Sri Lanka Red Cross Society
HIV Programme 2008-2010

EXECUTIVE SUMMARY

1. The purpose of the programme is to reduce vulnerability to HIV and its impact in Sri Lanka through preventing further HIV infection, expanding HIV care, treatment and support, and reducing HIV stigma and discrimination. The priority will be given to increase the capacity of the Sri Lanka Red Cross Society (SLRCS) to enhance the quality and ensure the sustainability of programming. All programming undertaken by the SLRCS will be implemented with the meaningful participation of people living with HIV (PLHIV) and affected communities.

2. While continuing to focus on key vulnerable populations, including estate sector workers, youth, prisoners, and people working in the tourist industry, the SLRCS will also seek funding to start programming among hotel workers in the southern costal belt of Sri Lanka. Hotel workers constitute a vulnerable group that has not yet received much attention in terms of HIV awareness raising and behaviour change communication (BCC). In prevention programmes, the SLRCS is working in close collaboration with the ministry of health, using peer education, community mobilization, information, education and communication approaches together with promotion of condom use and greater referral to voluntary counselling and testing (VCT) services. As the HIV epidemic continues to worsen, the SLRCS will scale up its effort in care and support by assisting PLHIV and their families with livelihood assistance. This assistance will be for income generating activities, facilitating referral to care and support, and establishing community support groups. In Sri Lankan society, stigma and discrimination towards PLHIV seriously hinders easy access to HIV information and care and support services. This contributes to a potentially further increase of HIV incidence rates. The SLRCS will scale up its interventions to reduce stigma and discrimination by establishing and mobilizing community support groups and networks of PLHIV, developing its workplace programme and addressing gender inequalities.

3. To achieve the SLRCS HIV programme targets and outputs, the SLRCS needs to further strengthen the capacity of its staff and volunteers. SLRCS wishes to remain a recognized local contributor to the national HIV response effort.

4. Through this programme, the SLRCS intends to double the number of beneficiaries reached and resources utilized by the end of the 2010. **The HIV Programme budget totals 1,568,301 over the three-year programme period.** The yearly funding requirements are: CHF 251,583 for 2008, CHF 624,000 for 2009, and CHF 586,000 for 2010. The available funding for 2008 is sufficient; however funding gaps of CHF 373,000 and CHF 335,000 are foreseen for 2009 and 2010, respectively. The SLRCS HIV programme is part of the South Asia HIV programme which is a component of the Red Cross and Red Crescent Global Alliance on HIV.

THE MAGNITUDE

5. Sri Lanka faces an HIV epidemic at an early phase, with limited potential for exponential growth unless behavioural patterns change (for example, predominant modes of drug use shift from inhalation to injection) and HIV spreads within and across networks of high-risk groups (such as injecting drug users (IDU) and female sex workers). Therefore, Sri Lanka is classified as a low

prevalence country, and globally recommended strategies for HIV prevention are being implemented accordingly.

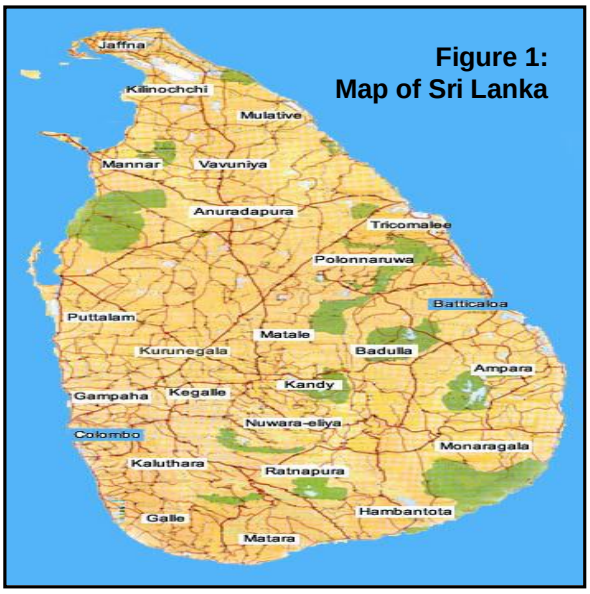

Figure 1: Map of Sri Lanka

6. The first case of HIV infection was reported in Sri Lanka in 1986, and 771 HIV infections have been reported by March 2006[1]. A cumulative total of 957 HIV infections and 266 AIDS cases have been detected in the country so far[2]. There has been a steady increase in the number of reported cases over the years, due in part to the increase in HIV testing facilities. To date, 172 persons have died of AIDS. The male to female ratio of reported HIV cases is 1.3:1. So far, 30 children have been infected with the virus as a result of vertical transmission from their mothers. Perinatal transmission accounts for 3.1per cent of all reported cases. The majority of HIV-affected people are in the 30 to 39-year age group. Injecting drug use is at present not reported as an urgent problem in the country. An Asian harm reduction network estimates there are 240,000 opiate users in Sri Lanka while the National Dangerous Drugs Control Board estimates there are 40,000 heroin and 20,000 cannabis users. Among heroin users, approximately 1 to 2 per cent are injecting. According to recent research findings, 0.2 per cent of the drug users are injecting. To date, two drug users are reported to be infected with HIV since the first case was reported in 2004. However, there are no cases of HIV transmission reported through sharing of injecting equipment as networking between IDU is limited.

7. Even though HIV is not a notifiable disease in Sri Lanka, all the confirmatory tests for HIV are done only at the national reference laboratory at the National STD and AIDS Control Programme (NSACP). From the laboratory, coded data is sent for the surveillance purposes. Sri Lanka, with its low HIV prevalence, is still considered to be at risk of a potential epidemic and it is important to interrupt transmission and care well for PLHIV while numbers are still low. Sri Lanka is at risk of a potential epidemic due to several factors. These are:

- An emerging sexually active youth population (17-19 per cent of the total population of 18.3 million in 2010).
- Increasing commercial sex (behavioural surveillance survey (BSS) mapping estimates 6,000 sex workers compared to previous estimates of 30,000).
- An open economy leading to large industrial zones with an estimated work force consisting of young people of over 100,000.
- External migrants (there are nearly 180,000 migrants yearly comprised mainly of Middle Eastern women).
- Large contingents of armed forces personnel as a result of the civil war in the north and east over nearly two decades.
- Child exploitation and abuse.

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8. Since 1993, the national STD / AIDS programme has conducted an annual HIV sero surveillance among various sentinel populations. In 2006, drug users in rehabilitation camps in the

[1] National AIDS Programme (NAP) epidemic 2nd quarter update 2008
[2] UNAIDS, Country Progress Report, Sri Lanka, 2008

southern and western provinces were included in the survey. Inclusion of men who have sex with men (MSM) as a sentinel group in the future is under consideration. In 2006, a total of 7,092 blood specimens were tested from patients with sexually transmitted infections (STIs), female sex workers, tuberculosis (TB), and military personnel; of these, only 12 specimens were HIV-positive – eight out of 2,216 (0.36 per cent) STD patients, two of a total of 1,216 (0.16 per cent) female sex workers, one of a total 1,332 (0.08per cent) TB patients, and one out of 432 (0.23per cent) drug users. The HIV prevalence is well below 1per cent. No data is available for MSM. These data still constitute the available and reported data for 2008.

9. In 2006, the first behavioural surveillance survey (BSS) was conducted among a representative sample of sex workers, MSM, factory workers, three wheel drivers, beach boys and drug users. Key findings were that the percentage of men buying commercial sex ranged from 1.1per cent among factory workers to 12.2 per cent among three wheel drivers and 15.5 per cent among drug users. Additionally, 0.8 per cent of factory workers and 5.5 per cent of drug users reported having male-to-male sex in the past year. Consistent condom use varied from a low of 46 per cent among MSM with non-regular partners to 80 per cent among factory workers with commercial sex workers.

10. The government of Sri Lanka is fully committed to the prevention and control of HIV, and has given the highest priority to achieving this goal by implementing a strong multi-sectoral and decentralized approach in its response. NSACP has made significant progress in[3]:

- Improving STD services;
- Ensuring safety of blood through screening of transfusions for HIV and upgrading of blood banks;
- Increasing awareness of HIV among high risk groups as well as among the general population;
- Promoting the use of the condom as the key prevention measure through the media;
- Encouraging the participation of government sectors other than health, such as education, labour, youth, military and women in national HIV prevention efforts; and
- Utilizing non-governmental organizations in prevention efforts directed at educational material, such as pamphlets, leaflets, brochures, posters, radio and TV spots, dramas and films occurs on a large scale.

Table 1: Key HIV and AIDS data in Sri Lanka (2007)

National data	
National population (census 2003)	20 million
Human Development Index	99
% of people with less than US$2 per day	41.6%
HIV and AIDS indicators	
Number of people (all ages) living with HIV	4,050
Adult (>15 years) HIV prevalence rate	< O.1 %
Adult (15 and over) living with HIV	Reported: 957 Estimate actual: 4,000
Women (15 yrs and over) living with HIV	<1000
Deaths due to AIDS (accumulated 2007)	172
Children (0-14 years) living with HIV	50
Orphans (0-17 years) due to AIDS	N/A
% of pregnant women receiving treatment to reduce mother to child transmission	N/A

[3] HIV/AIDS Manual, Ministry of Health 2004

% of HIV-infected women and men receiving ART	40% women, 60% men
% women and men (15-24 years) who correctly identify ways to prevent HIV	N/A
% women and men (15-24 years) who used condom last time they had casual sex	N/A

Source: National STD / AIDS Control Programme, Ministry of Health, HIV Surveillance data, Sri Lanka 7 Jan 08

THE IMPACT

11. Cultural and traditional practices in Sri Lanka related to family norms on sexuality and reproductive health issues often lead to reluctance to talk openly about how HIV is spread (mainly through sex and injection drug use) and how it can be prevented (especially through the correct and consistent use of condoms or through limiting the number of sexual partners). Failure to talk openly about these issues, including in the educational sector, has shown various negative effects (discouraging people from getting the facts they need to protect themselves, increasing fear, and causing rejection of those who are infected, for instance). Stigmatization in Sri Lanka is associated with any type of STI, which only worsens the situation. This environment also discourages people from getting tested and learning their HIV status. Unpublished reports have found that people living with HIV face rejection in many parts of their lives, and especially in health care settings. Various social and economic factors that may contribute to an increase of HIV in Sri Lanka are:

- External and internal migration, affecting both men and women, and including the Free Trade Zone workers (living away from spouses and family);
- Low use of condoms (3.8 per cent of couples use condoms as a contraceptive method in Sri Lanka, and many people report they are shy to enter a pharmacy to purchase condoms. Furthermore, to date there is little advertisement of condoms, and this method of prevention of HIV and some STIs is not mentioned in the education programmes for youth)[4];
- Displacement due to the civil conflict and the tsunami (which can lead to the destruction of protective community and family structures and to loss of livelihoods, both of which put people at risk);
- Apparent growth of sex work, often associated with military installations and three-wheel drivers, and including young people known to be selling sex in areas such as Kataragama, Anuradhapura and Ratnapura ;
- Existence of beach boys (who often sell sex with tourists) and men who have sex with men;
- Increasing rates of STIs reported bynational STD/AIDS programme;
- Large number of youth with limited information and services to help them protect themselves (findings of the 2006 UNICEF adolescent survey indicated that ‘awareness of symptoms of STDs was found to be very low’ and ‘more than two-thirds of adolescents were not aware of methods of HIV prevention’);
- Increasing average age of marriage, which means there are more years between the time that an individual attains sexual maturity and the time of marriage (during which time it is likely for people to have more than one sexual partner);
- Shyness to discuss issues related to sex.

12. However, there are also cultural factors that could help to prevent the spread of HIV:

- As society places great importance on the institution of marriage, the number of sexual partners that an individual is likely to have is believed to be low.

[4] UNAIDS, 2005

- According to the 2006 UNICEF adolescent survey, only six per cent of students reported that they have had a heterosexual experience, and ten per cent a homosexual experience. While this might be higher than in earlier years in Sri Lanka, it is low compared to other countries where youth become sexually active earlier.
- The number of injection drug users is low, and thus far HIV transmission through sharing injecting equipment has not been seen in Sri Lanka.

POLICY ON HIV

13. The SLRCS HIV programme is part of the South Asia regional HIV programme, which is a component of the Red Cross and Red Crescent Global Alliance on HIV.

14. The **purpose of our programme** is to reduce vulnerability to HIV and its impact in Sri Lanka through achieving the following **outputs**:

- Ø Preventing further HIV infection;
- Ø Expanding HIV care, treatment, and support;
- Ø Reducing HIV stigma and discrimination.

The above outputs are bolstered by a fourth:

- Ø Strengthening national Red Cross / Red Crescent society capacities to deliver and sustain scaled-up HIV programme.

15. The SLRCS work in accordance with the established principles of the International Red Cross and Red Crescent Movement to support the country's national HIV policies and programmes. The specific scope of the activities in this programme has been developed in coordination with the National AIDS Coordination Committee and harmonized with tasks agreed under international assistance arrangements in Sri Lanka, including UNAIDS, International Labour Organization (ILO), World Health Organization (WHO) and other UN agencies, non-governmental organizations and civil society groups, and donors.

TRACK RECORD AND LESSONS LEARNT

16. **Preventing further HIV infection:** The SLRCS has carried out HIV prevention activities since 1989, three years after the first cases were reported in 1986. At the time, SLRCS was engaged in HIV and AIDS awareness programmes through seminars, workshops and poster competitions complementing government efforts in prevention and control. These prevention activities only gained momentum in 2002 when SLRCS launched a series of 12 weekly radio programmes to create awareness on HIV and AIDS to the general public.

17. Since 2006, the SLRCS, with the International Federation Secretariat, has implemented an HIV prevention programme in the Tea Estate sector (because of low literacy levels, poverty, internal migration, local visitors visiting the area in seasons and alcohol, the sector is very vulnerable), which uses an adapted international model of HIV prevention in the work place setting. The programme is being expanded from two estates in 2007 to six estates in 2008 with regional multilateral Swedish Red Cross funding. Under the same regional programme, general HIV awareness raising in all branches is being carried out.

18. Though not primarily a HIV intervention, it is also worth noting that collaboration between SLRCS and the national blood transfusion services, the ministry of health, was established in 2008, with support of the German Red Cross and technical input from the International Federation Secretariat, for strengthening blood donor recruitment across the country. The approach is being pilot tested in two selected districts before expansion.

Table 1: Beneficiaries reached Jan 2005 – May 2008

	Key activities	2005	2006	2007	May 2008
Output 1	HIV prevention in tea estate sector,	5,000	6,500	7,000	10,000
Output 2	Livelihoods support to PLHIV through LANKA PLUS. Referral to VCCT through CBH.	50	60	80	120
Output 3	Reducing HIV stigma and discrimination, through: HIV prevention, HIV awareness countrywide & CBH / CBFA	5,500	7,500	10,000	10,500
Output 4	SLRCS staff and volunteers trained on HIV supported by the Federation Secretariat and partner NSs (bilaterally and multilaterally)	355	600	1,700	900

19. **Lessons Learnt:** Lessons learnt by SLRCS HIV prevention programme are as follows:

- It is useful to have an internationally recognized programme model, which has been country adapted (HIV prevention in the workplace setting, for example).
- The SLRCS has realized the need and benefits of collaborating with external partners (local and international).
- SLRCS branches should be enabled to raise funds.
- Gender equity is important in all programme components.
- Successful HIV prevention is best achieved through an integrated approach (addressing lifestyle related issues, personal hygiene promotion, reproductive health, safety and violence prevention).
- SLRCS branch must take ownership of programme.
- Programme sustainability is addressed through involving communities from the start and establishing community ownership, involvement of the ministry of health personnel in addition to seeking complementary funding.
- Programme monitoring needs to be improved.
- HIV in itself is not a priority to communities and so should be part of reproductive health services, for example.

20. **Expanding HIV care, treatment, and support:** The SLRCS is supporting PLHIV as part of the regional HIV programme for South Asia utilizing multilateral SRC funding. During 2008, 52 PLHIV are being supported with grants, through a local organization of PLHIV to initiate small scale livelihood and/or income generating activities. A new proposal is presently being generated to support an additional 15 PLHIV in a similar way during 2008.

21. Facilitating referral to health services for people in need and advocating for voluntary counselling and testing (VCT) is an important part of all HIV prevention programme activities as well as of community-based health services in 17 districts in Sri Lanka.

22. **Reducing HIV stigma and discrimination:** Addressing stigma and discrimination against PLHIV and creating a more open environment to discuss reproductive health issues, sexuality and life

style related issues are an important part of all HIV prevention programme activities as well as of community-based health services undertaken in 17 districts of the country.

23. The commemoration of World AIDS Day was started by SLRCS in 2002. In order to strengthen the national society capacity for HIV prevention activities, a training of trainers workshop was organized in June 2002 for national society branch volunteers from eight districts. Following the workshop, the branches were requested to conduct HIV awareness activities on World AIDS Day. The same year the national society health unit together with the national society youth wing, conducted a successful school art competition in observance of the World AIDS Day, which produced high quality information, education and communication materials on stigma and discrimination, as well as safe blood. The future commemorations of World AIDS Days have been expanded over the years to almost all branches across Sri Lanka. Awareness on HIV, AIDS and other STI has been an integral part of community-based health programme and first aid programme since 2003, implemented by SLRCS with support by nine different partner national societies and technical input from the International Federation country delegation and South Asia regional delegation.

24. **Strengthening national Red Cross/Red Crescent society capacities to deliver and sustain scaled-up HIV programme:** A comprehensive strategic plan for the SLRCS HIV programme during 2006 to 2010, was developed in December 2005, with the participation of the responsible executives from the national society, international experts and relevant ministry of health officials. The strategic plan emphasizes a focus on selected key populations for HIV prevention, using evidence-based high impact interventions, including promotion of condom use, support to PLHIV as well as anti-stigma and non-discrimination activities.

25. SLRCS's capacity on HIV has been significantly strengthening since 2005 through training of staff courses in and outside the country. Development of a participatory training guide on HIV to complement International Federation produced HIV materials was developed in collaboration with the American Red Cross to support training efforts. The community-based first aid programme has produced three fact sheets on HIV, STIs, and stigma and discrimination to be used by volunteers at community level.

26. The SLRCS and partner national societies have adopted a standardized approach to project implementation country wide, based on a ministry of health-approved framework and guided by technical manuals and materials. In this context, mechanisms for project sustainability and exit strategy, including roles and responsibilities, have been developed through a consultative process involving SLRCS central and branch levels as well as partner national societies. Moreover, a standardized evaluation tool is currently being rolled out by SLRCS and partner national societies.

27. The community-based first aid multilateral supported programme countrywide has the potential to become *the* vehicle for integrated programming in SLRCS across the core programmes. HIV is an integral part of the community-based first aid training curriculum which is being introduced in all branches of the country.

OUTPUT 1: HIV PREVENTION

28. To achieve Output 1, the following approaches will be implemented:

Table 4: Output 1 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Groups
1.1 Peer education and community mobilisation	**Peer education among community peer group leaders in tea estate sector and mobilization of estate population through formation of community groups in addition to general HIV awareness raising in key populations** **National society groups, conducted both by SLRCS countrywide and as an integral part of ongoing community-based health/community-based first aid projects. (HIV components are an integral part of community-based health/community-based first aid projects.)** • Advocacy for HIV prevention programme among estate management • Selection and training of community peer group leaders in targeted estates • Formation of community groups in targeted estates; youth, women, mixed adults • Training of staff, volunteers and peer leaders • Development of work plans with peer leaders • BCC sessions among estate populations • Implementation of community group activities • Provision of HIV key messages in connection with festival celebrations, street drama, poster competitions • Standard progress reporting and follow up visits • Respond to requests for general awareness raising in key	Badulla Newara Eliya Country wide coverage through general awareness raising and mainstreaming through community-based health/community-based first aid and blood donor recruitment project	Estate population: 30,000 (10 estates) districts covered by - 2010 About 7,500 key high risk and vulnerable populations across country: including: youth, migrant workers and their spouses, textile workers, prisoners, sex workers Communities, including youth, women: Plus awareness raising through community-based health/community-based first aid by 2010 (500,000 in numbers) HIV prevention work mainstreamed into 6 districts blood donor recruitment projects (youth circles about 1,500 registrations)

Approach	Key Activities	Geographical Target Areas	Target Groups
	vulnerable groups • Household visits for awareness raising on HIV, community group activities for community-based health /HIV awareness raising • Formation of HIV prevention youth clubs		
1.2 Information, Education, Communication (IEC) for targeted vulnerable groups	• Country adaptation of global materials (International Federation/WHO, community-based first aid/ HIV / TB component) • Revision of existing materials, NAP • Development of new materials, e.g. community-based first aid fact sheets on HIV, facilitators guide on participatory HIV training • Use IEC materials in connection with approach 1.1 above	Countrywide	50,000 in communities
1.3 Voluntary Counselling and Testing (VCT)	• As an integral part of all health projects to: 1.3.1. Advocate for target group to seek VCT • Accompany target groups to VCT • Community mobilizers (outreach workers) will be further trained	17 districts of country	Key high risk and vulnerable groups (approx.) 50,000
1.5 Skills for personal protection, including condom use	• Condom promotion will be an integral part of activities under Output 1 above.	From 2009; Southern costal belt (hotel workers Kalutera, Martara, Colombo and central part of isalnd Presently, tea estate population in two districts 17 districts where there are	1,200 male sex workers and their customers at 150 hotels 300 male sex workers (beach boys) and their customers in southern coastal belt Tea estate population

Approach	Key Activities	Geographical Target Areas	Target Groups
		community-based health/community-based first aid projects	HIV BCC with awareness raising: youth, migrant workers and their spouses, textile workers, prisoners, sex workers Community-based health/community-based first aid : 500,000 people

OUTPUT 2: EXPANDING HIV CARE, TREATMENT AND SUPPORT

29. To achieve Output 2, the following approaches will be implemented:

Table 5: Output 2 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Groups
2.4 Providing livelihood and food support for the most vulnerable	• Providing seed money for initiating income generating project	Across country	Members of national non-governmental organization for PLHIV (beneficiaries 75)

OUTPUT 3: REDUCING HIV STIGMA AND DISCRIMINATION

30. To achieve Output 3, the following approaches will be implemented:

Table 6: Output 3 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Groups
3.1 Developing community support groups and networks of people living with HIV, and partnerships with PLHIV organisations	• Advocate and facilitate referral to community groups and networks of PLHIV. E.g. LANKA + as part of all health activities • Continue partnerships with PLHIV organizations, e.g. Lanka+ • Training on community hygiene, management principles, income generation	Across country via above project activities	Members of national non-governmental organization for PLHIV (beneficiaries 75)
3.2 Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent national societies	• Adapt International Federation generic workplace programmes and policy • Analyze results of baseline survey in national societies • Training of headquarter staff and secondly branches • Develop national society workplace strategy • Implement HIV prevention in the workplace	Red Cross Red Crescent Movement in Sri Lanka	Red Cross Red Crescent Movement in Sri Lanka Staff and volunteers will be benefitted by the programme and policy
3.3 Tackling gender inequalities and sexual and gender based violence	• Further develop activities related to gender based violence and safety as part HIV prevention on tea estates • Under current memorandum of understanding between International Federation/ WHO on EPR, collaborate with WHO on prevention of gender based violence • Continue to promote home gardening as income generation with focus on women and family welfare • Collaborate with local non-governmental organization "Women in Need" as part of psychosocial support programme or community-based health	Badulla , Newara Elya Plus two new districts to be identified	30,000 (Tea estate population) Female community members in targeted community-based health project communities Women exposed to violence and reporting

Approach	Key Activities	Geographical Target Areas	Target Groups
3.4 Peer education, community mobilisation, and population-based information, education and communication	• Develop, distribute and apply community-based first aid fact sheet on stigma and discrimination as an integral part of all health activities mentioned above	Same as 3.1	Same as 3.1

OUTPUT 4: STRENGTHENING NATIONAL RED CROSS / RED CRESCENT SOCIETY CAPACITIES TO DELIVER AND SUSTAIN SCALED UP HIV PROGRAMMES

31. To achieve Output 4, the following approaches will be implemented:

Table 7: Output 4 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Groups
4.1 Further strengthening of SLRCS governance, accountability and leadership for advocating and implementing HIV workplace policies	• Ensure Global Alliance on HIV, plans and structure is fully implemented by SLRCS Governance and senior management group, partner national societies • Recruit Global Alliance coordinator and admin officer • Establish Global Alliance steering committee to: a) Set strategic directions, b) estimate/allocate resources, c) overlook and supervise the performance of Global Alliance partners/programmes, d) Ensure financial accountability to stakeholders, including budget management and standardized reporting e) safeguarding integrity of SLRCS f) establish SLRCS working group on HIV programmes under Global Alliance with membership of all involved, including branches as	SLRCS	SLRCS

Approach	Key Activities	Geographical Target Areas	Target Groups
	relevant		
4.2 Improving volunteer and staff support and management	• Implement recommendations on review of existing human resource assessment and career development strategy in national society • Review specifically the human resource assessment on regulation health to identify needs and gaps for ensuring appropriate qualifications and experience (right staff in right place, including women and PLHIV as appropriate) • Develop and implement volunteer and staff training, re Global Alliance approach • Conduct need based technical training • Implement recommendations of volunteer involvement value assessment (VIVA) • Development of volunteer database	SLRCS	SLRCS 10 hrs per week per volunteers (1,000 in number) SLRCS and volunteers
4.3 Strengthening programme cycle management	• Review of existing reporting system • Negotiate with all partner national societies/donors to accept standard reports • Working group to prepare comprehensive programme cycle management for approval of SLRCS governance and senior management	SLRCS	SLRCS
4.4 Widening partnerships and expanding resource mobilization	• Refer to Operational Alliance for community development programmes and work through those mechanism for the Global Alliance • Stakeholder analysis of existing and potential stakeholder in HIV • Overview of available resources and required funding for HIV • SLRCS leads resource mobilization efforts in country and beyond	SLRCS	SLRCS

IMPLEMENTATION AND MANAGEMENT ARRANGEMENTS

32. The programme will be implemented by the SLRCS with technical support of the International Federation country delegation and South Asia regional delegation in addition to the following partner national societies: Belgium, Canadian, Danish, Finnish, German, Italian, Japanese, Norwegian and Spanish Red Cross. Global Fund to fight AIDS, TB and malaria funding has been applied for during first quarter of 2008 for the coming three years. Collaboration is ongoing with UNAIDS, ministry of health, and LANKA+. All partner national societies and organizations have been informed of the Global Alliance membership and required collaboration and coordination mechanisms. Additionally, SLRCS/International Federation are looking for collaboration with local non-governmental organization partners like "Women in Need" and Sarvodaya[5] for more comprehensive HIV prevention, care and support interventions.

33. A steering committee of these stakeholders will be set up and chaired by the SLRCS. The in-country steering committee will meet on at least a three-monthly basis. A working group will be established under the steering group to carry out specific task and responsibilities.

34. The SLRCS health programme coordinator will coordinate the HIV Programme centrally. The SLRCS and its branches will be directly involved in HIV programme management and implementation. The working group for the Global Alliance on HIV to be established will draw on the membership of the present technical committee on health and psychosocial support programme (comprised of mangers, coordinators, the International Federation, and partner national society health delegates). The below will support the SLRCS health programme coordinator in his/her management of Global Alliance programming at headquarters:

- SLRCS, executive director health
- SLRCS, assistant director HIV
- SLRCS, programme support officer
- International Federation South Asia regional delegation, health team in Sri Lanka
- Partner national societies, health coordinators/delegates active in HIV

35. To scale up HIV programming, **community mobilizers** will be fully engaged and staff will play a strong role in volunteer recruitment, training and support. This will strengthen sustainability.

36. **The role of the SLRCS** is to provide country-specific leadership, priority-setting, coordination of partners, local advocacy and resource mobilization, and to take overall responsibility for programme delivery and accountability for results. The role of **partner national societies** is to provide resources, capacities (financial and technical), and specific inputs to support the products and services of the HIV Global Alliance in Sri Lanka, in accordance with the "seven ones". All above mentioned partner national societies supporting HIV in Sri Lanka have representatives in country. The role of the **Federation Secretariat (nationally, regionally and in Geneva)** is to provide leadership and facilitation to achieve Global Alliance objectives, in accord with the "seven ones" - specifically to provide:

- Policy and strategic guidance
- Coordination at global and regional level
- Advocacy
- Resource mobilization
- Knowledge and good practice sharing
- Technical support to enable achievement of objectives

[5] http://www.sarvodayasuwasetha.org/

- Framework for monitoring, reporting, accountability
- Management of financing system
- Technical input provided by health team (International Federation Secretariat in Sri Lanka)
- Needs based technical support for specific tasks and purposes (consultancies)

MONITORING AND REPORTING ARRANGEMENTS

37. This programme subscribes to the principles of the "seven ones" of the Global Alliance on HIV, including one performance monitoring system. Programme reviews (includes financial reporting) will be conducted on a regular basis (six-monthly and annually). A programme completion report will be produced at the end of the programme period. An external evaluation will be conducted in the final six months of the programme period.

RISKS, ASSUMPTIONS AND UNDERTAKINGS

38. **Risks:** Different requirements must be met for resources made available through different funding mechanisms, both multilateral (such as the Global Fund Country Coordinating Mechanism) and bilateral. This does not allow the programme to be managed as a single programme placing increased demands on programme managers that could otherwise be use in meeting programme objectives. Likewise, a single system of reporting among all partners would improve programme management. Increased collaboration among stakeholders to implement the Global Alliance seven ones would eliminate duplicate systems and reporting.

39. **Assumptions:** This programme has been developed on the assumptions that:
- Coordination is functioning well among Global Alliance on HIV stakeholders in Sri Lanka;
- Partner national societies and the International Federation Secretariat representatives in country understand the concept and implications of becoming members of Global Alliance on HIV, and provide management, technical and resource mobilization to support; and
- Partnership with external partners among the United Nations, non-governmental organizations, and the government enhances programme implementation.

40. **Challenges:** The above challenges will be best mitigated by:
- Appointing a Global Alliance coordinator within the SLRCS,
- Establishing the Global Alliance steering committee,
- Establishing the country working group to coordinate all programming,
- Advocating for a collaboration mechanism among the Red Cross Red Crescent Movement at country level (includes review of the SLRCS organizational structure),
- Reviewing human resource needs and implement recommendations,
- Establishing funding mechanisms in support of the Global Alliance, and
- Implementing a SLRCS-wide programme management and monitoring mechanism used among partners (adopting the Global Alliance framework and methodology as the basis).

SUMMARY OF RESULTS- BASED BUDGETARY FRAMEWORK

OUTPUTS	Jun - Dec 2008	2009	2010
1. Preventing further HIV infection (50%)	**150,950**	**374,400**	**351,600**
2. Expanding HIV care, treatment, and support (10%)	**25,158**	**62,400**	**58,600**
3. Reducing HIV stigma and discrimination (20%)	**30,190**	**74,880**	**70,320**
4. Strengthening national Red Cross / Red Crescent society capacities to deliver and sustain scaled-up HIV programme (20% plus monitoring and evaluation)	**48,285**	**115,320**	**110,480**
TOTAL	**254,583**	**627,000**	**591,000**

41. See Annex 2 for detailed HIV programme budget.

Explanation of costs

Output 4 budget allocation include the costs of monitoring and programme reviews, and an external evaluation at the end of the programme period.

Annex 2 detailed budget

Detailed HIV Programme Budget

Budget item		2008 (CHF)	2009 (CHF)	2010 (CHF)	Total (CHF)
OUTPUT 1					
1.A	Personnel	19,624	48,672	45,708	114,004
1.B	Capacity building / workshops, training & technical assistance	55,850	138,528	130,092	324,470
1.C	Capital expenses: equipment, supplies & materials	46,795	116,064	108,996	271,855
1.D	Transport and storage	6,038	14,976	14,064	35,078
1.E	Information, media, publications	10,566	26,208	24,612	61,386
1.F	Travel & communications	9,057	22,464	21,096	52,617
1.G	Office maintenance	3,020	7,488	7,032	17,540
1.I	*Subtotal*	*150,950*	*374,400*	*351,600*	
1.J	*Output 1 Total*				*876,950*
OUTPUT 2					
2.A	Personnel	2,515	6,240	5,860	14,615
2.B	Capacity building / workshops, training & technical assistance	6,290	15,600	14,650	36,540
2.C	Capital expenses: equipment, supplies & materials	4,780	11,850	11,134	27,764
2.D	Transport and storage	2,012	4,980	4,688	11,680
2.E	Information, media, publications	5,786	14,340	13,478	33,604
2.F	Travel & communications	3,775	9,390	8,790	21,955
2.I	*Subtotal*	*25,158*	*62,400*	*58,600*	
2.J	*Output 2 Total*				*146,158*
OUTPUT 3					
3.A	Personnel	603	1,499	1,408	3,510
3.B	Capacity building / workshops, training & technical assistance	20,530	50,918	47,818	119,266
3.C	Capital expenses: equipment, supplies & materials	906	2,246	2,109	5,261
3.D	Transport and storage	1,207	2,995	2,812	7,014
3.E	Information, media, publications	6,038	14,976	14,064	35,078
3.F	Travel & communications	604	1,498	1,406	3,508
3.G	Stationery	302	748	703	1,753
3.I	*Subtotal*	*30,190*	*74,880*	*70,320*	
3.J	*Output 3 Total*				*175,390*
OUTPUT 4					
4.A	Personnel	905	2,246	2,109	5,260

Budget item		2008 (CHF)	2009 (CHF)	2010 (CHF)	Total (CHF)
4.B	Capacity building / workshops, training & technical assistance	36,228	89,856	84,384	210,468
4.C	Capital expenses: equipment, supplies & materials	1,811	4,492	4,219	10,522
4.D	Transport and storage	1,811	4,492	4,219	10,522
4.E	Information, media, publications	2,266	5,618	5,274	13,158
4.F	Travel & communications	2,264	5,616	5,275	13,155
4.G	Programme monitoring, reviews and evaluations	3,000	3,000	5,000	8,000
4.H	*Subtotal*	48,285	115,320	110,480	
4.I	*Output 4 Total*				*274,085*
K	**Subtotal of all Outputs**				**1,472,583**
L	Programme support recovery (PSR)				95,718
M	**GRAND TOTAL**				**1,568,301**

* About 3% of K: subtotal of all Outputs

Annex 3 – targets for scaling up

HIV Programme Scaling up Targets

Output 1

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
1. People in tea estates (aged 15-45 years)	Number of beneficiaries targeted (2,000 in each of 4 estates): 8,000	Number of beneficiaries targeted (2,000 people in each of 6 states): 12,000	Number of beneficiaries targeted (2,000 people in each of 10 estates): 20,000	Number of beneficiaries targeted (2,000 people in each of 14 estates) 28,000	**Total number of beneficiaries reached: 28,000**
2. Hotel workers, their clients, beach boys, three wheel drivers (selected areas - southern costal belt)	--	Hotel workers: 80 Clients: 320 Beach boys: 40 Drivers: 50 Total: 490	Hotel workers: 160 Clients: 640 Beach boys: 50 Drivers: 80 Total: 930	Hotel workers: 240 Clients: 960 Beach boys: 100 Drivers: 100 Total: 1,400	**Total number of beneficiaries reached: 2,820**
3. Hotel workers, their clients, & three- wheel drivers (in specific areas in central districts of Sri Lanka)	--	Hotel workers: 80 Clients: 320 Drivers: 50 Total: 450	Hotel workers: 160 Clients: 640 Drivers: 80 Total: 880	Hotel workers: 240 Clients: 960 Drivers: 100 Total: 1,300	**Total number of beneficiaries reached: 2,630**
4. Students, youth, key vulnerable groups (throughout Sri Lanka)	1,500 Total target population: 1,000,000	17,500	30,000	45,000	**Total number of beneficiaries reached: 78,500**

Output 2

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
1. PLHIV and their families (Lanka PLUS members and their families)	Number of beneficiaries targeted: 20 PLHIV Total target population: 107	Number of beneficiaries targeted: 53 PLHIV Total target population: 107	Number of beneficiaries targeted: 60 PLHIV Total target population: 107	Number of beneficiaries targeted: ***follow up on 60 PLHIV*** Total target population: 107	**Total number of beneficiaries reached: 60** Increase in no of beneficiaries 40

Output 3

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
1. SLRCS governance, senior management, staff and volunteers	Number of beneficiaries targeted 250	Number of beneficiaries targeted: 750	Number of beneficiaries targeted, 2250	Number of beneficiaries targeted, 5500	**Total increase in number of beneficiaries targeted: X**
2. Individuals in targeted high risk and vulnerable key populations such as hotel workers, beach boys, prisoners, tea estate workers etc (integral part of Psychsocial support, Public Health in Emergencies, Community Based Health and first aid)	Number of beneficiaries targeted: 7,500 Total target population: 1,500,000	Number of beneficiaries targeted: 28,500	Number of beneficiaries targeted: 56,600	Number of beneficiaries targeted: 85,100	**Total increase in number of beneficiaries targeted: 54,000**

Output 4

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
1. SLRCS governance, senior management, staff and volunteers	Number of beneficiaries targeted 250	Number of beneficiaries targeted: 750	Number of beneficiaries targeted, 2250	Number of beneficiaries targeted, 5500	**Total increase in number of beneficiaries targeted: X**