

Sri Lanka

Country Review December 2011

SRI LANKA AT A GLANCE

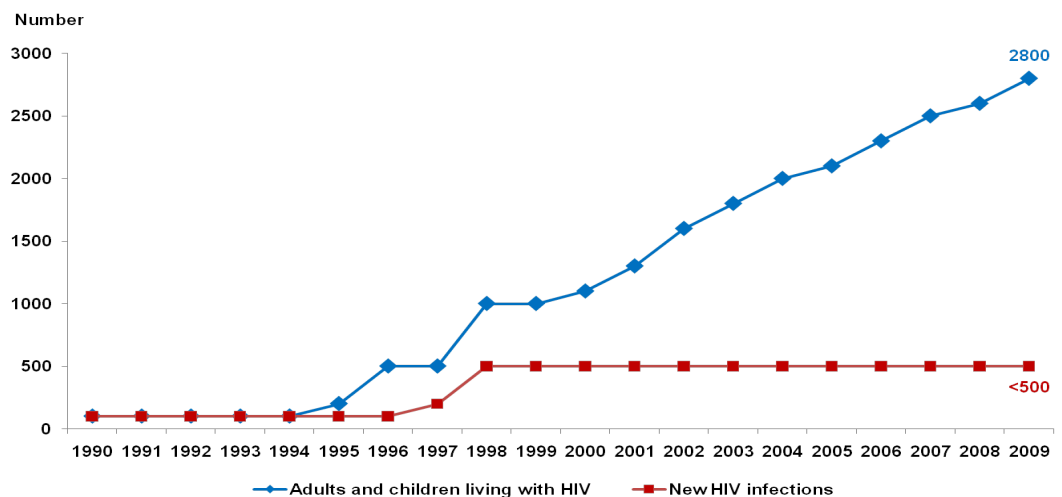
Total population (in thousands)	20,410 (2010) ¹
Annual population growth rate	0.7% (2010-2015) ¹
Population aged 15-49 (thousands)	10,862 (2010) ²
Percentage of population in urban areas	14% (2010) ³
Crude birth rate (births per 1,000 population)	18.8 (2008) ⁴
Under-5 mortality rate (per 1,000 live births)	17 (2008) ⁵
Human development index (HDI) - Rank/Value	91/0.658 (2010) ⁶
Life expectancy at birth (years)	74.4 (2010) ⁶
Adult literacy rate	90.6 (2005-2008) ⁶
Ratio of girls to boys in primary and secondary education (%)	103.5 (2003) ⁴
GDP per capita (PPP, \$US)	4,771 (2009) ⁴
Per capita total health expenditure (Int.\$)	179 (2007) ⁵



HIV EPIDEMIOLOGY AND TRENDS

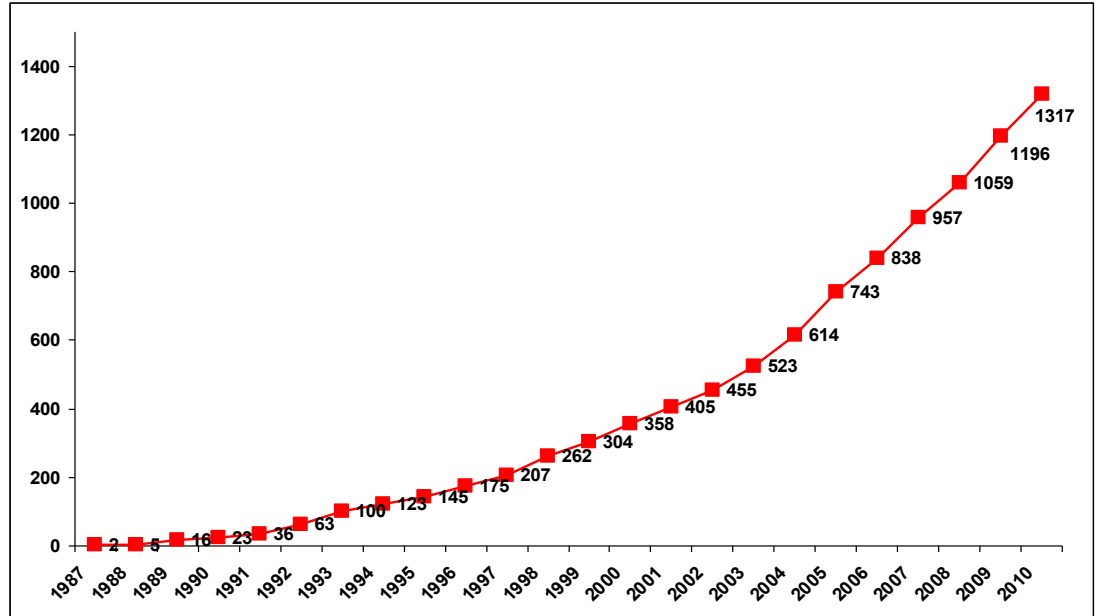
Sri Lanka – one of the few countries in the Asia Pacific region with a low level epidemic – had an estimated adult HIV prevalence of less than 0.1% in 2009.⁷ The first case of HIV was detected in 1987 and it has been estimated that 2,800 people were living with HIV in 2009, up from 1,300 in 2001 (Fig. 1).⁷ By the end of 2010, the reported cumulative number of HIV cases was 1,317 (784 male and 533 female) with a male-to-female ratio of 1.5:1.⁸ Two-thirds (66.4%) of the reported HIV cases in 2010 were in individuals between the ages of 30 to 49 and 60% of the reported HIV cases were from the Western province. The reported number of cumulative AIDS cases and AIDS-related deaths were 340 and 221, respectively.⁸ In 2009, over 397,374 people were tested for HIV, of which 137 cases were confirmed as HIV positive, 0.03% sero-positive rate.

Figure 1: Estimated number of adults and children living with HIV vs estimated new HIV infections, 1990-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

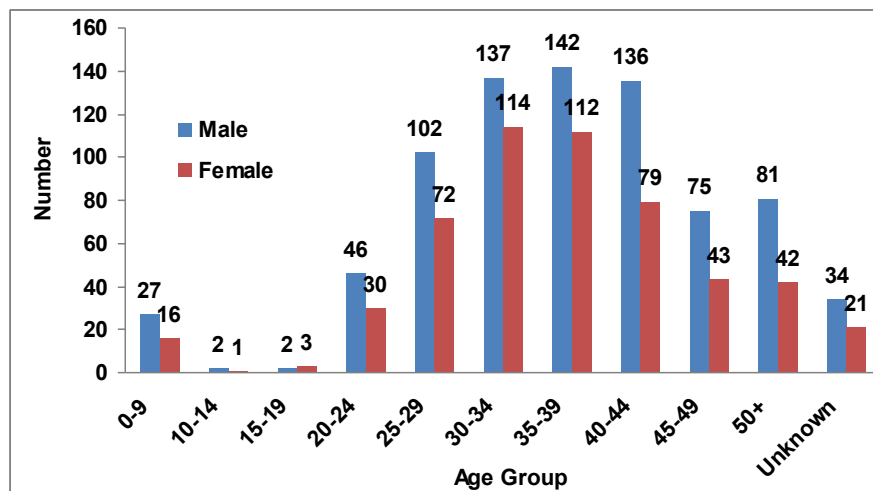
Figure 2: Cumulative reported HIV cases, 1987-2010



Source: Prepared by www.aidsdatahub.org based on Strategic Information Management (SIM) Unit, National STD/AIDS Control Programme Sri Lanka, 2010

Figure 3 illustrates the cumulative number of HIV cases, disaggregated by age group and gender. The numbers of HIV positive men are higher than that of women in all age groups, except for the 15-19 year age group in which the numbers are almost equal. According to age disaggregation, the highest number of HIV infected people was observed in the 35-39 year age group – nearly 20% of all cases.⁹

Figure 3: Cumulative HIV cases by age and sex, 2010



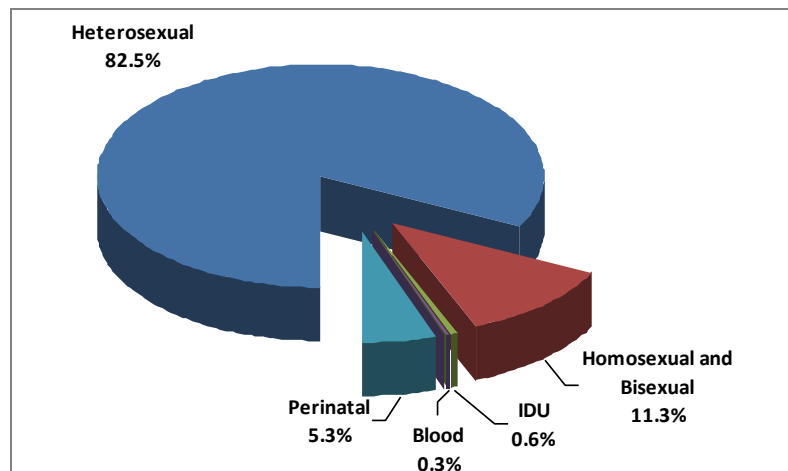
Source: Prepared by www.aidsdatahub.org based on Strategic Information Management (SIM) Unit, National STD/AIDS Control Programme Sri Lanka, 2010. HIV/AIDS Situation in Sri Lanka as of end 2010, PowerPoint Presentation.

Surveillance Systems:

- HIV Sentinel Surveillance survey since 1993, to be conducted every two years from 2007
- First Round Behavioural Surveillance Survey in 2006
- Established management information system linking all STI clinics to central NSACP

Figure 4 shows the proportions of known modes of HIV transmission for the cumulative number of cases. It is evident that the major mode of transmission of HIV in Sri Lanka is through heterosexual means.⁹ Heterosexual transmission accounts for 82.5% of cases while homosexual and bisexual transmission constitutes 11.3%. Peri-natal transmission accounts for 5.3%, whilst blood transfusion (0.3%) and injecting drugs (0.6%) combined make up less than 1% of transmission. The number of HIV cases attributable to injecting drug use is low despite the fact that the percentage of injecting drug users (IDUs) sharing needles and syringes is considerably high – as explored in the section on IDUs.^{9; 10}

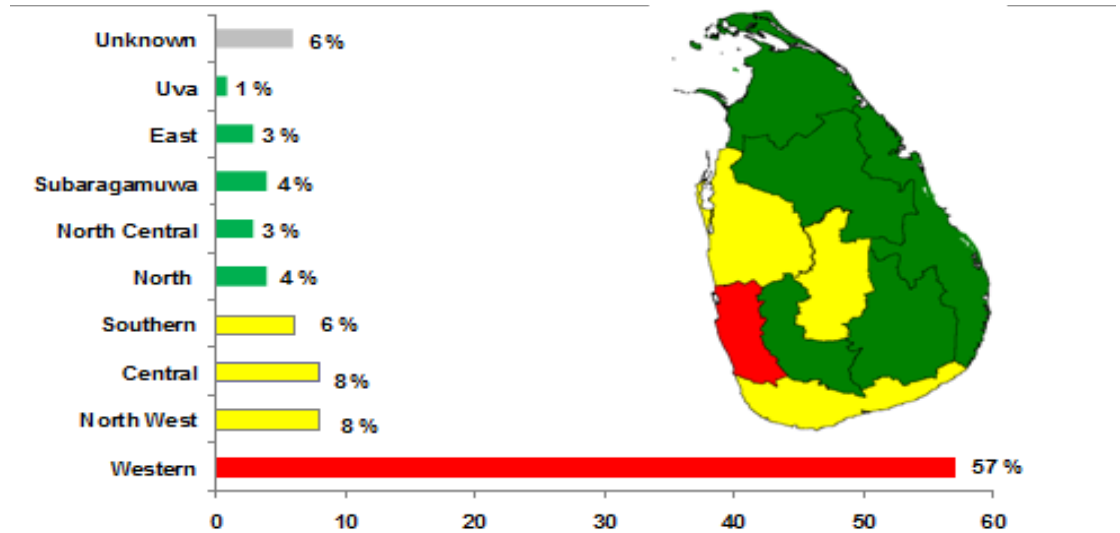
Figure 4: Cumulative HIV cases by mode of transmission, 2010 (n=888, known mode of transmission)



Source: Prepared by www.aidsdatahub.org based on Strategic Information Management (SIM) Unit, National STD/AIDS Control Programme Sri Lanka, 2010. HIV/AIDS Situation in Sri Lanka as of end 2010, PowerPoint Presentation.

Figure 5 reveals the distribution of HIV cases by district. It is clear that nearly six of every 10 reported cumulative HIV cases (57.2%) have been concentrated in the Western province, where the national capital district of Colombo (36.2% of overall total) is found.⁹

Figure 5: Cumulative HIV cases by province, 2010 (n=1,236)



Source: Strategic Information Management (SIM) Unit, National STD/AIDS Control Programme Sri Lanka, 2010. HIV/AIDS Situation in Sri Lanka as of end 2010, PowerPoint Presentation.

In order to track the level of HIV infections in different sub-groups, the National STD/AIDS Control Programme has been conducting HIV sentinel sero-surveillance surveys since 1993. In 2009, six types of sentinel groups were included in HIV sentinel sero-surveillance: female sex workers, sexually transmitted diseases (STD) clinic attendees, men who have sex with men (MSM), patients with tuberculosis (TB), military service personnel and drug users. A total of 8,120 samples were obtained and only 6 HIV positive samples were detected: 4 were STD clinic attendees and 2 were MSM. No positive cases were detected among female sex workers, drug users, TB patients or from military service personnel.¹¹

Who is at risk of HIV in Sri Lanka?

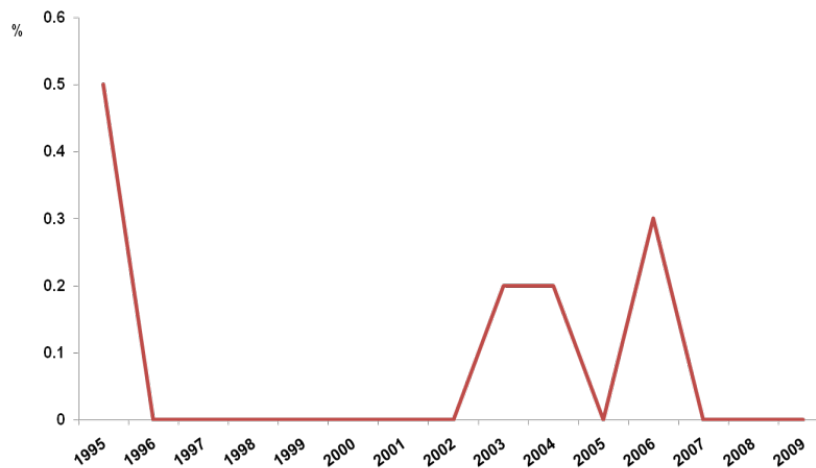
Six groups have been considered as at risk of HIV infection according to findings from the first round of Behavioural Surveillance Survey (BSS) (2006-2007), namely sex workers, drug users, MSM, beach boys, three-wheel drivers and factory workers in the free trade zone.

Female sex workers

The estimated number of FSWs in Sri Lanka ranges from 35,000-47,000 – with an estimated 8,332 in Colombo and 1,138 in Anuradhapura.¹² Generally, sex workers are categorized into three types: brothel-based, street-based, and others (i.e. those based at massage parlours, karaoke bars and casinos). Sri Lanka has an estimated 700,000 clients of FSWs, including students, police officers, truck drivers, dockworkers, and sailors¹³ and the BSS 2006-2007 found that 70% of male patients at STI clinics had reported frequenting sex workers.¹⁰

HIV is currently low among FSWs. HIV prevalence remains at 0% as of 2009, although it was detected to be 0.2% from 2003 – 2004 and reached 0.3% in 2006 in Colombo (Fig. 6).^{11; 14}

Figure 6: Trend of HIV prevalence among FSWs in Colombo, 1995-2009



Source: Prepared by www.aidsdatahub.org based on NSACP, HIV Sentinel Sero-Surveillance Survey, 2007, National STD/AIDS Control Programme, June 2008; UNGASS country progress report 2010

Injecting Drug Users

Current estimates of opiate users range from 30,000 to 240,000 individuals and the majority of heroin users inhale or snort heroin.¹³ A study carried out in 2006-2007 among 278 drug users in three prisons in Sri Lanka found that the prevalence of intravenous drug use was higher than has been officially reported (15.8% vs. 1%). In addition, there was a high prevalence (53%) of risk-taking sexual behaviour – meaning lifetime prevalence of sex with an FSW was high (67%) and regular condom use with an FSW was low (14%).¹⁵ The first case of HIV infection attributable to injecting drug use was reported as late as 2004.¹⁰ Findings from the BSS 2006-2007 indicated that 4.4 % of male drug users injected drugs in past 12 months, among whom 42% had injected with used needles or syringes and 51% shared a needle or syringe they had used with someone else. Hence there might be a potential epidemic among injecting drug users. Drug users were included as a surveillance group beginning in the 2007 HIV Sentinel Sero-Surveillance Survey (HSS) and were found to have an HIV prevalence of 0.3%, followed by 0.2% in 2008 and 0% in 2009.¹¹

Men who have sex with men

The current size estimate for MSM is 30,554 (including 8,869 in Colombo and 700 in Anuradhapura)¹² and they make up a key vulnerable population in Sri Lanka where 11% of the reported HIV infections are attributable to homosexual transmission. The MSM population was included as a surveillance group beginning in the 2008 HIV Sentinel Sero-Surveillance Survey (HSS) and, up until this point, HIV prevalence among this group was 0% in 2008 and 0.48% in 2009.¹¹

MSM at a Glance

HIV prevalence (2009) ¹¹	<ul style="list-style-type: none"> 0.48%
Selected behaviours (2007) ¹⁶	<ul style="list-style-type: none"> Mean number of sexual partners in the past year is 11 (n=300); 23% had sex with a woman in the past year; 61% used a condom the last time they had anal sex with a male partner; 14% were tested for HIV in the past year and knew their results.
National response ¹⁷	<ul style="list-style-type: none"> Absence of non-discrimination laws or regulations which specify protections for MSM; MSM HIV prevention is incorporated for the first time in the National HIV Strategic Plan in 2007-2011; 10% of the total resources for HIV prevention is allocated for MSM (US\$ 240,000 in 2009).

Between November 2006 and February 2007, Companions on a Journey, a Sri Lankan NGO, undertook a cross-sectional survey of 494 men from the gay community – gay identified and/or men who have sex with men (MSM) – in 5 cities across 3 provinces.¹⁸ Of those surveyed, 80% had multiple sexual partners in the previous 3 months with over 36% of these men having more than 21 partners at that time. Anal sex was common, with over 80% of men having had anal sex in the last 3 months. In the past 12 months, 16% of men reported being forced into sex against their will.

Beach Boys

The term “beach boys” refers to young men who work near or on the beaches, typically tourist beaches, and who offer sexual services in exchange for some form of payment. They also include those working in restaurants, hotels, guest houses and boat-related tourism. The United Nations Development Program (UNDP) estimates that there are 30,000 beach boys in tourist resorts. They are at risk of HIV infection due to low levels of condom use and having unprotected sex with male and female sexual partners including tourists from high HIV prevalence countries.¹⁰

Three-wheel drivers

Approximately 111,000 registered three-wheeled taxi drivers operate within Sri Lanka and they make up a vulnerable group for HIV infection given their close association with the commercial sex trade. Three-wheeled taxis are frequently used to transport sex workers and their clients and they are used as venues for sex. Furthermore, the drivers function as brokers, employers, and customers of sex workers.¹⁰



VULNERABILITY, KNOWLEDGE AND RISK BEHAVIOURS

Key aggravating factors for the spread of HIV infection

Though Sri Lanka is still in the early epidemic phase with limited epidemic potential, the prevalence of a number of risk factors suggests this may not be maintainable unless appropriate action is taken. These risk factors include:

- An emerging sexually active youth population (17-19% of the total population of 18.3 million in 2010) and low levels of HIV knowledge among them¹⁶
- An open economy leading to large industrial zones with an estimated workforce consisting of young people of over 100,000¹⁶
- High mobility (both emigration and immigration)¹⁶
- Increasing commercial sex and networks between sex workers, MSM and IDU
- Low level of condom use in MSM, beach boys, IDU, and some types of sex workers¹⁰
- High rate of sharing needles and syringes among IDU¹⁰
- Low level knowledge about HIV transmission among high-risk groups¹⁰
- Low rate of HIV testing among key affected populations (FSWs 43%, MSM 14% in 2009)¹¹

Key inhibitory factors for the spread of HIV infection

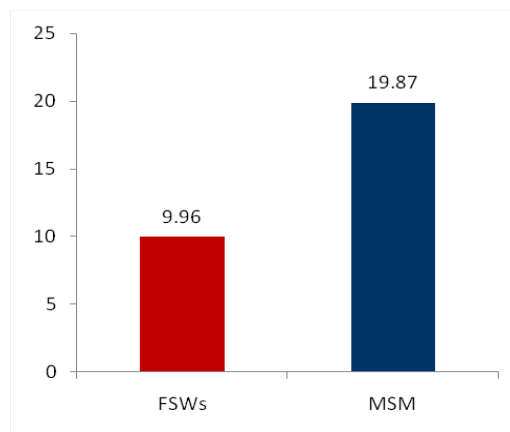
However, at the same time, there are some factors which work in favour of containing a low-level epidemic such as

- High literacy rate among women¹⁹
- The comparatively low number of sexual partners an individual is likely to have correlates to the importance and respect that society places on the institution of marriage.²⁰
- Existence of National HIV/AIDS policy which promotes human rights of vulnerable and affected populations¹¹
- Coordination of other Government non-health Ministries such as Ministry of Labor, Education, Dept of Prisons, Sri Lanka Bureau of Foreign Employment and the Tri-Forces¹¹
- Fairly high quality of health care and consequent access to health services, particularly in the public sector¹⁶

Knowledge about HIV

Generally a low level of HIV knowledge was observed in each of the key populations at higher risk. In 2007, only 9.96% of FSWs and 19.87% of MSM had comprehensive knowledge of HIV – that is, were able to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions (Fig. 7).¹⁶ While 95% of FSWs surveyed in the BSS 2006-2007 had the correct knowledge that HIV can be transmitted through sexual intercourse, from a mother to her unborn child, and through transfusion of blood and blood products, almost half of sex workers incorrectly believed that HIV could also be transmitted by mosquitoes.¹⁰ Similarly among MSM, although 99% correctly identified HIV as a sexually transmitted disease, only 66% knew that they could protect themselves from HIV by using a condom, while 32% believed people could get HIV from a mosquito bite and 35% believed that a person with HIV could not look healthy.¹⁰

Figure 7: Percentage of female sex workers and men who have sex with men with comprehensive knowledge, 2007



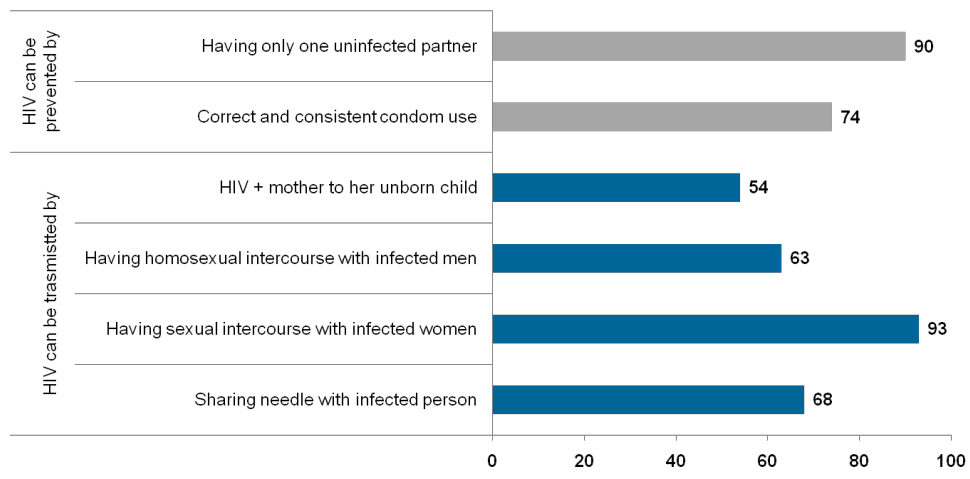
Source: Prepared by www.aidsdatahub.org based on National STD/AIDS Control Programme, Ministry of Healthcare and Nutrition, Sri Lanka Behavioural Surveillance Survey (First Round Survey Results 2006-2007), Sri Lanka, 2007

Findings from the BSS in 2006-2007 suggested that although the level of knowledge for HIV transmission is higher among beach boys compared to other risk groups, 34% still believed that people could get HIV from mosquito bites, 20% believed that condoms would not protect them from HIV and 33% felt that a person with HIV could not look healthy.¹⁰ In addition, while almost all three-wheel drivers included in the BSS survey understood that HIV was sexually transmitted, only half understood that using a condom would protect them, and fewer than half identified that they could not be infected with HIV by a mosquito.¹⁰ The majority did not understand that a person with HIV could show no signs of the disease.¹⁰ The level of knowledge about HIV transmission is still low among drug users and although over 90% of the drugs users correctly answered that HIV can be transmitted through sexual intercourse, almost half of the participants still believed that HIV can be transmitted through mosquito bites.¹⁰ Moreover, a quarter of the respondents didn't think that using condoms could protect them from HIV and almost half of them thought that someone with HIV could not look healthy.¹⁰

In 2007, 8% of young people aged 15-24 years had comprehensive knowledge of HIV (7% among females; 10% among males).¹⁹ More recently, in 2009, comprehensive knowledge was found to be much higher (at 46%) among in-school youth in Sabaragamuwa province (n=6,007).¹¹

A 2008 survey of HIV awareness among military personnel (n=900) reveals further information regarding knowledge of HIV prevention and mode of transmission (Fig. 8). Many knew that HIV can be prevented by having only one uninfected partner and that HIV can be transmitted by having sexual intercourse with infected women (90% and 93%, respectively).²¹ However, knowledge was variable about the risks pertaining to consistent condom use, mother-to-child transmission of HIV, homosexual intercourse and sharing needles.

Figure 8: Percentage of military personnel with correct knowledge on HIV prevention and mode of transmission, 2008



Source: Prepared by www.aidsdatahub.org based on International Center for Ethnic Studies, A survey of HIV/AIDS Awareness and Risky Sexual Behaviour in a Vulnerable Population in Sri Lanka, ASCI Report No.22, January 2009

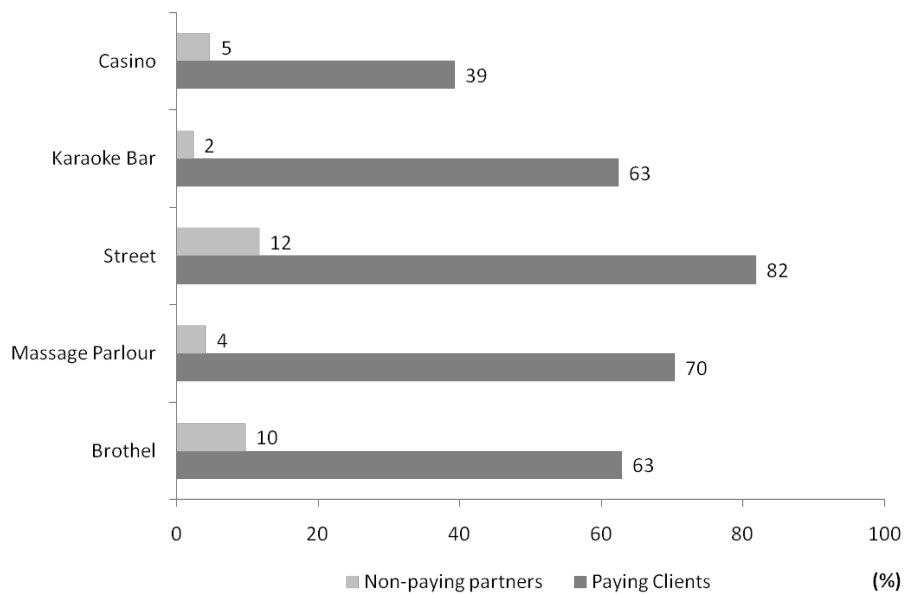
A 2007 baseline study on HIV and STI knowledge, attitude, and practice was conducted at two construction sites in the towns of Rathmanala and Althugama found that misconceptions persists among this groups as well (n=611).²² Most respondents had heard about HIV/AIDS and STIs (81.6% and 89.7% respectively). Yet only 55.3% and 53.5% were able to answer that condom use and/or abstaining from sex were means of prevention, respectively. Around 22% knew that unsafe drug injection was a mode of transmission. Only 16.9% of those who were sexually active (n=558) used a condom during their last sexual intercourse and 37% reported that they knew how to use it.

Condom use

Findings from the BSS 2006-2007 indicated that the pattern of consistent condom use varied considerably among groups and also depending on the type of sexual partner.

Approximately half of FSWs surveyed who had sex with clients reported also having had sex with non paying partners.¹⁰ However, condom use was very low with non-paying partners. Figure 9 shows the percentage of consistent condom use in the last year among different types of sex workers with their paying and non-paying clients. Notably, consistent condom use with non-paying partners is significantly lower than that of clients in all types of sex workers. The highest level of condom use was seen in street-based sex workers with both non-paying partners and paying clients; whereas the lowest level of condom use was observed between casino-based sex workers and their clients.¹⁰

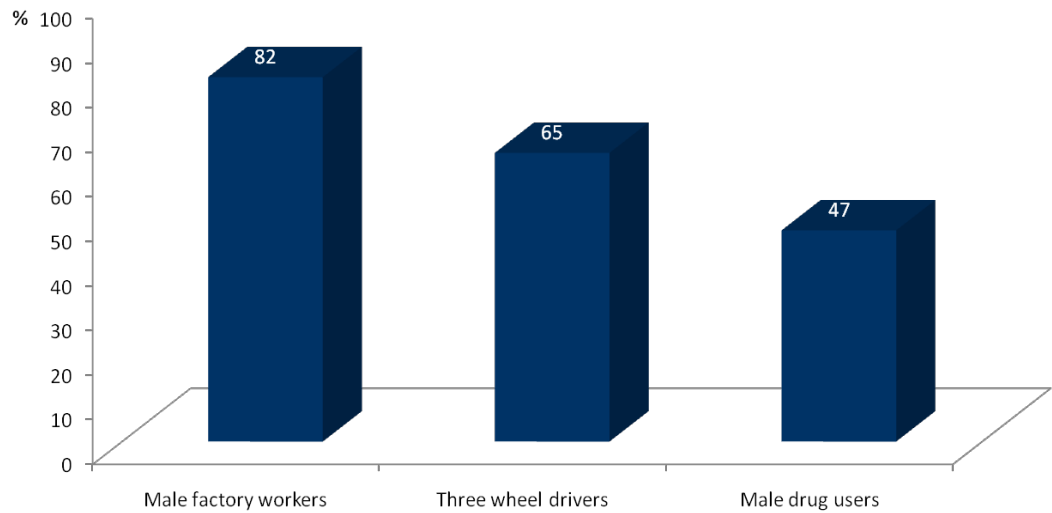
Figure 9: Percentage of consistent condom use among different types of female sex workers in the past year, 2006-2007



Source: Prepared by www.aidsdatahub.org based on First Round Behavior Surveillance Survey Results 2006-2007, NSACP

Figure 10 shows the percentage of consistent condom use in the last year with commercial partners as reported by men in high-risk occupational groups. A low level of condom use was reported among male drug users whereas it was considerably high in male factory workers.

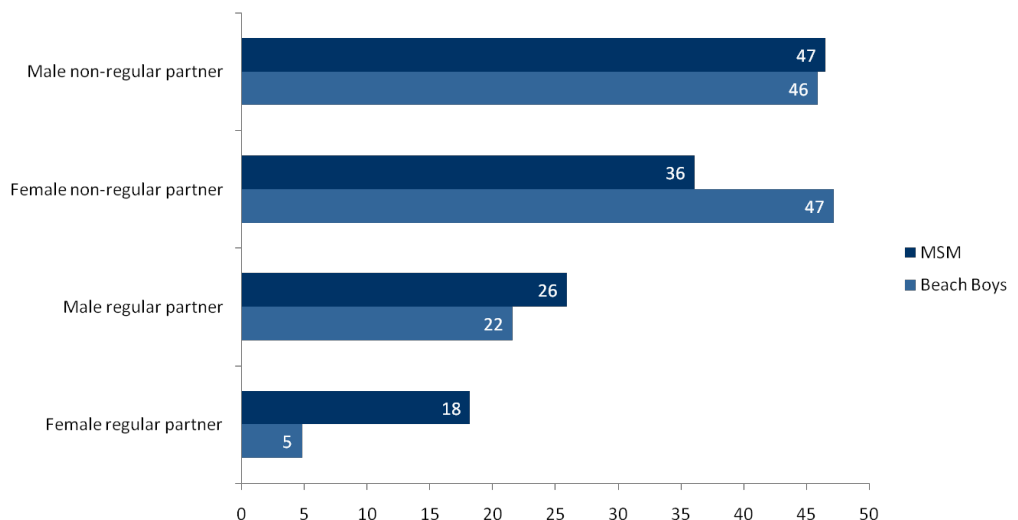
Figure 10: Percentage of consistent condom use with commercial partners among specific male population groups in the past year (2006-2007)



Source: Prepared by www.aidsdatahub.org based on First Round Behavioral Surveillance Survey Results 2006-2007, NSACP

Figure 11 compares the pattern of consistent condom use in the last 12 months among beach boys and MSM with their regular and non-regular partners (male and female), as reported in the BSS 2006-2007. Consistent condom use with any type of sexual partner is less than 50% in both beach boys and MSM. Condom use with regular partners is lower than that with non-regular partners. Moreover, consistent condom use with male regular partners is higher than with female regular partners in both groups. Sixty-one percent of MSM reported using a condom the last time they had anal sex with a male partner.¹⁰

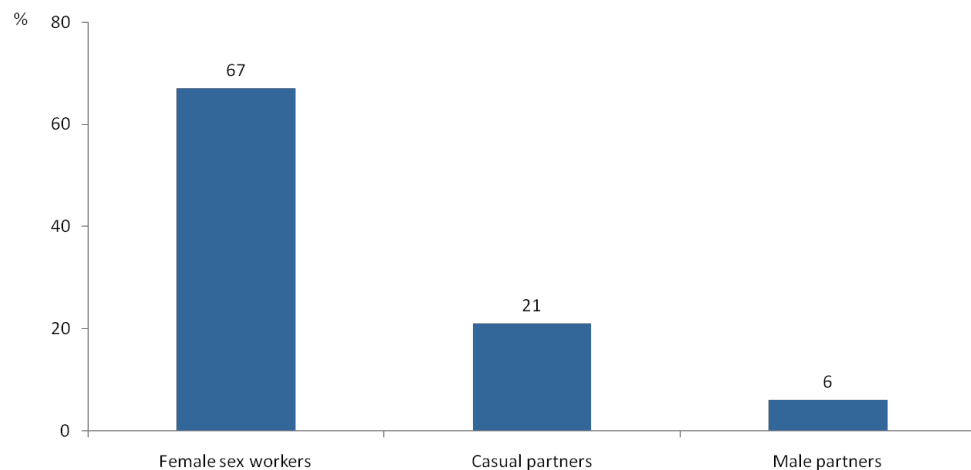
Figure 11: Percentage of consistent condom use among beach boys and MSM with regular and non regular partners in the last year, 2006-2007



Source: Prepared by www.aidsdatahub.org based on First Round Behavioral Surveillance Survey Results 2006-2007, NSACP

In 2008, consistent condom use among male military personnel varied – but was consistently low – with different types of sexual partners (Fig. 12).²¹ Similar to other vulnerable groups, the highest percentage of consistent condom use was reported with commercial partners (67%) followed by casual partners (21%) and was only 6% with male partners.²¹ While 31% of military personnel reported ever having had a homosexual relationship, only 10% used a condom at last homosexual encounter.²¹ Furthermore, while 19% reported having had extramarital sex in the last 12 months, 29% used a condom during last extramarital sex.²¹

Figure 12: Percentage of consistent condom use among military personnel with different types of sexual partners in the last 12 months, 2008



Source: Prepared by www.aidsdatahub.org based on International Center for Ethnic Studies, A survey of HIV/AIDS Awareness and Risky Sexual Behaviour in a Vulnerable Population in Sri Lanka, ASCI Report No.22, January 2009

Stigma and Discrimination

Findings from the People Living with HIV (PLHIV) Stigma Index Sri Lanka, which analyzes levels of stigma and discrimination from the perspective of PLHIV, indicate high levels of “internalised stigma” – e.g. feelings of shame (>50%), self-blame (>50%) and guilt (>40%) – experienced by people who are infected or affected by HIV and that the “corresponding decisions” – e.g. not getting married (>45%), not having sex (>35%), not having children (>75%) –they make in the face of the many structural or invisible societal barriers in Sri Lankan society and may have their root in interaction with healthcare professionals. “In a nutshell, the respondents to the Stigma Index have poor knowledge of rights; they are reluctant to disclose their status to family and friends and therefore lack crucial social support; and they are totally dependent on the government health sector for treatment.”²³

This report makes specific recommendations to address the needs of people living with HIV in Sri Lanka, as identified through the Stigma Index, focusing primarily on Health Care Settings, Law and Rights and Positive Living. Please see the full publication, available at: <http://www.aidsdatahub.org/en/reference-materials/stigma-and-discrimination>

National Response

Law and policy implementation

Male-to-male sex is illegal in Sri Lanka by virtue of Laws of Sri Lanka, Chapter 22 and the Penal Code, Article 365 and Article 365A. Punishment involves imprisonment for a term which may extend 10 years (for carnal intercourse 'against the order of nature') or imprisonment for a term which may extend to 2 years, or a fine, or both (for 'gross indecency' in public or private).²⁴ A bill was introduced in the 1990s proposing the abolishment of legislation that criminalized sexual relationships between two males.²⁵ However, the bill was withdrawn after being opposed by Muslim and Catholic Members of Parliament on the grounds that homosexuality was not recognized by their faiths. Unfortunately, the alternative path to reform – that is, judicial review of legislation – is barred in Sri Lanka, making it impossible to challenge the constitutional validity of laws against homosexuality.²⁵

While sex work is not illegal *per se*, soliciting is illegal by virtue of the *Vagrancy Act 1978*, which is sometimes invoked to arrest sex workers for loitering (being "idle and disorderly").²⁵ About one third of the street-based sex workers reported having been harassed by the police for carrying condoms in the past 12 months in 2007.¹⁰

Sri Lanka has laws that are prohibitive of needle and syringe programmes; the possession of injecting equipment is illegal for anyone who is not a medical practitioner. Furthermore, the provision of needles and syringes is prohibited.²⁶

Governance

In 1985, the Ministry of Health incorporated HIV prevention and control as part of the mandate of the National Sexually Transmitted Disease Control Programme (established in 1951) after it received an alert about India's first case of AIDS.¹³ The first Medium Term Plan (MTPI) and the National AIDS Committee (NAC) were formed in 1988, followed by the MTP II in 1994, the formation of a UN Theme Group in 1996 and the National Integrated Work Plan in 1998.

In 1992, the Government of Sri Lanka initiated HIV prevention and control efforts through the National STD and AIDS Control Program (NSACP) of the Ministry of Health under the Director General of Health Services. In addition, the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis and Chest Diseases (NPTCCD) strengthened their responses to reduce transmission and prevent further spread of HIV. Sri Lanka's response to HIV and AIDS is carried out by the coordinated efforts of the National AIDS Council, the National AIDS Committee (NAC) and the National STD/AIDS Control Programme at the national level.¹⁷ The NSACP, in collaboration with the Provinces, undertook HIV prevention activities (e.g., a mass media communications strategy to improve knowledge and awareness of HIV) and provides care and treatment to people living with HIV. The NSACP improved STI services by refurbishing STI clinics, providing equipment, and facilitating HIV prevention work conducted through contracted NGOs and through the Government Provincial and District Health authorities in order to better reach vulnerable groups. The NSACP also engaged 12 line Ministries including the National Institute of Education, the Ministry of Labour, the Foreign Employment Bureau, the Vocational Training Authority, the Ministry of Fisheries, the National Child Protection Authority, the National Youth Services Council, the Army, the Navy, the Air Force and the Police. Their work includes advocacy, improving HIV prevention awareness and knowledge of available facilities, encouraging condom use among the armed services, and introducing voluntary counselling and testing (VCT) services.

National Strategic Plan (2007-2011)

The National Strategic Plan (NSP) for 2007-2011 was prepared during 2007 with participation of all relevant stakeholders and using recommendations from an external review and information from both active and passive surveillance and research studies. It is a comprehensive plan which intends to re-focus the program on key populations at higher risk, to scale up integration of HIV-related activities with other health, sectoral and civil society activities and to improve the efficiency of the ongoing Behavior Change Communication (BCC) activities. The target groups identified for interventions include female sex workers, MSM, and IDUs. The plan also recognizes beach boys and prisoners as special vulnerable groups. The operation of the NSP is to be detailed by a biennial plan and budgeted by the NASCP.

Monitoring and Evaluation

Monitoring and Evaluation (M&E) was identified as a priority in the strategic plan 2007-2011. During 2008, a Strategic Information & Management (SIM) Unit was established with six full-time staff. In addition, a national draft M&E plan was developed, with a set of national core indicators incorporating relevant UNGASS & Universal Access indicators. A computerized comprehensive patient information management system for STI (PIMS) has been available since 2008.¹¹

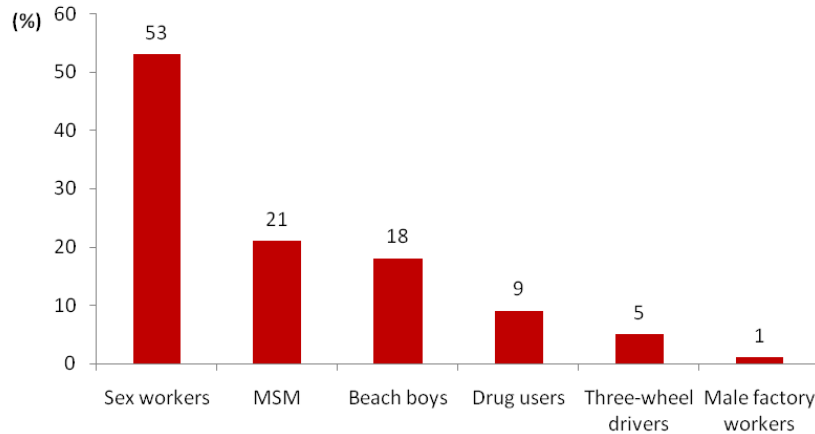
HIV prevention programmes

National HIV/AIDS Policy states that voluntary counselling and testing will be promoted. In addition, according to the national STD guidelines, testing for HIV is encouraged for persons attending STD clinics where consent is obtained prior to testing.¹¹ There are 26 administrative districts in Sri Lanka and each district has at least one STD clinic with laboratory facilities (1 central and 30 peripheral STD clinics). Of the 30 public STD clinics offering HIV testing, 22 perform testing onsite (up from 13 in 2007); STD clinics without onsite testing send samples to the National Reference Laboratory or the closest STD laboratory.

Recent estimates of prevention coverage for key affected populations in Sri Lanka are not available; however, non-nationally representative data for 2006-2008 show that the percentage of sex workers and MSM reporting having been reached with an HIV prevention program in the last 12 months was 44% and 14%, respectively.²⁷

According to the findings from the BSS 2006-2007, the percentage of people who are ever tested for HIV is still low among key populations at higher risk. Figure 13 shows the percentage of individuals in six sentinel groups reporting ever having been tested for HIV.¹⁰ With the exception of sex workers and MSM, the percentage of HIV testing is less than 20% despite their high vulnerability of HIV infection.¹⁰ At the same time, 43% of FSWs and 14% of MSM had received an HIV test in the last 12 months and knew the results.¹⁶

Figure 13: Percentage of selected populations ever tested for HIV, 2006-2007



Source: Prepared by www.aidsdatahub.org based on First Round Behavior Surveillance Survey Results 2006-2007, NSACP

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

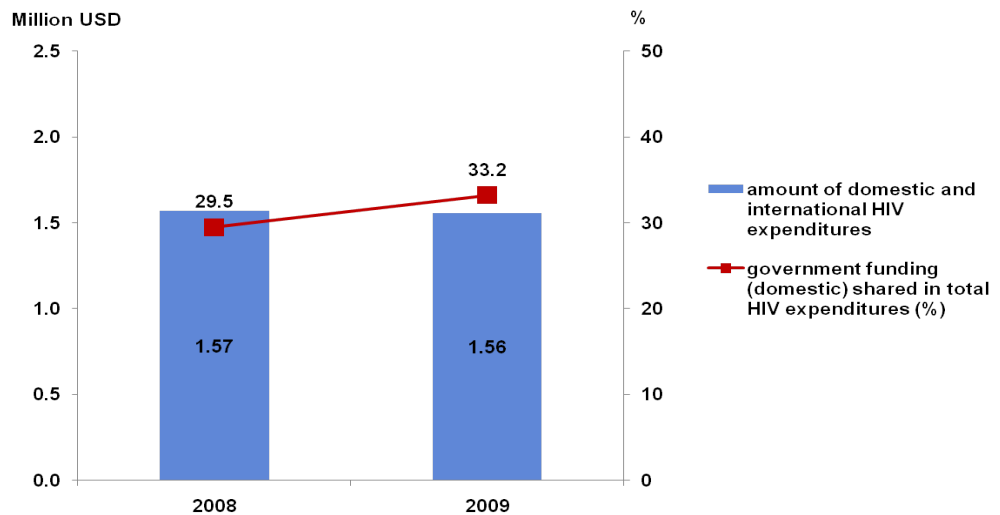
In 2006, the country agreed upon a universal access coverage target of 80% for key populations at higher risk and at least 90% of eligible patients are targeted to be receiving ART by 2010.²⁸ An estimated 510 adults and children were in need of ART in 2009 with an estimated coverage of 20%.²⁹ Comparatively, coverage of PMTCT was estimated to be between 9% and 31%.²⁹

In 2009, only 4% of pregnant women were tested for HIV in the previous year and received the results,²⁹ yet it has been estimated that an overwhelming majority (95%) of pregnant women have access to antenatal care.¹⁹ In 2009, 4 HIV-positive pregnant women received ARVs – estimated to be between 9% and 31% coverage – to reduce the risk of mother-to-child transmission, and 4 infants born to HIV-infected mothers received ARVs and co-trimoxazole prophylaxis within two months of birth (15% coverage).²⁹

ECONOMICS OF AIDS

AIDS expenditure in 2009 on funds received for the national response to HIV totalled US\$ 1.56 million, of which 67% came from international donors, a slight decrease from 71% in 2008 (Fig. 14).⁷ The primary sources of AIDS funds were the Global Fund (28.4%) followed by the UN (18.6%) and all other multi-laterals (19.8%).⁷ This reflects Sri Lanka's high reliance on funding support from the donor sector to deliver HIV & AIDS services.

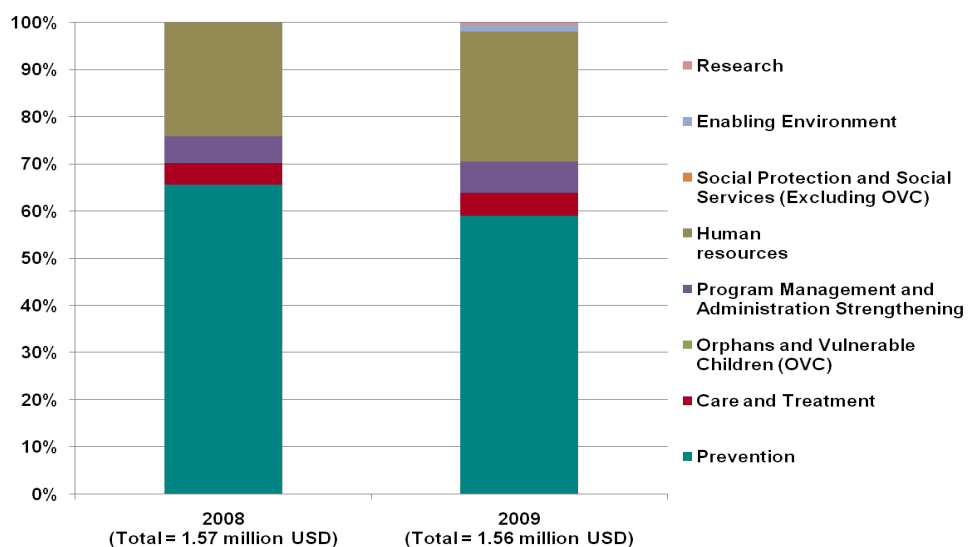
Figure 14: Amount of domestic and international HIV expenditures and % shared by government, 2008 - 2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

In 2009, prevention continued to be the largest spending category (59%), followed by human resources (28%), and program management and administration strengthening (7%) (Fig. 15).⁷ The percentage of funding allocated for prevention programmes targeting key affected populations (FSWs and their clients, harm-reduction for IDUs and MSM) in 2009 was 9%, which was double the number from 2008 at 4%.⁷

Figure 15: Percent distribution of total HIV expenditures by major spending category, 2008-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

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