# Scaling Up Towards Universal Access to HIV/AIDS Prevention, Care, and Treatment

# Sri Lanka Country Report

National STD/AIDS Control Programme

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# I. Executive Summary

Sri Lanka currently has an HIV prevalence rate of less than 0.1 percent. In order to maintain the low prevalence rate, Sri Lanka's universal access priority will be in the area of prevention, though treatment and care will also be expanded. Sri Lanka also plans to conduct advocacy and campaigns to improve attitudes towards HIV and AIDS in the society and facilitate access to all services.

Sri Lanka's primary focus will be on increasing access to prevention services and programs by 2010. In particular, emphasis will be placed on expanding counseling and testing services at the community level, promoting condom use among high risk groups as well as in the general population, and improving knowledge about HIV transmission and prevention among various target groups. With regard to sexually transmitted infections (STIs), Sri Lanka will aim to increase health-seeking behavior and to ensure that general practitioners are properly trained in STI management protocols. Prevention of mother to child transmission (PMTCT) will continue, though the emphasis will shift to areas of higher prevalence and a risk-screening tool will be introduced to support the PMTCT efforts. Finally, post-exposure prophylaxis and universal precautions will be promoted among medical personnel to reduce the risk of transmission in health care settings and to help reduce fear among health care providers.

For those Sri Lankans that are living with HIV and AIDS, universal access to treatment and care will be provided. The number of sites offering ART will be increased in order to ensure that 90 percent of medically-eligible patients receive ART, which is available free of charge in government settings. Drug procurement will need to be improved and personnel will need to be trained in the latest disease management protocols in order for patients to receive optimal treatment. In addition, home-based services will be augmented throughout the country.

In order to ensure access to prevention, treatment, and care, it will be important for Sri Lanka to understand the characteristics of the current epidemic in greater detail. Thus, surveillance, both sero- and behavioral, will be improved in order to aid in service planning exercises.

In addition to lack of data, attitudes in Sri Lanka, among the general population, policy makers, health personnel and others, need to change in order to facilitate expansion of services. HIV and AIDS need to be understood as concrete issues, despite the current low prevalence, and the importance of prevention needs to be emphasized. More importantly, stigma and discrimination need to be addressed in order to ensure that people living with HIV and AIDS receive necessary services in a confidential, respectful manner.

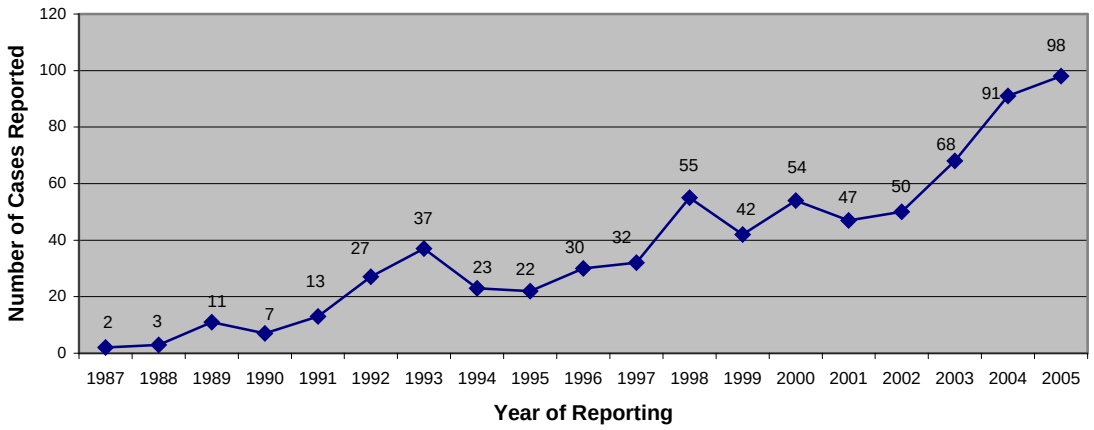
In gearing up for universal access, there are several obstacles besides the lack of data and the prevailing attitudes in the country. The ongoing conflict in the North and East makes surveillance and delivery of services difficult for a significant percentage of the population. In addition, limited human resources hamper expansion of services. In order to overcome these obstacles, facilities will need to be improved in key areas, and a large effort will need to be undertaken to train trainers and conduct capacity building in the government, private, and NGO sectors throughout the country. If Sri Lanka can overcome these various obstacles, universal access to needed prevention and treatment services for those living with and at-risk for HIV and AIDS will be achievable by 2010.

# II. HIV/AIDS in Sri Lanka

## A. Epidemiology

HIV prevalence in Sri Lanka is estimated to be less than 0.1 percent. Although prevalence remains low, the number of reported HIV cases generally has been increasing since the first cases were reported in 1987, as shown in the figure below.

**Number of Reported HIV Cases from 1987 to Third Quarter 2005**




As of the end of 2005, the National STD/AIDS Control Programme (NSACP) reported 743 cumulative positive HIV test results since 1986. This figure does not include all tests conducted in private clinics or those conducted abroad. UNAIDS estimates that 5,000 Sri Lankans between the ages of 15 and 49 are living with HIV. At the end of 2005, the NSACP reported 207 cumulative AIDS cases, of which 144 have died.

Of the known 743 cases of HIV, the vast majority (85 percent) was infected through heterosexual sex, 11 percent through homosexual sex, 3 percent from mother to child, and 1 percent through blood transfusions. The only known individual to be infected through injection drug use contracted HIV abroad.

In terms of the geographic distribution, every province in the country has reported positive cases, though sixty percent reportedly come from the Western Province and the area near Colombo. This percentage may be misleading, however, as individuals may travel to Colombo from other parts of the country for testing and may not provide accurate contact details.

Although surveillance data provides information about the number of cases and reported modes of transmission, little information exists about risk groups and behavior. Data do indicate that women are increasingly becoming infected, currently representing 47 percent of known infections. In addition, data indicate that the rates of sexually transmitted infections other than syphilis have increased over the past few years, which may reflect more unprotected sex or simply more health seeking behaviors. Very limited information exists about the behavior of sex

workers, men who have sex with men, transport workers, uniformed service personnel, and fishermen, all of whom are considered to be at risk or vulnerable groups.

### B. The Cultural, Social, and Economic Context

There are numerous cultural, social, and economic factors that may play a role in the epidemiology of HIV/AIDS in Sri Lanka. In general, Sri Lankan culture and traditional family norms relating to sexuality and reproductive health issues have limited the discussion of the spread of HIV and methods of prevention. Restricted discussion of issues such as sex, injection drug use, and condoms may limit the ability of individuals to protect themselves and may result in increased fear of the virus and stigmatization of those infected with HIV. In an environment in which there is stigma associated with all types of sexually transmitted infections, individuals may be reluctant to get tested and determine their HIV status, which may in turn result in the unknowing spread of the virus.

Additional risk factors in Sri Lanka include:

- *Migration*. Both external and internal migration of men and women (including the Free Trade Zone workers) and the resulting separation of individuals from spouses and family may increase risk of exposure to the virus.
- *Limited Condom Use*. Only 3.8 percent 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. Further, to date there is little advertisement of condoms, and this method of prevention of HIV and some STIs is not mentioned in the education programs for youth.
- *Displacement Due to Civil Conflict and Tsunami*. Displacement may destroy protective community and family structures and result in loss of livelihood, both of which put people at risk.
- *Sex Work*. An apparent growth in 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.
- *Men Who Have Sex With Men*. Beach boys and other men who have sex with men may be at high risk, as anal sex is a highly efficient mode of HIV transmission.
- *Regional Travel*. Travelers to areas of higher HIV prevalence, such as India, Thailand, and Europe may become infected.
- *Sexually Transmitted Infections*. Rates for many STIs are increasing and people are reportedly not seeking medical treatment due to shame.
- *Lack of Information for Youth*. A large number of youth have limited information and services to help them protect themselves, as found in the UNICEF Adolescent Survey.
- *Increasing Average Age of Marriage*. The average age of marriage is increasing, meaning that there are more years between sexual maturity and time of marriage, so multiple sexual partners are more likely.

There are also numerous cultural factors that may limit the spread of HIV, including:

- *Institution of Marriage*. Society highly values the institution of marriage, so the number of sexual partners an individual is likely to have is believed to be low.
- *Low Sexual Activity Among Youth.* UNICEF Adolescent Survey found that 6 percent of students reported a heterosexual experience and 10 percent 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 at much younger ages.
- *Low Numbers of Injection Drug Users.* The number of injection drug users is low, and thus far this mode of HIV transmission has not been seen in Sri Lanka.
- *Tea Plantation Workers.* The fact that tea plantation workers in the past have lived with their families and did not migrate for employment has probably helped to keep HIV low in Sri Lanka (despite their low knowledge of STIs and HIV and the fact that this situation is now changing).

# III. National Response

## A. Overview

The national response to HIV/AIDS in Sri Lanka is led by the Ministry of Health, NSACP, which is responsible for planning, monitoring, some implementation, and provision of technical guidance to provincial and district health authorities, who have the major implementation responsibility. While the response has been in place for many years, it has been augmented in the past few years with the support of a growing number of partners and with significant financial support through the National HIV/AIDS Prevention Project (NHAPP) financed by a World Bank grant.

The NHAPP funds are used for a wide range of prevention initiatives. One key element is encouragement of a multi-sectoral response through support to the following: National Child Protection Authority, Sri Lanka Bureau of Foreign Employment, National Institute of Education, Ministry of Labour/Workers' Education Unit, the Department of Prisons, National Youth Services Council, Army, Navy, Air Force, Police Department, Vocational Training Authority, and Ministry of Fisheries. NSACP is liaising with provincial and district health authorities to encourage a multi-sectoral effort down to decentralized levels. This has led to establishment of Provincial and District AIDS Committees functioning in most provinces and a few districts. Specialized projects have been carried out by some of the district teams addressing antenatal mothers in Kandy, guest house owners and their clients in Badulla, female sex workers Kalutara, fishermen in Puttalam, men having sex with men in Anuradhapura, garment factory workers in Kegalle, and three-wheel drivers in Ratnapura District.

In addition, NHAPP has supported a major effort to sensitize political leaders at all levels of government, as well as religious leaders from all four religious groups. Moreover, a number of critical activities are now about to commence, including a mass communication campaign, development of a behavior surveillance system, a condom social marketing initiative, engagement of a firm to manage and strengthen the NGO response, targeted work with vulnerable groups (sex workers, transport workers, drug users, and internal migrants), and

establishment of a management information system for NSACP, the National TB Control Programme and the National Blood Transfusion Services. The Management Information System will link all public sector STD clinics to the NSACP, and will include patient record, drug availability, and HIV information. This system will also be used for program monitoring purposes. Further, the project has supported 47 NGOs who have been working with vulnerable communities in all districts islandwide.

Finally, under NHAPP, the NSACP has put in place a comprehensive care and treatment program offering anti-retroviral drugs to anyone who is medically eligible. The program provides both drugs and laboratory support at no cost to patients at the NSACP Central Outpatient Clinic, with links to the Infectious Diseases Hospital.

As a complement to the NHAPP, all UN agencies are involved in a range of prevention activities, in partnership with ministries and NGOs. These include provision of support to the private sector (ILO with Ministry of Labour, under a three-and-a-half year project financed by the U.S. Department of Labor in collaboration with the private sector), the agriculture sector (WFP and FAO with the Ministry of Agriculture and FPA), migrants, FTZ workers and tsunami-affected communities (IOM with Janasetha Sahana Foundation, SLBFE), displaced people in the north and east (UNHCR with SAC, SLRCS, RDF, and several DPDHS offices), in- and out-of-school youth (UNICEF and UNFPA with Sarvodaya, Girl Guides, NIE, MOL, NYAC, SLA, FPA), prison staff and inmates (UNFPA and SLAVC), people living with HIV/AIDS (UNDP with Lanka+), women leaders in the north and east (UNDP with CDS), and drug users (UNODC with ADIC, SLANA, Mithuro Mithuro and Apekedella, SLFONGOADA). Further, technical support on epidemic surveillance and estimation has been provided to NSACP by WHO.

Through the Asia-Pacific Leadership Forum (APLF), the UNAIDS Secretariat is supporting work with a variety of leaders, also through UN agency execution and NGO implementation. These include: health sector leaders, with the objective of improving the quality of care of AIDS patients in four hospitals (World Bank with the Ministry of Health and The Salvation Army), religious leaders (UNICEF with Sarvodaya), political and civil society leaders in the north and east (World Bank with Sarvodaya), a media initiative featuring popular leaders (media firm with World Bank), and high-level leadership (UNAIDS with the Presidential Secretariat and Ministry of Health). APLF also funded a study on stigma and discrimination (UNDP with CPA) and a leadership mapping exercise (prepared by a professor with UNAIDS Secretariat).

Further, in addition to the 47 NGOs that received funds through NHAPP, other NGOs are working islandwide with financial support provided through the AIDS Coalition or through independent financing. These include, among others, Lanka+ (the only organization of people living with HIV in Sri Lanka), Companions on a Journey (working with men who have sex with men), the Salvation Army and Nest (both providing care and support to people infected and affected by HIV, Community Development Services (working with sex workers and training NGOs), Alliance Lanka and the Family Planning Association (doing general awareness), and Sarvodaya (working with youth and religious leaders). The major international NGO is ActionAid/Sri Lanka, providing training to NGOs on behavior change communication and

working with tsunami-affected communities. Other international NGOs doing some awareness work include Plan International and the Christian Children's Fund.

Importantly, the private sector has demonstrated commitment to preventing the spread of HIV among employees and providing a constructive policy environment to ensure non-discrimination in the workplace. This work was initiated through the Ceylon Chamber of Commerce and the Employers Federation of Ceylon (in collaboration with ILO), and is now expanding with support from both the NHAPP and the ILO. The major private sector player at the moment is John Keels Holdings, which has initiated a three-year AIDS awareness programme for their staff, their families, and the communities surrounding the company's holdings.

In order to improve the national response, the National AIDS Committee (NAC), through its sub-committee on legal and ethical issues, been developing an HIV/AIDS policy document. As of late 2005, the NAC has issued a draft HIV/AIDS policy document for comment by stakeholders. The document provides clear statements on the Government's commitment to most of the critical issues: HIV testing is to be voluntary and confidential; human rights are to be respected; efforts are to be made to reach out to the sex work community; condoms are highlighted as one method of HIV prevention; people living with HIV are to be accorded the right to confidentiality; both adolescents and prisoners are to be given the right to information and access to reproductive health and HIV/AIDS services; and the importance of workplace education programs and non-discrimination policies are highlighted. A number of policy areas need to be added to the draft (e.g., operational policies on anti-retroviral drugs, provision of drugs to prevent mother-to-child transmission, management of TB/HIV, and the need to offer education and services to men who have sex with men; protection of health care workers). The one area for concern is the draft language on contacting blood donors who test positive for HIV during screening, as such people would not have access to the pre- and post-test counseling that should accompany all HIV testing. The NAC is now receiving comments on the draft policy, after which it plans to hold a consultation at which the policy will be finalized.

A National Strategic Plan has guided the national response in the past. In 2001 the NSACP produced a National Strategic Plan for 2002-2006. The plan included a long list of relevant actions, but did not indicate priorities or the costs of implementing the various actions. At this point, it is time for a consultative review of the progress made during the current plan period and to produce a new plan for 2007-2011 through a participatory process. It is hoped that the new plan can include clear priorities, identify associated costs and financing sources, and present operational details to help implement the priority activities.

The Universal Access Country Consultation Workshop should serve as a useful prelude to the development of a new strategic plan. Participants in the workshop, which included members of the government and civil society, identified a number of priority areas, namely in the areas of prevention, treatment, care, and policy. For each area, targets, quantifiable if possible, have been established in order to achieve universal access to all HIV/AIDS related services by 2010. The matrix of baselines, targets, obstacles, and solutions is attached as Appendix A. The following section does not repeat all of the details contained in the matrix, but refers to selected targets, obstacles, and solutions where relevant.

### B. Advocacy, Public Policy, and Legal Framework

In order to achieve universal access to HIV/AIDS services over the next four years, Sri Lanka will aim to make several key policy changes through a sustained advocacy effort. The primary goal will be to reduce the stigma of HIV and to change attitudes among the general public, health personnel, and policy makers in order to ensure that people living with HIV/AIDS are treated with respect and receive the services they need in a confidential, respectful manner.

Stigma and discrimination limit access to services in a number of ways in Sri Lanka. Because health personnel are unaware of the availability of PEP and fail to practice universal precautions consistently, they fear infection and therefore do not always treat people living with HIV and AIDS with dignity and respect. In addition, the attitude of some community members and health personnel makes some patients reluctant to seek necessary health care. The reportedly common failure of health personnel to respect patient confidentiality further exacerbates the reluctance to seek care.

In addition to improving attitudes among the health care delivery system and community, scaling up to universal access will require the public and policy makers to accord more importance to HIV/AIDS. Until HIV/AIDS is perceived as a priority at all levels of government, such as through the establishment of a dedicated Parliamentary Forum and active and functioning provincial level AIDS Committees, it will be difficult to mobilize the resources needed to achieve universal access. In the next four years, Sri Lanka will rely on lobbying and advocacy efforts by NGOs and the Asia Pacific Leadership Forum as well as on leadership from the Minister of Health and other key ministries to bring HIV/AIDS to the forefront of public discourse.

Finally, a number of changes are needed to ensure full respect for the human rights of people living with and affected by HIV and AIDS. Such changes include availability of legal assistance, elimination of coercive HIV testing, full respect of confidentiality, change in attitude of the police force towards marginalized groups, and increased access to psychosocial services. The main obstacles to achieving these targets are also attitude-related, so that strong leadership, sensitization, and advocacy will assist in reaching the goals.

Relevant targets:

- Educate all health workers in the government clinics and institutions and in private health care settings about the availability of post-exposure prophylaxis
- At least 90 percent of health workers (private and public) will practice universal precautions
- Strengthened NGO, private sector, and non-health agency participation in the national response
- Have a core group of provincial counselors and parliamentarians to provide leadership on HIV/AIDS
- All provincial level AIDS Committees functioning and active
- Establish a Parliamentary Forum on HIV/AIDS
- At least one NGO or bar association providing free legal assistance to persons infected and affected by HIV/AIDS

- Ensure testing is conducted on a voluntary basis
- Reduce number of incidents of breach of confidentiality
- 90 percent of police personnel showing favorable attitudes towards marginalized groups
- National Policy on Disability will include reproductive health education and access to information and services for persons with disabilities
- Provide psychosocial services to those infected and affected by HIV/AIDS

### C. Strategic Planning, Alignment, Harmonization, and Partnerships

A major obstacle to achieving universal access is the lack of adequate data for planning purposes. The current lack of data regarding the at-risk populations, such as sex workers, makes it difficult to calculate the need for services and target them effectively. Data collection efforts are being improved through the addition of sentinel groups and data collection sites. By involving NGOs in order to reach at-risk groups, particularly in the North and East, it may be possible to more fully capture the characteristics of the epidemic in Sri Lanka. Further, limited information exists regarding risk behaviors, but conducting an annual behavioral surveillance survey, which is currently underway, should provide needed information to assist in program planning.

A data-based response will require a coordinated multi-sectoral approach in order to achieve universal access. By developing NGO linkages and involving non-health agencies, such as the Ministry of Education or the Armed Forces, Sri Lanka will be better able to meet the diverse needs of the affected population. For example, the Ministry of Education should be actively involved in improving delivery of the existing reproductive health curriculum in order to achieve the desired results in the knowledge of youth about HIV transmission and prevention. Coordination among the various sectors involved will be crucial to identifying service gaps and preventing duplication of services. For this reason, an NGO network needs to be formed that will also interface with the public and private sectors in order to facilitate planning of a comprehensive response.

Relevant targets:

- Expand data collection by including additional sentinel groups (MSM, drug users) and additional sites for sero-surveillance
- Conduct behavioral surveillance survey annually and feed results into program planning
- Establish district level NGO network
- Increase the number of capable NGOs
- Strengthen NGO, private sector, and non-health agency participation in the national response

### D. Sustainable Financing

Due to the low prevalence of HIV in Sri Lanka and a substantial World Bank grant, funding for ongoing programs has not been a significant issue in the past. Moving forward, however, it may be necessary for NGOs and the government to diversify funding sources and

ensure sustainability of prevention, treatment and care efforts. Some capacity building for NGOs would be useful in this regard. In addition, policy-makers will need to prioritize HIV/AIDS in order for resource allocation to be sufficient to meet expected needs.

Relevant targets:

- Improve law maker commitment to HIV/AIDS issue, including advocacy for increased government spending
- Increase capacity of NGOs to raise funds

### E. Human Resources

Discussion during the consultation brought out the small number of trained clinicians available to treat opportunistic infections and prescribe and monitor antiretrovirals, as well as the limited number of NGOs able to work effectively with high risk groups at the community level. The availability of skilled human resources is critical to achievement of universal access. The issue of human resources as a resource need and obstacle and possible ways to address the shortage of human resources are discussed Sections IV.B. and V. below.

### F. Organization, Systems, and Infrastructure

Sri Lanka will expand and improve some of its existing infrastructure and systems in its effort to achieve universal access in the next four years. In particular, counseling and testing will be expanded through the establishment of 10 additional centers at the community level and 2 additional VCT counselors per MOH target area.

In terms of treatment, greater access will depend on improvement of existing drug procurement management as well as infrastructure improvements. Currently, there is a lack of certain antiretroviral drug combinations and limited availability of pediatric formulas in syrup form. Similarly, certain drugs for opportunistic infections are not available. With improved procurement management, a full range of drugs should be made available, particularly as funding exists for obtaining the necessary medications. In addition to procurement issues, additional hospitals need to offer ART in order for patients throughout the country to be able to access treatment. Further, laboratory facilities for the diagnosis of opportunistic infections need to be improved in order to guarantee access to needed OI drugs.

Relevant targets:

- Establish 10 community level sexual health promotion and counseling and referral centers
- Train 2 VCT counselors per MOH target area
- At least 90 percent of eligible patients will receive ART
- At least one hospital per province should offer ART (with Kandy, Jaffna, and Anuradhapura to offer ART by 2007)
- All HIV positive people will have access to high quality, affordable drugs for opportunistic infections

## G. Service Coverage

As mentioned previously, Sri Lanka is primarily focused on expanding access to prevention programs, though efforts will also be made to increase access to high quality, affordable care and treatment. Among prevention efforts, counseling and testing, condom use, and education are particularly important, particularly for high-risk groups, women, and youth. Every opportunity to reach high-risk individuals should be taken, for example by expanding testing and improving treatment for sexually transmitted infections and offering HIV testing to high-risk tuberculosis patients. The major challenges associated with reaching the targets identified below are the recurring issues of the lack of human resources, the conflict, stigma, and attitudes. The Management Information System currently under development will be used to track both clinical and programmatic information.

Relevant targets:

- By 2007, 60 percent of female CSW will use condoms consistently, and 70 percent by 2010
- By 2006, 80 percent of female CSW will be reached with effective HIV prevention interventions
- 50 percent of MSM will use condoms consistently
- 5 percent of couples will use condoms for contraceptive purposes
- Promotion of dual protection at all service delivery points (government or private)
- 80 percent of youth (both in and out of school) able to correctly identify modes of HIV transmission and methods of prevention
- 80 percent of women in general population and 60 percent of women on estates know 3 modes of HIV transmission and 3 methods of protection
- Implementation of HIV/AIDS education programs for women in the general population
- By 2007, 3 peer educators trained and functioning in each GN division; 20 peer educators by 2010
- Youth friendly services provided in 10 districts by 2008, in all districts by 2010
- Commence HIV/AIDS education programs at special education units and orphanages by 2008
- Offer HIV testing to 100 percent of patients seeking care at government STI clinics
- Increase health seeking behaviors for STIs
- 50 percent of GPs trained and using the standard protocols on management of STIs by 2007 and 80 percent by 2010
- In three selected high prevalence areas, conduct a pilot program for antenatal risk screening for pregnant women and offer HIV testing to pregnant women as needed, with the goals of 70 percent of pregnant mothers accepting VCT, 60 percent of HIV infected mothers detected, and 80 percent of infants born to HIV infected mothers free from HIV
- Antenatal syphilis screening for all pregnant women attending antenatal services
- Increase voluntary blood donations and centralize screening for TTIs
- At least 90 percent of eligible patients will receive ART
- All HIV positive people will have access to high quality, affordable drugs for opportunistic infections

- 100 percent of high risk TB patients will be offered HIV testing
- Comprehensive home-based services (including transportation, food, companionship, and other services) should be offered by at least 1 NGO in each province

# IV. Resource Needs

## A. Financial

Presently, funding is not viewed as a significant obstacle to achieving universal access. The two areas that will require additional financial resources are expansion of counseling and testing and education efforts. The overall perception, however, is that existing donors can meet needs, provided the needs are clearly identified.

While the national HIV/AIDS program does not currently require large financial contributions, there are a number of NGOs that need to build their capacity to obtain sustainable financing. Training regarding fundraising and development should be conducted in order to ensure that current and future efforts are not jeopardized by the financial instability of relevant organizations.

## B. Human

The primary obstacle to achieving universal access by 2010 will be human resources. In order to overcome this obstacle, efforts will need to be made to train sufficient numbers of trainers to fulfill the capacity-building needs of all services and sectors. For example, training for government and private physicians on ART, particularly for pediatric cases, is a crucial need. Without adequate numbers of skilled trainers, universal access to ART will not be achieved.

Prevention efforts also hinge on the availability of adequate human resources. Counseling and testing, for example, will be expanded by establishing ten new community-level sexual health promotion and counseling and referral centers as well as by training two counselors per MOH target area. In order to make these goals a reality, however, significant training will be required. Similarly, in order to promote condom use and carry out behavior change and education campaigns, the capacity building of NGOs targeting relevant groups will be critical. Finally, the targets of conducting a PMTCT pilot program with antenatal risk screening will not be possible without a significant increase in the number of trained health personnel because antenatal clinics are already struggling to meet the needs of the high volume of patients. Again, training of trainers followed by widespread training of personnel will be critical to meeting the human resource requirements of the planned prevention programs.

# V. Regional and Global Action Needed

One way to address the important issue of limited human resources in Sri Lanka and other countries in the Asia-Pacific region, as well as in less developed countries generally, would be to encourage trained personnel to remain in their home countries. Perhaps if governments of industrialized countries would refrain from recruiting medical personnel from less-developed countries, this would aid in preventing their migration. In addition, if donors would finance

recurrent costs, medical personnel could be paid more competitive salaries in their home countries, which may also reduce the drain on valuable human resources from less developed countries.

In addition, greater commitment of experienced international NGOs to building the capacity of local NGOs would bring much-needed quality inputs to the potential civil society role. Perhaps donors could create incentives through funding mechanisms to encourage such training in the NGO sector in order to improve national responses to HIV/AIDS.

# APPENDIX A: Sri Lanka Country Consultation: Baselines, Targets, Obstacles, and Solutions Matrix

### TABLE 1: PREVENTION: COUNSELING AND TESTING

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • 26 clinics offer testing and by 2008 will have sites targeting transportation workers, sex workers, drug users and internal migrants<br>• Inadequate sexual health promotion centers at community and workplace level to provide referrals to testing centers | • Establish 10 sexual health promotion and counseling and referral centers<br>• Train 2 counselors per MOH target area | • Funds and trainers<br>• Need system to ensure sustainability<br>• Lack of motivation to seek counseling<br>• Conflict in Northeast impacts access | • Donor commitment—negotiate for funding<br>• Capacity building for training of trainers and management<br>• Establish system at provincial level for the centers<br>• Awareness creation through existing system<br>• Address vulnerable and high risk groups to encourage testing<br>• Encourage NGO role |

### TABLE 2: PREVENTION: CONDOM PROMOTION

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • 25-30% of sex workers use condoms consistently | • By 2007, 60% of female CSW will use condoms consistently, and 70% by 2010<br>• Reach 80% of female CSW with effective HIV prevention interventions by 2007 | • Inadequate cooperation from brothel-house owners<br>• Inadequate support from police dept.<br>• Powerful networks in sex industry<br>• Conflict and tsunami<br>• Few NGOs working with sex workers | • Capacity building (including continuity of funding) of trainers and NGOs that target CSW and brothel house owners<br>• Continued advocacy for police dept. |
| • 1/3 of MSM in Anuradhapura did not use condoms during their last anal sexual act while 18% reported regular condom use | • 50% of MSM should use condoms consistently | • Only 1 NGO working with MSM | • Build capacity of more NGOs to work with MSM or help Companions on a Journey expand their coverage |

| | | | |
|---|---|---|---|
| • 3.8% of couples use condoms for contraceptive purposes | • 5% of couples using condoms for contraceptive purposes<br>• Promotion of dual protection at all service delivery points (government or private)—e.g. during family planning process should promote condom use and discuss STIs | • Unfamiliarity with/reluctance to use condoms for dual protection | • MOH to support Family Health Bureau to encourage condoms for dual protection<br>• Condom social marketing<br>• Integrate STI management and dual protection (promotion of condom use and prevention of STIs) in reproductive health services<br>• Promotion through subcontract NGOs working with selected vulnerable groups |

**TABLE 3: PREVENTION: EDUCATION AND BEHAVIOR CHANGE COMMUNICATION**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • UNICEF survey found low levels of knowledge among adolescents know HIV transmission and prevention | • 80% of youth (both in and out of school) able to correctly identify modes of HIV transmission and methods of prevention | • Teacher training is inadequate—lack of skillful teachers<br>• Need commitment from policy makers<br>• Need coordination between Dept. of Education and National Institute of Education<br>• Parents and teachers are reluctant to talk about this issue, and Ministry of Education | • Leadership from top of MOH, MOE, NIE to ensure students are well taught<br>• National Council of Youth Services supported to expand their efforts<br>• Outreach programs for children in main stream of education |
| • DHS survey 2000 indicated women in the general population and estate women had a low level of knowledge of HIV transmission and methods of protection | • 80% of women in general population and 60% of women on estates know 3 ways of HIV transmission and 3 ways to protect themselves<br>• Implement HIV/AIDS | • Funds & human resources<br>• HIV not yet a priority<br>• Lack of resources and motivation among women-focused NGOs to address | • Advocacy<br>• Fund commitment<br>• Motivate and mobilizing women's groups to address HIV/AIDS and developing |

| | | | |
|---|---|---|---|
| • Women in the general population need more access to information about HIV/AIDS and services | education programs for women in general population | HIV/AIDS | their capacities to implement such programs<br>• Media forum & communication agency to target women |
| • National youth services council has commenced training peer educators at community level | • By 2007, 3 peer educators trained and functioning in each GN division<br>• By 2010, 10 peer educators trained and functioning in each GN division | • Lack of ownership for sustainability of the project | • |
| • Youth friendly health services are provided in 5 districts | • Youth friendly services provided in 10 districts by 2008, all districts by 2010 | • Lack of resources both financial and human to establish services at periphery<br>• Stigma attached to seeking such services | • Trained persons and financial resources should be provided<br>• NGOs and public health staff should conduct outreach programs<br>• Reduce stigma by educating community |
| • No HIV/AIDS education programs at special education institutes and orphanages | • Commence HIV/AIDS education programs at special education units and orphanages by 2008 | • Belief that the children attending special education institutions or in orphanages do not need such access to information | • Advocacy and lobbying to of Ministry of Social Services to provide HIV/AIDS education to children attending special education institutes and in orphanages |

**TABLE 4: PREVENTION: SEXUALLY TRANSMITTED INFECTIONS**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Policy exists that all those diagnosed with STIs will be offered HIV testing | • Offer HIV testing to 100% of patients seeking care at government STI clinics | • | • NSACP will monitor adherence to protocols and policies based on quarterly STD clinic reports |
| • 30-40% of people seek treatment for STIs from government services | • Increase health seeking behaviors for STIs | • Stigma limits access<br>• Physical distance from clinic, particularly in the North and | • Strengthen the syndromic management of STI at first contact level (private and |

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|---|---|---|---|
| | | East<br>• Lack of awareness and training of health workers<br>• Confidentiality issues | public sector)<br>• Increase general awareness of STIs and promote health seeking behaviors for STIs through media channels and subcontracted NGOs<br>• Establish STI clinics with laboratory facilities in three districts in North and East (Jaffna, Mannar, and Ampara) |
| • Standard treatment protocols exist to train GPs in syndromic management of STIs | • 50% of GPs trained and using the standard protocols on management of STIs by 2007 and 80% by 2010 | • Limited number of trainers | • NSACP to train a core group of GPs from each province as trainers in order to train GPs in the STI management protocols |

**TABLE 5: PREVENTION: PREVENTION OF MOTHER TO CHILD TRANSMISSION**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • 100% of pregnant women in 3 districts are offered HIV testing; none have tested positive thus far | • In three selected high prevalence areas, conduct a pilot program for antenatal risk screening for pregnant women and offer HIV testing to pregnant women as needed, with the goals of 70% of pregnant mothers accepting VCT, 60% of HIV infected mothers detected, and 80% of infants born to HIV infected mothers free from HIV<br>• Antenatal syphilis screening for all pregnant women attending antenatal services | • Limited human resources for conducting risk screening<br>• Women fear being blamed if found positive | • Include counseling and PMTCT in public health training curricula<br>• Have awareness program for obstetricians and gynecologists through the College of Obstetricians |

**TABLE 6: PREVENTION: BLOOD SAFETY**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • 63% of national blood collection in the public sector is from voluntary blood donations; nearly 100% of blood in private sector is replacement donations | • 100% of blood donations in the public sector should be voluntary<br>• implement Blood Policy to prevent replacement blood collection in private sector | • Logistics<br>• Shortage of manpower<br>• Legislation yet to be approved by Cabinet | • Recruitment of staff<br>• Special budget for blood donor recruitment<br>• Follow up at the Ministry level |
| • 85% of total centralized screening for transmission transmitted infections is happening in 10 centers | • Centralize all TTI screening in 6 to 10 centrally managed centers | • Lack of transport for samples<br>• Lack of laboratory system<br>• Lack of staff and standby equipment | • Provision of vehicles<br>• Provision of fax or internet services<br>• Extra staff and equipment for testing centers |
| • Blood banks network is linked only by paper | • Computerize blood information system | • Absence of software, hardware, and liveware<br>• Staff attitudes | • Procurement of software and hardware<br>• Training of staff<br>• Increase motivation of staff for data entry |

**TABLE 7: PREVENTION: POST-EXPOSURE PROPHYLAXIS**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • A circular on the availability of PEP has been distributed to all heads of government health institutions, but it has not been disseminated widely | • Educate all health workers in the government clinics and institutions and in private health care settings about the availability of PEP | • Logistics<br>• Commitment and attitudes<br>• Lack of monitoring<br>• Limited coordination and monitoring of private health sector | • MOH should make availability of PEP known<br>• MOH should monitor knowledge of universal precautions |
| • Survey by Sri Lanka Medical Association in 2004 found lower category of health care workers (laborers, minor staff) had poor knowledge of | • At least 90% of health workers (private and public) will practice universal precautions | • Attitude—issue not perceived as important<br>• Lack of supplies due to failure to adhere to supply chains and request needed items | • MOH should monitor use of universal precautions |

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|---|---|---|---|
| infection control practices and received inadequate training | | | |

**TABLE 8: TREATMENT**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Approximately 60% of eligible patients receive regular ART<br>• Currently, ART is offered at one site in Colombo, by 2006 will be offered at three additional sites and by 2007 the infectious disease hospital will have expanded inpatient care facilities | • At least 90% of eligible patients will receive antiretroviral therapy<br>• At least one hospital per province should offer ART (with Kandy, Jaffna and Anuradhapura to offer ART by 2007) | • Default<br>• Lack of certain drug combinations; limited availability of pediatric formulas in syrup form<br>• Lack of expertise, especially in pediatric management<br>• Many facilities, especially in the Northeast, need upgrading | • Continue carrying out training programs for health care personnel<br>• Improve drug procurement, especially for second line drugs<br>• Establish linkage with regional center for resistance testing<br>• Training in ART and pediatric management<br>• Immediately attend to professional and physical plant weaknesses in Jaffna Teaching Hospital and other identified provincial hospitals |
| • Limited access to high quality, affordable drugs for opportunistic infections | • All HIV positive people will have access to high quality, affordable drugs for opportunistic infections | • Limited diagnostic and laboratory facilities to diagnose OIs<br>• Certain OI drugs are not available | • Improve diagnostic facilities<br>• Improve procurement management |
| • Limited number of TB patients are offered HIV testing | • 100% of high risk TB patients will be offered HIV testing | • TB personnel are concerned that by raising HIV issue, TB patients will be re-stigmatized and will default<br>• Lack of guidelines for identification of TB patients at high risk of having HIV | • Sensitizing TB personnel<br>• Develop guidelines for risk assessment of TB patients |

**TABLE 9: CARE**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Two NGOs offer comprehensive home-based services, one offers some welfare services | • Comprehensive home-based services (including transportation, food, companionship and other services) should be offered by at least 1 NGO in each province | • Funding and NGO capacity | • Resource mobilization and NGO training |

**TABLE 10: SURVEILLANCE**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| Sentinel groups:<br>• Female sex workers<br>• STD clinic attendees<br>• TB patients<br>• Military<br>• Transport workers<br>• Pre-employment (in North and East) | • Expand data collection by including additional sentinel groups (MSM, drug users) and additional sites<br>• Strengthen analysis of data for program planning | • Difficult to collect samples from North and East<br>• Difficult to enroll female sex workers in sentinel groups for survey | • Behavioral surveillance will identify sex workers<br>• Have NGOs working with high risk groups aid in enrollments |
| • Behavioral surveillance survey beginning 2006 | • Conduct BSS annually and feed results into program planning | • NE conflict areas<br>• Funding sustainability | • Demonstrate need for funds |

**TABLE 11: MULTI-SECTORAL COOPERATION AND SERVICES**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Participation by NGOs, private sector and non-health agencies (other ministries, armed forces, etc.) has begun to promote multi-sectoral contribution | • Strengthened NGO, private sector, and non-health agency participation in the national response | • HIV/AIDS still viewed by many as a health issue<br>• Limited human resources to support and expand a multi-sectoral response | • Changing attitudes and advocacy for participation of other stakeholder groups |

**TABLE 12: PROTECTION OF HUMAN RIGHTS**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • No legal assistance available to those infected and affected | • At least one NGO or bar association providing free legal assistance to persons infected and affected by HIV/AIDS | • Confidentiality, stigma and discrimination, which has led to lack of consciousness among lawyers | • Sensitize legal community |
| • Some districts in the Northeast are imposing HIV testing on returnees from India against Ministry policy | • Ensure testing is conducted on a voluntary basis | • Nonadherence of provincial administrations to communications from the MOH | • NGOs and MOH should lobby the Provincial National AIDS Committee to adhere to government policy |
| • Insufficient respect for confidentiality | • Reduce number of incidents of breach of confidentiality | • Attitude of service providers | • Strong message from MOH and hospital directors regarding the importance of confidentiality<br>• Awareness programs for service providers |
| • Rights of marginalized groups insufficiently respected, which discourages some from accessing information and services | • 90% of police personnel showing favorable attitudes towards marginalized groups | • Mistreatment of marginalized groups by police | • Sensitize police to rights and needs of marginalized groups |
| • National Policy on Disability does not refer to HIV/AIDS | • National Policy will include reproductive health education and access to information and services for persons with disabilities | • Lack of understanding of HIV risk and reproductive and sexual rights of disabled persons | • Work with respective Ministry to ensure issues are incorporated into policy |
| • Limited access to psychosocial services for people living with and affected by HIV and AIDS | • Provide psychosocial services to those infected and affected by HIV/AIDS by 2010 | • Lack of awareness on need of psychosocial support for HIV infected and affected persons<br>• Invisibility of HIV infected and affected persons in the community | • Create awareness<br>• Lobby and advocate for such services at all levels |

**TABLE 13: ADVOCACY**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Political leaders are being sensitized | • Have a core group of provincial counselors and parliamentarians to provide leadership on HIV/AIDS | • Lack of commitment and lack of participation in context of low prevalence | • Advocate for higher level political commitment at chief Minister level |
| • Provincial level AIDS Committees established | • All provincial level AIDS Committees functioning and active | • Lack of motivation and sensitization<br>• Considering AIDS as a health issue, not as development issue<br>• Denial<br>• Turnover of provincial councils | • Motivation and mobilization<br>• To change the attitudes and to make them realize AIDS is a development issue not merely a health issue<br>• Counteract denial and promote acceptance of the realities that Sri Lanka is at high risk |
| • Parliamentarian Champion being identified - Minister of Health | • Establish a parliamentarian forum on HIV/AIDS | • Lack of motivation and low priority as advocating of AIDS does not have an impact on number of votes at an election | • To make parliamentarians realize ignorance can have an impact on voters<br>• Use Asia Pacific Leadership Forum advisory group and people living with HIV/AIDS to lobby parliamentarians |

**TABLE 14: COMMUNITY EMPOWERMENT**

| Baseline | Target for 2010 | Obstacles | Solutions |
|---|---|---|---|
| • Lack of networking among NGOs at community level<br>• Limited capacity of NGOs | • District level NGO network established<br>• Increased number of capable NGOs | • Human resources | • Capacity building technical & financial<br>• Develop linkages |