in the client feedback form.

After a successful contact with the client, the CM then fills the second form called CLM follow up form for further details of the SI

After having administered the CLM follow up form, the case mange can refer the client to relevant services such as

HIV or health services

Counselling services

Legal services including police

Social welfare services

Other needed services

If the management of serious incidents is beyond the scope of the case manager which need higher level analysis, the case will be referred to the SIM committee for necessary actions.

The CM has to liaise with the SIM committee to complete the follow up of serious incidents.

The CM has to respond to the SI as early as possible (the maximum permitted delay is 30 days).

The case manager need to help in calculating the following indictors to the CLM management staff.

- **Prevalence of serious incidents:** Number and percentage of key population service visits where a serious incident (SI) is reported
- **Prevalence of stigma and discrimination:** Number and percentage of key population HIV service visits where stigma and discrimination was reported
- **Serious incidents follow up rate**: Number and percentage of serious incident reports followed up
- **Successful contact rate**: Number and percentage of serious incident reports where a successful contact
- **Correctly recorded SI rate:** Number and percentage of serious incidents correctly recorded
- **SI referral rate:** Number and percentage of serious incidents referred to services
- **SI resolution rate within 30 days:** Number and percentage of serious incidents Resolved within 30 days

4.5. Roles and responsibilities of the SIM committee

SIM committee has the following roles

(a) advisory role

(b) dialoguing role

(b) lobbying or advocacy role

Generally, all the SIs are first analysed by the "case manager" and necessary action are taken without a delay as early as possible (maximum allowed delay is one month). However, if the case manager's capacity to attend the client need is limited, then the case manager may need to consult the SIM committee for further advices.

The next main role of the SIM committee is to closely scrutinize reported serious incidents in order to examine whether any of the legal, policy or ethical standards (see the table below) violated by the service provider. Based on the individual case analysis, the SIM committee need to take necessary actions through dialoguing, lobbying or advocating with relevant parties.

Local, international laws and political tools	
Constitution of the Sri Lanka (Fundamental rights)	ICCPR: International Covenant on Civil and Political Rights
Penal code of Sri Lanka	CEDAW: Convention on the Elimination of All Forms of Discrimination against Women
UDHR; Universal Declaration of Human Rights,	CESCR: International Covenant on Economic, Social and Cultural Rights
Right to health	
Health policies and relevant local policies	

The SIM committee has to collectively take decision about next step of actions to mitigate the effect of service use by the key populations. Options for different actions are outlined below as examples

1. Inform the facility manager/s by sending letter with the details of violation of relevant sections of the law or policy and persuade the health management to take constructive decisions in order to create enabling environment for key populations
2. SIM committee can persuade or recommend the facility managers to take following actions to prevent serious incidents at workplace such as

- Advice to the healthcare worker (HCW) concerned
- Request for a letter of explanation from the HCW to the serious incident
- Requesting a letter form the person concerned (HCW) to provide reasons for not to proceed with legal actions
- Departmental disciplinary actions according to the establishment code (E-code) or relevant circulars
- Task shifting at health facility
- Request to carry out training and capacity building for those who are not competent in carrying out the duties as a professional work.

3. Guide the affected service users to take relevant legal actions against the HCW who is responsible for the serious incidents**.**

Annex X. Technical Working Group - Members

	Name	Designation	Institution
1	Palitha Wijayabandra (Chair)	KP Focal Point – Persons Living with HIV	KP Taskforce – CCM
2	Dr K A M Ariyarathne	Consultant Venereologist	Strategic Information Management (SIM) Unit - NSACP
3	Lakshan Fernando	SI Officer	Strategic Information Management (SIM) Unit - NSACP
4	Dr Sathya Herath	Community Health Physician	GFATM Project Lead - NSACP
5	Nadika Fernandopulle	Project Lead for GFATM Grant	FPA Sri Lanka
6	Amal Bandara	Assistant Director M&E	FPA Sri Lanka
7	Mahesh Nissanka	KP Focal Point – Persons Who Inject Drugs	KP Taskforce – CCM
8	Imasha Perera Kumarawadu	KP Representative - TG	
9	Manju Prasanna Hemal	KP Focal Point – MSM	KP Taskforce – CCM
10	S P I Niroshan	Alternate KP Focal Point – Persons Living with HIV	KP Taskforce – CCM
11	Singhe S. Wickramasinghe	Alternate KP Focal Point – Persons Who Inject Drugs	KP Taskforce – CCM
12	Ranjith Liyanage	Alternate KP Focal Point – Tourism Service Providers (formerly known as Beach Boys)	KP Taskforce – CCM
13	Januka Tillakaratne	KP Representative – Migrant Workers	Community Development Services
14	Kanthi Abeykoon	Alternate KP Focal Point – FWS	KP Taskforce – CCM
15	Jake Oorloff	Programme Officer - SKPA-2	FPASL


fpa
SRI LANKA
enriching relationships


SK
PA·2


National STD/AIDS
Control Programme
SRI LANKA


Lanka Plus
Towards Positive Living