UNGASS REPORT
Sri Lanka
2008-2009

United Nations General Assembly Special Session on HIV/AIDS
COUNTRY PROGRESS REPORT - SRI LANKA 2008-2009

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SRI LANKA

Reporting period: January 2008-December 2009

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I.I List of Acronyms

ADB	Asian Development Bank
ANC	Antenatal clinics
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioural Surveillance Survey
CCC	Ceylon Chamber of Commerce
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHBC	Community Home-Based Care
CSDF	Community Development Services Foundation
CSO	Civil Society Organisation/Non-Governmental Organization
CSR	Corporative Social Response
DMH	De Soysa Maternity Hospital for Women
ECS	Elimination of Congenital Syphilis
EFC	Employment Federation of Ceylon
ELISA	Enzyme Linked Immunosorbent Assay
EQAS	External Quality Assessment
FHB	Family Health Bureau
FHI	Family Health International
FPA	Family Planning Association
FSW	Female Sex Worker
GAMCA	Gulf Approved Medical Centers Association
GDP	Gross Domestic Product
GFATM	Global Fund on AIDS, TB and Malaria
GOSL	Government of Sri Lanka
HEB	Health Education Bureau
HSV	Herpes Simplex Virus
HPV	Human Papilloma Virus
ICS	Immuno Chromatographic Strip test
ICAAP	International Conference in AIDS in Asia Pacific
IDH	Infectious Disease Hospital
IDP	Internally Displaced Persons
IDU	Injecting Drug User
IEC	Information, Education, Communication
ILO	International Labor Organization
IVDU	Intravenous Drug Users
ISA	In-Service Assistants
ITI	Industrial Technology Institute
JKSRF	John Keels Social Responsibility Foundation
LGBT	Lesbians, gay, bisexuals and trans-genders
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MCH	Maternal & Child Health
MDG	Millennium Development Goals
MLT	Medical Laboratory Technicians
MOH	Ministry of Healthcare & Nutrition
MO/STD	Medical officer of sexually transmission disease clinic
MSM	Men having Sex with Men
NAC	National AIDS Committee
NBC	National Blood Centre

NBTS	National Blood Transfusion Service
NCPI	National Composite Policy Index
NDDCB	National Dangerous Drugs Control Board
NGO	Non-Governmental Organization
NHAPP	National HIV/AIDS Prevention Project
NIE	National Institute of Education
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
NVP	Nevirapine
NTB	National Tuberculosis Programme
OSH/HR	Occupational Safety Health and Human Resources
PDHS	Provincial Director of Health Services
PEP	Post Exposure Prophylaxis
PHI	Public Health Inspector
PHM	Public Health Midwives
PHN	Public Health Nurse
PHNS	Public Health Nursing Sister
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RDS	Respondent Driven Sampling
SAARC	South Asian Association for Regional Corporation
SIM	Strategic Information Management Unit
SLBFE	Sri Lanka Bureau of Foreign Employment
SLSI	Sri Lanka Standards Institute
SR	Sub-Recipient
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TOT	Training of Trainers
TTI	Transfusion Transmitted Infections
UAE	United Arab Emirates
UNHCR	United Nations High Commission for Refugees
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
VCCT	Voluntary Counselling and Confidential Testing
VD	Venereal diseases
WB	World Bank
WHO	World Health Organization
YFHS	Youth Friendly Health Services
ZDV	Zidovudine

II. Status at a glance

The 2008/09 Progress Report of the National Response to the Declaration of Commitment on HIV/AIDS (UNGASS) was prepared by the National STD/AIDS Control Programme (NSACP) of Ministry of Healthcare & Nutrition and several stakeholders using a participatory method during November 09 to March 2010. An initial meeting with the participation of several stakeholders was held to review the 2010 guidelines and identify the process for the preparation of the report. A technical working group was nominated to undertake the responsibility of the process and writing the report. Two workshops were held to introduce and train the government sector and civil society organizations (CSO) to complete National Composite Policy Index - Part A and Part B respectively. The vetting meeting was held in March for consensus of the document and thereafter finalized.

Currently Sri Lanka is experiencing a low level HIV epidemic. The estimated number of people living with HIV as at end 2009 was 3000 and the estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Survey data observes that even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1% up to end of 2009. As at end December 2009, a cumulative total of 1196 HIV persons were reported to the NSACP. The main mode of transmission is due to unprotected sex between men and women (82.8%). Men who have sex with men have accounted for 11.2% of the transmission while mother to child transmission was 5.4%. Transmission through blood and blood products was 0.4%. Injecting drug use in Sri Lanka is not a common phenomenon. However, certain socioeconomic and behavioral factors which are present in the country may ignite an epidemic in the future. The presence of a large youth population, internal and external migration, clandestine but flourishing sex industry, low level of condom use, concurrent sexual relationships among most-at-risk-populations (MARP) are some such factors. Low level of sexually transmitted infections (STI), availability and accessibility to free of charge health services from the state sector, high literacy rate, low level of drug injectors, are factors considered to be protective.

The National STD/AIDS Control Programme spearheads the activities that drive forward the countries national response together with many stakeholders who actively participate in planning, implementation and monitoring & evaluation. The political leadership given by His Excellency the President, Minister of Health, Minister of Education, Minister of Labor & Governor and Chief Minister of Sabaragamuwa Province has helped the NSACP in continuing the national HIV/AIDS response during the years including the years under review.

The National AIDS Policy of Sri Lanka has been submitted in 2009, to the Cabinet of Ministers for approval. The policy focus on prevention, treatment, care and support for all citizens in a non discriminating environment where the protection of fundamental rights are upheld to the highest standards as enshrined in the Constitution of the Democratic Socialist Republic of Sri Lanka.

The National AIDS Committee (NAC) recommended that more focus should be given to targeted interventions for the identified most at risk populations (MARPs). The female sex workers and their clients, men who have sex with men, injecting drug users are identified as the most at risk populations in the country based on epidemiological evidence and regional experiences. Thus the main aim of the National strategic Plan (2007-2011) is to increase the coverage and quality of targeted interventions for the most at risk populations and increase the coverage and quality of treatment, care and support.

The Behavioral Surveillance Survey (BSS) observed the risk MARPs impose in that in general they do not use condoms consistently with regular and non regular partners. Almost half of the sex workers who have had sex with clients have unprotected sex with other non paying partners.

Voluntary counselling and testing (VCT) among female sex workers is not optimum. Similar risk levels are observed among men who have sex with men and drug users in the country. The NSACP together with CSO have increased the coverage and quality of targeted interventions for MARPs. During the last two years, NSACP also took steps to develop a stronger link between the national programme, CSO and people living with HIV (PLHIV) in engaging them more frequently in all activities. A behavior change communication (BCC) intervention was undertaken by a CSO in 2008, with full participation of sex workers in the planning and implementation process and technical support from NSACP can be considered as an important milestone. Peer sex workers were trained for outreach work and one to one counseling and condom distribution and referral for STI services. The post intervention impact survey results showed that consistent condom use and linking up sex workers with STD services for STI screening and VCT had increased as a result of the intervention.

In 2009, a mapping exercise was commenced to map the female sex workers and men who have sex with men. By end of the year three districts were covered. The activity is ongoing and the data will help in estimating the size of each of the MARP sub populations.

In 2008/09 the NSACP continued its collaborative efforts with the National Blood Transfusion Service in maintaining the spread of HIV through transfusion of contaminated blood at low levels. During 2008 and 2009 no transfusion related HIV infections were reported in the country. Prevention of mother to child transmission of HIV is being addressed using the four prong strategy recommended by WHO/UNICEF and the main focus is on the first prong considering the low HIV prevalence in the country.

The annual sentinel sero surveillance which took place since 1993 will now be conducted once in two years from 2007 onwards. In 2008 the survey was done only among drug users and MSM to enlist them as sentinel groups for future surveys. The routine survey which was carried out in 2009 including female sex workers, MSM, drug users continued to observe the low prevalence of HIV.

During the years 2008/09 the GFATM funds were mobilized for interventions among in school youth, plantation sector workers and provision of antiretroviral therapy (ART). The in- school HIV/AIDS programme was launched in 2008 in selected provinces. The strategy adopted was using the life skills development approach to improve knowledge on STI/HIV/AIDS and develop life skills to face societal and sexual challenges. The programme was designed with full participation of school principals, teachers, students and officials involved in curriculum development in a culturally sensitive nature. . By end of 2009, a total of 2285 teachers in 698 schools were trained to implement this programme.

The plantation workers were selected for an intervention in HIV/AIDS as some of the health and social indicators in this population are poor. These workers are from a very low socioeconomic background and draw poor wages. Their literacy rate is poor, work in harsh environments and lives in poor housing schemes. On account of some of these factors it was imperative to include this group for a HIV intervention. This need was confirmed at the baseline survey carried out in 2009 which showed that they have very poor knowledge on HIV/AIDS and also practice some risk behaviors which may put them at risk of HIV infection. A BCC package was designed for the project and is currently being implemented by a CSO. Peer educators have been trained and a communication strategy was developed. In order to improve the provision of STD services Estate Medical Assistants were trained in syndromic management of STI. Voluntary counseling centers were established and 57 counselors were trained to promote VCT and behavior change and behavior development. It is worth mentioning that in 2008, ILO successfully implemented a results orientated HIV/AIDS education package with a BCC intervention for manufacturing, hotel and plantation

workers. SLBFE successfully internalized a structured HIV/AIDS programme into pre departure programmes for female external migrants. HIV/AIDS education and skills building programme for middle east bound female migrants was extended to cover all the island wide training centers. Discussions were held to prepare a similar programme for male migrants. The HIV/AIDS education and Condom distribution programme of the tri-forces continued amidst an ongoing war situation in the country.

Successive governments in Sri Lanka adopted a policy of providing free health services to people from the state sector. In keeping with this policy ART is being offered in the government sector since 2004. More varieties of first and second line ART drugs were procured using GFATM funds during 2009. As at end 2009, there were 207 adults and 11 children on ART covering 40.6% of those in need of ART as per the estimates. Due to close monitoring, counselling and services provided by the NSACP and other treatment centers the default rates were low. The 12 month survival rate for a cohort of PLHIV on ART was 93.3%. During the two years, nine antenatal mothers were given ART to prevent mother to child transmission of HIV. PMTCT interventions were integrated into existing maternal and child health services.

The STD clinics continued to carry out primary prevention interventions together with other stakeholders and also provide comprehensive STI management to interrupt the transmission of STI and HIV. Voluntary counseling and testing services were strengthened in the STD clinics with refresher training courses for counselors. The medical and paramedical staff was trained in counseling, and STI data management during the years under review. In 2009, the NSACP launched a programme for the elimination of congenital syphilis in Sri Lanka by 2015.

A separate strategic information and management (SIM) unit was established to improve collection of data, analysis and timely dissemination to all stakeholders for policy and programme development. The draft M&E framework was prepared in 2008 to monitor the national response.

Since beginning of the epidemic, Sri Lanka has worked towards a comprehensive HIV/AIDS programme with political leadership, recognizing the importance and value added of effectively engaging all relevant sectors and planning evidence based interventions. The National Programme is linked with poverty reduction strategies and millennium development goals (MDG). During the last two years the programmes have given a broader focus to target MARPs. In addition the NSACP has continuously strived to increase the coverage and quality of all programmes such as blood safety, school based education through life skills development, control and prevention of sexually transmitted infections, workplace education and skills development for behavior change, reducing stigma and discrimination, programmes for PLHIV, linking HIV/AIDS programmes to existing government health and non health sector programmes and provision of treatment including ART, care and support to maintain the low HIV prevalence in the country with support from all stakeholders including development partners.

UNGASS Indicator Table[1]

Data for the indicators given below were collected from different sources. The Report on HIV/AIDS estimates and projections, Universal access for prevention, treatment and care report, sentinel sero surveillance reports, Sri Lanka Behavioral Surveillance Survey, first round survey results 2006-2007 report, Demographic and Health Survey of Sri Lanka -2006/07, individual survey reports, reports from the National Blood Transfusion Service, Epidemiological surveillance report of NSACP, STI surveillance reports were used in compilation of the UNGASS 08/09 report.

National commitment and action	
Indicator 1: Domestic and international AIDS spending by category and financing sources	Indicator relevant; Limited data available.
National programme indicators	
Indicator 3: Blood Safety – Donated	100%
Indicator 4: HIV Treatment: Antiretroviral Therapy (2009)	40.6%
Indicator 4: HIV Treatment: Antiretroviral Therapy (2008)	32.1%
Indicator 5: Prevention of Mother-to-Child Transmission (2009)	11.1%
Indicator 5: Prevention of Mother-to-Child Transmission (2008)	16.1%
Indicator 6: Co-Management of Tuberculosis and HIV Treatment	10.0%
Indicator 7: HIV Testing in the General Population	*Subject matter relevant: Indicator not relevant
Indicator 8: HIV Testing in Sex Workers (2006/07)	42.6%
Indicator 8: HIV Testing in Men who Have Sex with Men (2006/07)	13.6%
Indicator 8: HIV Testing in Injecting Drug Users	** Indicator relevant; but no data available
Indicator 9: Prevention Programmes: Sex Workers	** Indicator relevant; but no data available
Indicator 9: Prevention Programmes: Men Who have Sex with Men	***Indicator relevant; but no data available
Indicator 9: Prevention Programmes: Injecting Drug Users	***Indicator relevant; but no data available
Indicator 10: Support for Children Affected by HIV and AIDS	Subject matter relevant: indicator not relevant
Indicator 11: life Skills-based HIV Education in Schools	Subject matter relevant: indicator not relevant
Knowledge and behavior indicators	
Indicator 12: Orphans: School Attendance	Subject matter not relevant
Indicator 13: Young People: Knowledge about HIV Prevention (2006/07)	17.3 (limited data available)
Indicator 14: Knowledge about HIV Prevention: Sex Workers	Indicator relevant to our

[1] * Indicator reported in UNGASS 2007 was among factory workers as the sexual behavior is thought to be proxy to general population. However the comments by the UNGASS team on SL report 2007 were that FW should not be reported for this indicator. Hence we are not reporting the indicator as no data available from a general population survey .
**Very limited data available from BSS , as the number of ever IV drug users were low and the current IVDU were low even more. The indicator is not computed due to very small numbers.
*** of the two the specific questions for UNGASS indicator, only one question where MARP can get a HIV test done was asked , but whether MARP received condoms was not asked In the BSS 2006 THUS the indicator cannot be computed.
**** First question out of 5 questions to compute this indicator was asked in a slightly different manner in 2006 BSS questionnaire. For the 2007 UNGASS report, while explaining this indicator was computed, and reported. However the UNGASS experts commented that it's not correct to report the indicator as such. Thus the indicator is not reported.
*****for the UNGASS 2007 HIV prevalence of sex workers in western province has been reported (0.16%) as data was not available at other sites at the time of reporting

	country; no data available
Indicator 14: Knowledge about HIV Prevention: Men Who have Sex with Men	Indicator relevant to our country; no data available
Indicator 14: Knowledge about HIV Prevention: Injecting Drug Users	Indicator relevant to our country; no data available
Indicator 15: Sex Before the Age of 15 (2006/07)	1.4% (limited data available)
Indicator 16: Higher-risk Sex	Indicator relevant to our country; no data available
Indicator 17: *Condom Use During Higher-risk Sex	Indicator relevant to our country; no data available
Indicator 18: Sex Workers: Condom Use (2006/07)	89.3%
Indicator 19: Men Who Have Sex with Men: Condom Use (2006/07)	60.9%
Indicator 20: Injecting Drug Users: Condom Use	indicator relevant to country; no data available
Indicator 21: Injecting Drug Users: Safe Injecting Practices	Indicator relevant to our country; no data available
Impact indicators	
Indicator 22: Reduction in HIV Prevalence (09)	0.04%
Indicator 23: Reduction in HIV Prevalence: Sex Workers (2009 Sentinel survey, number tested 1032)	0%
Indicator 23: Reduction in HIV Prevalence: Men Who have Sex with Men (2009)	0.48%
Indictor 23: Reduction in HIV Prevalence: Injecting Drug Users	Indicator relevant; no data available
Indicator 24: HIV Treatment: Survival After 12 Months on ART	93.3%
Indicator 25: Reduction in Mother-to-child Transmission	30.6%

III. Overview of the AIDS epidemic

Sri Lanka is classified as a country with a low level epidemic of HIV in the South-East Asia region. According to UNAIDS estimates, around 3000 people were living with HIV as at end December 2009. The estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1%. The female sex workers and their clients, men who have sex with men, injecting drug users are identified as the most at risk populations in the country. Although classified as a middle- income country, with a population of almost 20 million, Sri Lanka, has achieved remarkable social and health indicators some of which are in par with those of developed nations.

In order to track the level of HIV infection in different sub populations and to provide strategic information for policy and programme development, the National STD/AIDS Control Programme (NSACP) has been conducting annual HIV sentinel unlinked sero-surveillance (SS) since 1993. Low HIV prevalence levels were observed over the years and this was maintained in 2008/09 even among the most at risk populations (Table 1).

Table 2. HIV Sero-prevalence among sentinel population groups in Sri Lanka during last 5 years

Population group	Year of sentinel surveillance survey				
	2005	**2006**	**2007**	**2008**	**2009**
Female sex workers	(0%) 0/1136	(0.2%) 2/1,216	(0%) 0/1218	Not included	(0%) 0/1032
MSM	Not included	Not included	Not included	(0%) 0/242	(0.48%) 2/411
Drug users	Not included	Not included	Not included	(0.19%) 1/539	(0%) 0/1004
STD attendees	(0.04%) 1/2272	0.4% 8/2,215	(0.08%) 5/2456	Not included	(0.15%) 4/2746
TB patients	(0.1%) 2/1528	(0.1%) 1/1,332	(0.08%) 1/1233	Not included	(0%) 0/1547
Military	(0%) 0/3200	(0%) 0/1200	(0%) 0/1241	Not included	(0%) 0/1380

A policy decision was made in 2007 to conduct the SS once in two years in future as HIV prevalence levels remained at low levels without significant changes over the years. In 2008 two new groups (MSM and DU) were surveyed to be included in routine surveys. The last survey was in 2009 where the sero-prevalence was observed to be 0.2% among MSM and 0.15% among STD clinic attendees whilst it was at zero level among the other groups (Table 2). No significant changes in the HIV prevalence were noted over the years among the subpopulations included in the sero-surveillance.

The National AIDS Policy encourages voluntary counseling and testing and disallows mandatory testing. VCT services are available at STD clinics. STD clinic attendees are offered the HIV test routinely and testing is done with consent following counseling. Provider initiated counseling and testing is carried out in hospital settings when signs and symptoms or medical conditions are suggestive of HIV/AIDS. The private sector carry out HIV testing for pre-departure external migrants at the request of the destination country and the screening test positive samples are referred to the NSACP for confirmation of HIV infection but data on the numbers tested carried out in these settings is not supplied to the NSACP routinely. Donated blood is routinely screened for HIV in the respective blood centers. Data from such sources reveal the following important epidemiological information.

Almost three decades since the detection of the first HIV infection in Sri Lanka, as at December 2009, a cumulative total of 1196 HIV infections have been reported to the National STD/AIDS Control Programme. Of them 326 have been reported as AIDS and 202 have succumbed to the illness. Over the years a slow but a gradual increase in the number of reported cases is observed in part due to the increase in testing. Availability of ART free of charge in the country has encouraged more people to come forward for HIV testing.

Figure 1. Number of Annual HIV Cases Reported as of end 2009

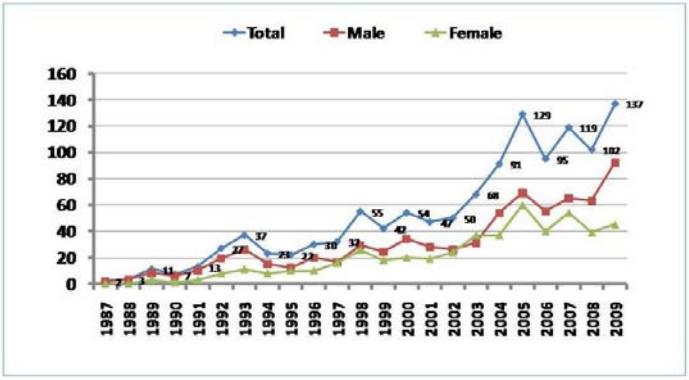
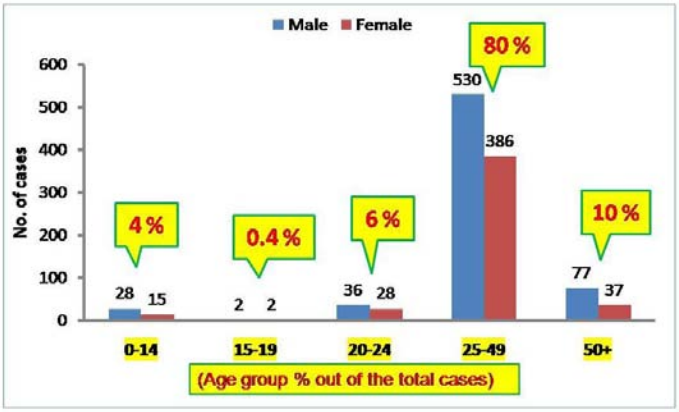


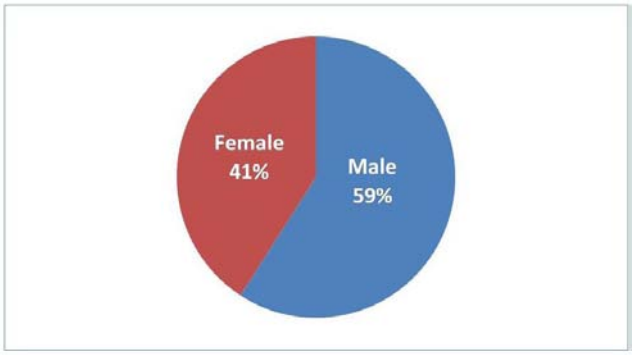
Figure 2. Cumulative HIV Cases by Age and Sex as of end 2009 (N=1141 *)



(**data on 55 people were not available*)

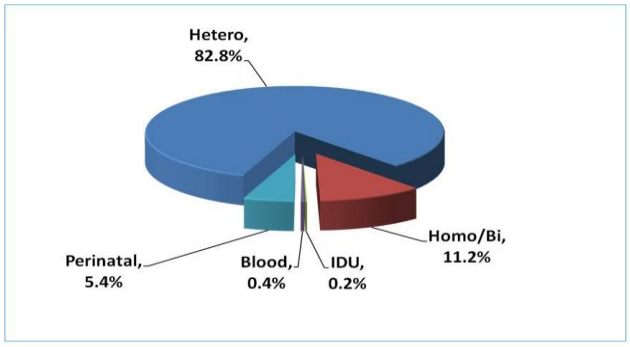
The majority (80%) of those infected were in the 25-49 year age group. The current ratio of HIV positive men to women in Sri Lanka is 1.4:1. It is important to note that women are over represented in testing since a large number of migrant women undergo pre departure mandatory testing as a requirement of the destination country.

Figure 3. Male Female Distribution of Cumulative HIV Cases (N=1196)



Of the total number of HIV cases reported from 1987 to end 2009 the probable mode of transmission was known only in 67% (n=802), reflecting the gaps in data collection and disclosure. Where data is available on mode of transmission, almost 82.8% were due to unprotected sex among men and women. Unprotected sex between men or bi-sexual category accounted for 11.2% of the transmission.

Figure 4. Cumulative HIV Cases by Mode of Transmission as of end 2009 (N=802 *)



(data on 395 people were not available)*

HIV infection due to blood and blood products has been extremely low (0.4%). Only 3 cases of transfusion related HIV infections have been reported to NSACP before year 2000. Thereafter none were reported. The blood safety policy adopted in Sri Lanka since 1988 has helped to maintain this low prevalence. Government sector blood banks carry out HIV tests as per standard operational procedures on all donated blood prior to transfusion. During the years under review (08/09), a total of 588,146 samples of donated blood in the government sector were screened for HIV antibodies and 23 of them were positive giving a seropositivity rate of 0.03%. Over the last five years the HIV sero-positivity rate among donated blood samples has been fluctuating between 0.02-0.04 percent. In 2008 the sero-positivity rate for hepatitis B and C were 0.94% (300/320,091) and 0.27% (879/320,091) using the ELISA screening test as confirmatory tests are not available in the country for Hepatitis B and C viruses. The corresponding figures for 2009 are 0.14% (438/309,909 and 0.31% (970/309,909). In 2008, 10 new HIV cases were detected by screening donated blood and the corresponding figure for 2009 was 13 cases. These accounted for 9.8% of total cases detected in 2008 and 9.1% cases detected in 2009.

The Harm Reduction Network estimates that there are almost 240,000 opiate users and the National Dangerous Drug Control Board(NDDCB) estimates that there are about 45,000 heroin users and 20,000 cannabis users in the country. According to NDDCB estimates, less than 2% of the heroin users are injectors. At present injecting drug use is practiced only by a very few. To date transmission through sharing of injecting syringes and needles is reported only among two persons with one acquiring the infection outside the country. If there is a shift in drug use patterns to injecting then the change would result in the establishment of another important most at risk population which would fuel an epidemic.

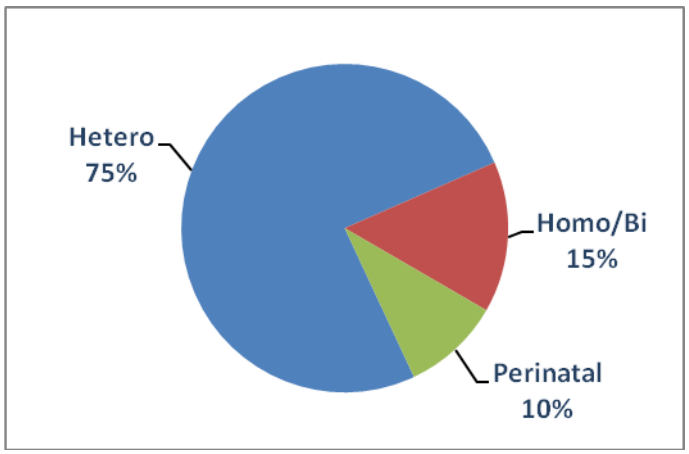
Vertical transmission was accountable for 5.4% of the total reported cases. The sero-positivity among antenatal mothers has been low. A low sero-positivity of 0.02% was recorded in both 2008 and 2009.

In the year 2008, a total of 389,786 HIV screening tests were carried out and reported to NSACP (this includes HIV testing carried out by the NSACP and in government STD clinics, National blood transfusion service and some of the private hospitals). The corresponding figure for 2009 was 387,557. During year 2008 and 2009 a total of 102 and 137 HIV infections respectively were detected giving a sero-positivity rate of 0.03% for both years. It should be noted that while the total number of confirmed HIV positives are available at the NSACP, the total number of HIV tests done in the private sector are not reported routinely.

Due to scarcity of information it is difficult to demonstrate a trend in prevalence and transmission patterns and have a complete profile of the sociodemographic and behavioral patterns of the reported cases. For years 2008 and 2009 where data is available it is observed that transmission among men and women has been 75 %. Men who have sex with men have accounted for 15 %. In 2008 and 2009 blood donors accounted for 9.8% and 9.1% respectively of the detections. In 2008, three paediatric HIV/AIDS patients were detected and it increased to ten in 2009. However, the number may be more as diagnosis of paediatric AIDS is limited as PCR-DNA testing is not available.

In 2008, concordance for HIV infection was observed in eight couples and the corresponding figure for 2009 is 19 highlighting the spousal transmission. The issue of spousal transmission is addressed at counseling sessions for newly diagnosed HIV patients.

Figure 5. Probable mode of transmission of HIV cases detected during 2008 and 2009 (N=134*)



(data on 122 people were not available)*

Certain socio-economic, cultural, behavioral and health related factors such as high literacy rate, accessibility and availability to free health services including STD services, high school enrolment rates, high levels of gender equality, the relatively high status of women, low levels of injecting drug use may be helping to keep HIV infection at low levels. On the other hand there is a sizeable number of MARP operating in the country. Although soliciting sex is illegal, the sex industry is flourishing and the mapping exercise has estimated that there are 35,000-47,000 sex workers in the country. The estimate for MSM is 24,000-37,000. In addition to the presence of most at risk groups such as female sex workers and their clients, MSM including beach boys and the practice of high risk behaviors such as low consistent condom use, multiple partnerships among them are potential risk factors for the spread of HIV. Consistent condom use among female sex workers during the last sexual act with a paying partner was in the range of 80-95% and 64% among men who had sex with another male partner. Since consistent condom use with all types of partners is low among sex workers and MSM exposes them to the risk of HIV infection. Although the injecting drug users are few in number, the ones who inhale and snort drugs do engage in sex with other men and patronize the sex trade. Although not sizeable but overlapping sexual behaviors among female sex workers, MSM and drug users would be a potential threat to the spread of HIV in the country. The proportion of men who visits female sex workers is estimated to be 3.5% of the total male population. However, the daily clients turn over in the sex trade is low. The BSS (06/07) observes that the number of clients per female sex worker is between 1.6-3.3 during the last working day. A study among MSM (2008) has shown that the average number of male partners for a year was 6.8. More data on concurrent sexual relationships among these groups will throw light on the future of the epidemic and planning targeted interventions.

Low STI rates have been observed among MARPs and in the general population. Similar to the global trends, the STI surveillance data shows that the bacterial STI are declining but viral STI (HSV and HPV) trends are increasing. Genital herpes is the leading STI in the country. The presence of genital ulcers can influence on the HIV epidemic dynamics. The majority of male STD attendees are clients of sex workers and primary and secondary prevention of STI has a major role in the control of HIV. All STD attendees are offered HIV testing and during 2008 and 2009, a total of 20,340 and 20,579 HIV tests were carried out among STD clinic attendees and 39 and 66 respectively were tested positive. Antenatal screening for syphilis is a routine procedure in the country and the prevalence of syphilis among antenatal mothers is maintained at a low level of 0.04% during 08/09.

The BSS carried out in 2006/07 has shown that relatively low levels of risky behaviors take place among vulnerable groups such as three wheel drivers and factory workers in the free trade zone. A study in 2009 among a group of youth along the Southern coastal belt area in the country which is a tourist destination, observed that employed youth, alcohol consumption, visiting night clubs, watching pornography on internet, poor communication with parents and having liberal attitudes towards sex were the risk factors for engaging in risky sexual behaviors. Attention should be drawn to the expected influx of large numbers of tourists to the country with the dawn of peace after the end of a dreadful separatist war which prevailed over 30 years.

Vulnerability factors such as separation of spouses due to overseas migration appear to be posing a threat to the HIV burden in Sri Lanka. Since the detection of the first HIV infection in Sri Lanka it was observed that a significant number of HIV infections are being diagnosed among external migrant workers. The available data reveals that 40% of HIV infected females have acquired the infection probably outside the country. The analysis of 2008/09, HIV data observes that almost 22% of the infections in each year were associated with external migration. It appears that HIV is being introduced to the country to some extent by external migrants. The high mobility of the military during the war situation which engulfed the country over three decades does not appear to be a

vulnerable factor in Sri Lanka. To date the HIV sentinel sero surveillance among soldiers is observed to be zero HIV prevalence.

Although the surveillance data shows low prevalence among MARPs and is in the early epidemic phase, the BSS has shown that female sex workers, men who have sex with men are practicing high risk behaviors exposing them to the risk of HIV infection. Not only is the presence of sizeable populations of MARP, the presence of overlapping and concurrent sexual relationships among them to some extent may facilitate the spread of HIV and change the landscape of a latent epidemic. The clients of sex workers and men who have sex with men who also have female regular partners will serve as the bridge populations that link risk groups with the broader general population. It is also observed that for around 40% of infected women the risk factor was being married as they claimed that their only sexual partner was the husband. Increasing rates of spousal transmission and the introduction of HIV to the country by external migrants needs to be controlled. Although infected returning migrant workers may not appear to seed local networks and cause a chain of infections they are certainly a part of the burden of infection in the country.

IV. National response to the AIDS epidemic

1. National commitment and action

The Government of Sri Lanka (GOSL) has responded to HIV/AIDS even before the detection of the first HIV infection in Sri Lanka. The Anti VD Campaign which was established in 1952, based on a British Model for control and prevention of venereal diseases was restructured in 1985 and was named National STD/AIDS Control Programme (NSACP). The GOSL is fully committed to the prevention and control of HIV/AIDS in the country and has recognized it as a developmental issue with social and health implications and responded by the formulation of policies and series of strategies with broad participation of all stakeholders. The NSACP which comes under the purview of the Ministry of Health is spearheading the national response with all other stakeholders of the health and non- health state sectors, non-governmental organizations, business community, people living with HIV in its multi-sectoral, decentralized approach. The three ones principle guides the national response, one multi sectoral strategy, one national comprehensive strategy and one HIV/AIDS monitoring and evaluation framework. The first Medium Term Plan launched in 1988, followed by the second in 1994, National Integrated Work Plan (1998) and the National HIV Prevention Project (2003-2008) under a grant from the World Bank/International Development Association have helped in maintaining a remarkably low level of spread of HIV among both the general population and individuals considered at higher risk on the basis of their sexual behaviors and practices. The award of the Global Fund for AIDS Tuberculosis and Malaria (GFATM) six round grants has helped in the implementation of interventions to curb the spread of HIV infection.

The National AIDS Council formed in 2006 is the highest governing body chaired by His Excellency the President with relevant ministers as members. The National AIDS Committee (NAC) which was formed in 1988 as the policy formulating body of the Ministry of Health on HIV/AIDS continued its commitment by overseeing implementation of the response to HIV/AIDS during the years 2008/09. The NAC which is chaired by the Secretary for the Ministry of Health care & Nutrition (MOH), with representation from various government, non government, civil society and people living with HIV/AIDS was restructured in November 2009 to improve inter sectoral collaboration. Six subcommittees, namely prevention, treatment, care and support, advocacy & communication, multisectoral, policy, legal and ethical, strategic management & information, are set up to deal with operational issues and make recommendations to the NAC concerning the national response. The National AIDS Policy was submitted to the Parliamentary Cabinet of Ministers in 2009.

The National Strategic Plan (2007-2011) which was formulated with participation of a wide group of stakeholders provides guidance for the national response. The National Strategic Plan (NSP) supports the Poverty Reduction Strategic Paper and the Millennium Development Goals especially MDG-6: to halt and reverse the HIV epidemic by 2015. The goal of the National STD/ AIDS Control Programme (NSACP) is to maintain the current low prevalence of HIV infection with targeted prevention interventions to the most at risk populations (MARP) and also to other vulnerable groups and the general population and scaling up care, support and provision of treatment anti retroviral therapy (ART) and mitigating stigma and discrimination to improve the quality of life of people infected with or affected by HIV. The National Programme provides both preventive and curative services together with a network of 30 peripheral STD clinics distributed island wide Guiding principles for the national HIV/AIDS response are strategies based on evidence, respect for human rights, gender considerations and involvement of PLHIV. Two core strategic objectives namely 1) increased coverage and effectiveness of prevention interventions 2) increased coverage and effectiveness of care, support and treatment interventions and four supportive objectives 1) Improved generation and use of information for planning and policy development 2) increased involvement of relevant sectors and levels of government in the response 3)more supportive public

policy and legal environment for HIV/AIDS control 4)improved management and coordination of the response have been identified. In 2008, the draft indicator frame work was prepared with the objective of monitoring and evaluating the national response. The National M&E framework will help in tracking the epidemic with its indicators which are grouped into five key priority areas: prevention; care, support and treatment; policy development and legislation; strategic information management and strengthening national coordination and management capacity. These indicators reflect the national information needs as articulated by UNGASS declaration of commitment, Universal Access and the AIDS related MDG (2015).

The following programme areas continued to function in 2008/09 to achieve the above mentioned objectives;

- HIV Care, Support and treatment
- Comprehensive Management of STI
- Counseling
- IEC activities targeting the general public and specific risk groups.
- STD/HIV surveillance system.
- Condom promotion in prevention of transmission of STD/HIV infections.
- Laboratory facilities
- Screening blood and blood products
- Instituting Infection control measures including universal precautions in all medical institutions and in the field services.

The NSP has moved towards greater integration of HIV related activities with other health, development and sectoral activities. In such a backdrop towards achieving its goal, the national programme in 2008/09 continued to direct the national response through planning, monitoring and coordination of all stakeholders such as health sector organizations eg; Family Health Bureau, Health Education Bureau, National Blood Transfusion Services, National Respiratory Disease Control Programme and other Government non-health, Ministries such as Ministry of Labor, Education, Dept of Prisons, Sri Lanka Bureau of Foreign Employment and the Tri-Forces, and several CSOs distributed island wide and organizations of PLHIV. With the devolution of administrative powers under the 13th amendment of the Constitution of Sri Lanka, the provincial health services including HIV/AIDS comes under the purview of the Provincial Director of Health Services (PDHS). The majority of STD clinics come under the provincial administration. District level HIV/AIDS action plans for 2008/09 were prepared through a dialogue between the central level planners and provincial stakeholders taking into consideration the risks and vulnerabilities and were implemented under the supervision of the PDHS and Regional Directors of Health Services. The peripheral STD clinics which are manned by a trained medical officer together with its public health team carry out community based field services and curative care with technical guidance from the NSACP. The primary health care personnel, civil society organizations work in partnership with the STD team.

During the years 08/09, the main strategy was to scale up the coverage of comprehensive prevention interventions among those most at risk with priority given to sex workers and clients, men who have sex with men (MSM) and partners, drug users and prisoners. Since sex work, drug use and sex between men are barely tolerated and is illegal and is frequently looked down upon by society there are limitations in mounting and supporting effective prevention efforts focusing on people at the highest risk of HIV in the country. Over the last four to five decades, government health services are provided free of charge to all citizens and in this background in 2004, a policy decision was taken by the Government to provide ART free of charge to PLHIV in the Government sector. In 2004, the WB fund was used to purchase ART and in 2008, the GFATM funds were used for this purpose. Both first and second line drugs, adult fixed dose combinations are available. Availability and accessibility to treatment, support and care services for PLHIV and their families

were enhanced during the reporting period. The Strategic Management Unit (SIM) was established in 2009 and is expected to improve collection of strategic information, analysis and generation of evidence based information for dissemination to programme planners for the development of district level plans in accordance with national policies and strategies.

2. Governance

2.1 Leadership

His Excellency the President of the Democratic Socialist Republic of Sri Lanka is the Chairman of the National AIDS Council. The "*Mahinda Chintana*" the future vision for the country was updated in 2009 and has recognized the need to maintain the low HIV prevalence in the country. The Minister of Healthcare & Nutrition plays an active role in taking part in many HIV prevention seminars, workshops and conferences. The Minister of Health was the chief guest at the 2008 and 2009 National World AIDS day programme. In addition he attended the HIV/AIDS Poster competition and the AIDS Walk organized by the Department of Prisons. In November 2009, at the launch of the "Strategy for elimination of congenital syphilis in Sri Lanka by 2015" the Minister of Healthcare & Nutrition stressed the importance of prevention and control of other STI as they facilitate the acquisition and transmission of HIV. The Secretary Healthcare & Nutrition chairs the National AIDS Committee and reviews the policies and implementation of the national programme. The Director General Health Services and the Deputy Director General Public Health Services continuously monitors and evaluate the national response.

The Minister & Secretary of Labor Relations and Manpower gave leadership for the development of the "Tripartite declaration of Prevention of HIV" endorsed by the Employer's Federation, trade unions and the Ministry of Labor. A technical working group was established under the chairmanship of the Secretary to develop the National Policy on Prevention of HIV in the World of Work. The current GFATM funded school HIV/AIDS education programme is being carried out under the guidance and leadership of the Governor and Chief Minister of the Sabaragamuwa Province. During negotiations in 2008, in order to provide island wide coverage and mainstream the activity, the Minister of Education agreed to include HIV/AIDS education for Grade 6-9 students as a component in the Science subject with the next curriculum changes that will take place in 2012. The majority of school students will benefit from this programme as Science is a compulsory subject.

In 2009, a policy decision was taken and the Director General of Sri Lanka Bureau of Foreign Employment (SLBFE) took steps to integrate HIV/AIDS education programme to the pre departure training programme for female migrants in all 34 training centers of the SLBFE in the country. The Commanders of the Tri-forces & their officials continued their leadership and commitment for HIV/AIDS prevention programmes in spite of the war situation in the country. The response from the officials of the Department of Treasury of Ministry of Finance and the Chairman and officials of the State Pharmaceutical Corporation during the procurement process of ART from the Clinton Foundation was noteworthy. The Minister of Justice and the Director General of the Department of Prisons and his officials are fully committed to prevent the spread of HIV in the prisons.

2.2 Multi sectoral Approach

The Government of Sri Lanka recognizes the importance of the participation of multiple stake holders in the national response. The NSP which was developed with the participation of several stakeholders has identified roles and responsibilities of state, CSO and PLHIV. During the reporting period of 2008/09, central bodies such as the Family Health Bureau integrated PMTCT into Maternal & Child Health Services, National Blood Transfusion Service continued its efforts in the provision of a

safe HIV free blood supply to the nation, Health Education Bureau supported in development of IEC material, National Respiratory Disease Control Programme took steps to increase prevention and control of TB and assisted in the management of HIV-TB co-infection, National Institute of Health Sciences incorporated HIV/AIDS in training curricula. These partnerships enriched the national response. The response from the provincial health services response has been very encouraging and HIV/AIDS prevention interventions were included in the district development plans. Provincial and district planning process harmonized with the national strategy and was based on local situations and needs. National Committee on Reproductive Health, College of Community Physicians, College of Physicians, College of Venereologists, and College of Obstetricians & Gynecologists carried out sensitization and training programmes during the two years under review.

With the blessings of the Ministry of Labor several workplaces have developed workplace policies based on the ten principles of the ILO Code of Practice and some have already commenced programmes which were mainly focusing on education on safer sexual practices and behavior change. The GFATM funded plantation sector programme is being implemented by a CSO (Alliance Lanka) as a sub-recipient (SR) for the benefit of the plantation workforce which lag behind in respect of achieving the same levels of social and health indices of other districts. Ministry of Plantation, estate sector hierarchy, trade unions, medical staff of the plantation sector, and the employees themselves has positively supported this programme. The Ministry of Education through the Asia Development Bank (ADB) project is addressing the issue of HIV in schools. However, mainstreaming HIV/AIDS interventions to the respective ministerial action plans is slow and needs a push.

Community Strength Development Foundation a leading CSO has actively undertaken work towards increasing quality and coverage of prevention of HIV among MARP as stated in the NSP. They networks with eight other CSOs to deliver a package of interventions to female sex workers, including creating an enabling environment, behavior change communication through peers, distribution of condoms, promoting VCT and referral to STD clinics. A similar package is offered by Companions on a Journey for MSM. The issues of lesbians, gay, bisexuals and transgender people are being looked into by a CSO called Equal Grounds. The NSACP provides technical support for capacity building for all these programmes. The continued commitment of civil society organizations is helping the national response.

Civil society:
In 2009, several CSOs were actively involved in prevention interventions. Most of them were funded by the AIDS Foundation of Lanka which was established after the 8th ICAAP.

Business sector:
The private sector participation in the national response to HIV/AIDS has improved significantly. The Sri Lanka Business Coalition on HIV/AIDS was established in 2004 and was strengthened with international linkages at the 8th ICAAP with local 34 companies registering with the coalition. This has increased to 64 members as at end 2009. The Standard Chartered Bank together with leading business partners are taking the leadership with a vision to increase the number and diversity of companies committed to respond to the HIV/AIDS epidemic. The main objectives are for each company to have a HIV/AIDS workplace policy within the framework of the ILO Code of Practice and the National Policy and National Strategic Plan, to enhance and facilitate the use of Companies core competencies, products and services towards prevention of HIV/AIDS among the workers and their families and to provide advocacy and leadership among key stakeholders in response to HIV/AIDS. Since the Employment Federation of Ceylon (EFC) and the Ceylon Chamber of Commerce (CCC) and the Business Coalition were partners of the ILO Code of Practice on HIV/AIDS and the World of Work which was launched in 2004 they continued awareness and skills building programmes in 2008/09 towards maintaining the low HIV prevalence in the country.

The business conglomerate John Keells (Pvt) Ltd is an active partner in the national response. They recognized early the potential impact of HIV/AIDS, particularly on social and economic development, both at business level, as well as national level. The John Keells HIV/AIDS Awareness Campaign was launched in 2005, in collaboration with the National STD/AIDS Control Programme of the Ministry of Health, International Labor Organization (ILO) and the Ceylon Chamber of Commerce, which focuses on prevention through awareness and education for behavior change; they continued intervention during 2008 and 2009. It was the first such campaign to be undertaken by a local corporate in Sri Lanka. Starting with World AIDS Day in 2008, the John Keells Group has rolled out an HIV/AIDS Workplace Policy, based on ILO's 10 Principles, among ten different companies belonging to its Leisure industry. The awareness programme conducted by JKSRF is structured to educate people on HIV and AIDS, how the virus spreads and could be prevented and the care and supported needed by the infected and the affected. The campaign comprises 3 phases which are as follows: - Phase 1 – Sensitization and awareness on HIV/AIDS for staff of the John Keells Group continued as an ongoing exercise. Phase 2 – Business Surroundings – This included building awareness in the various high-risk environments around the Group's business locations – e.g. persons attached to the Leisure industry, manufacturing industry, city-based corporate, members of the armed forces and police as well as the inmates of Prisons have been covered under this phase, which will also be continued on a need basis. Phase 3 – General Public - In the third phase, the campaign hopes to cover island-wide awareness programs for the benefit of the general public. As at end 2009 a total of over 13,000 people across Sri Lanka have benefited from this programme including both the staff of the John Keells Group as well as persons from other private as well as public sector organizations as well as vulnerable communities living in close proximity to the Group's business locations.

2.3 Policy development

With new policy developments taking place globally and regionally, several consultations were held in 2008, to re-review the draft National AIDS Policy. The policy envisage Sri Lanka to mobilize all social forces and stake-holders to mount a thorough and well coordinated national response through a National Strategic Plan (NSP) and by doing so, to avoid possible expansion of HIV epidemic and its' un-imaginable health, social and economic impact in Sri Lanka. The two major objectives of the policy are 1) To prevent HIV and other sexually transmitted infections in Sri Lanka through effective strategies aimed at reducing transmission through unprotected sex, blood and blood products and mother to child 2) To improve the quality of life of people infected and or affected by HIV/AIDS through minimizing stigma and discrimination and providing quality care and support. It has identified several priority areas including prevention of STI/HIV, surveillance, monitoring and evaluation, voluntary counseling and testing, treatment, care and support, safety in health care settings, interventions at world of work and respect of human rights.

The Ministry of Labor Relations & Manpower has been an active partner in the national response to HIV/AIDS and several consultations were held to mobilize the employers, trade unions to contribute to the efforts of maintaining the low HIV prevalence in the country. The National Tripartite Declaration which eventually is expected to become policy was signed in 2008. The declaration calls for a mutual understanding of the three tripartite constituents with regard to their responsibilities towards prevention of HIV in the world of work, elimination of stigma and discrimination against workers. A Joint Trade Union Policy was signed in 2009 which has been a major milestone in HIV/AIDS in the workplace.

3. Prevention Programmes

3.1 Programmes for Most-at-risk populations (MARPS)

The NSP identifies female sex workers, men who have sex with men including beach boys, injecting drug users and prisoners as those at a higher risk of HIV infection. Since soliciting sex, substance use and same sex sexual relationships are illegal, reaching these populations is difficult even for civil society organizations. Yet, the NSACP together with civil society organizations have carried out several interventions to prevent HIV infection getting a foothold in these groups. Sensitization programmes behavior change communication for safer sexual practices and promoting VCT, STI services for screening and treatment, were some of the interventions focused during the two years. The estimates of MARPs for 2008/09 were carried out by a group of experts using data of the BSS (2006). In order to have more realistic data on size estimations of MARP for better planning and monitoring and evaluation a mapping exercise for sex workers and MSM was commenced in 2009 in three districts of the country by the NSACP and civil society organizations with technical assistance form University of Manitoba, UNAIDS and WB in order to provide inputs for size estimation software packages.

3.1.1 Programmes for female sex workers

Although soliciting sex is illegal in Sri Lanka, the sex industry appears to be flourishing rapidly especially in Colombo, the most populous city, which is the economic hub of the country. The estimates of female sex workers were carried out by a group of experts using data of the BSS (2006) is 4800-7200 for 2007. However, in 2009 FSW estimates were conducted using mapping methodology estimated that there are 35,000-47,000 FSW in the country.

Although the BSS (2006/07) noted that brothels, hotels and lodges are the main locations of the sex trade in 2008/09, the sex work environments changed. A shift from brothels, hotels, lodges and restaurants to indirect settings such as karaoke bars, massage parlors and private houses was observed. This shift could be attributed to the increase in police and military vigilance to combat terrorism during the years 2008/09. Due to frequent security checks street sex workers and institution based sex workers faced difficulties in soliciting sex. This fact is borne out in a study carried out in June 2008, which observed that 38% of the participants lived in boarding houses while 31% lives in private homes and only 14% in lodges.

Community Strength Development Foundation (CSDF), the CSO which was awarded a contract in year 2007 through World Bank prevention project to implement an intervention package for sex workers in the district of Colombo continued this activity during 2008 and 2009 with funds provided by UNFPA. Since most experts and key informants were of the view that the majority of sex workers are based in the city of Colombo, the intervention was carried out in Colombo and a close suburb Gampaha. The intervention package consisted of geographical mapping of brothels/entertainment establishments and locations where street based sex workers solicit sex, behavior change communication through peer leaders, outreach through peers, voluntary counseling and testing and linking with STI services. The NSACP supported the CSO in capacity building, preparation of IEC material and providing condoms. They were able to identify 4299 sex workers. It translates to locating 60-90% of the estimated number of sex workers in the country according to the 2007 estimates. The mapping recorded that 35.5% of sex workers were street based, 25.5% were operating in shanty dwellings. The proportions associated with hotels (5.4%), brothel houses (5.3%) and lodges (5.9%) were small and almost equal. Another 11% were a mobile group as they make contact with clients with the help of trishaw drivers or taxi drivers and then move on to a private location or engage in the sexual act in the vehicle. This data also shows the shift of sex workers from

the traditional hotel and lodges. In such a scenario reaching these groups is extremely difficult as they operate in a clandestine manner. In addition, accessing them for interventions become more difficult as sex workers and those associated with the sex industry are subjected to harassment by the police as sex work is illegal. The BSS (2006/07) observed that during a period of 12 months, 33.2% were harassed by the police for carrying condoms. Police probably discover condoms during security checks where all items including handbags are checked at security check points.

The "Drop in Center" of the same CSO which was initiated in 2006 under the World Bank project continues to function and a total of 890 new sex workers were registered in 2009. There are 38 trained peers who were used for outreach work and they were able to reach out to 2950 sex workers. One to one counseling sessions for promoting 100% condom use on the basis of "no condom no sex" practice and promoting voluntary counseling and testing for HIV infection were carried out by them. During the year 2009 a total of 254000 condoms were distributed by the CSO for sex workers, their clients, pimps and brothel house owners. The NSACP supply condoms to the CSO. Although an attempt was made to introduce the female condom it was not very well accepted. In 2009, the CSO was able to network with eight other CSOs in districts outside Colombo. The eight CSOs are being trained to provide the same intervention package. Six CSOs have already commenced on outreach work. In the district of Anuradhapura (n=95), Ratnapura (n=65), Kurunegala (n-42) and Kandy (n=28) sex workers have been reached for behavior change communication during 2009.

A group of medical officers, public health nursing sisters and public health inspectors of the NSACP were mobilized to visit hotels, restaurants, lodges, massage parlors etc to promote 100% condom use and voluntary counseling and testing for HIV among sex workers and the need for brothel house owners to support sex workers to use condoms and link with STD clinics for screening for STI and HIV infection. During 2008/09 total of 36 new sex work establishments were approached by this team. This outreach work enabled sex workers to understand that government STI services are free of charge and provides services by maintaining confidentiality and in a non stigmatizing and non discriminative settings. As at end 2009, the NSACP had mapped a total of 71 sexual establishments in the city of Colombo. This activity was supported by UNFPA.

During the year 2008, a total of 406 sex workers attended the STD clinics. They account for 24.5% of all STD attendees and 12.3% were diagnosed and treated for syphilis and 26.3% were treated for bacterial vaginosis which is one of the common reproductive tract infections among women. Among them herpes genitalis infection and genital warts infection were extremely low.

The BSS observed that in general consistent condom use with clients was low although varied proportions have admitted to consistent condom use. Almost half of the sex workers who have had sex with clients have sex with non paying partners as well. Only 10% have used condoms always during such exposures. According to the BSS 42% of the sex workers surveyed had received a HIV test in the last 12 months and knew their results.

The sero surveillance among the female sex workers in 2009 remained at a low level as seen in the preceding eight years. Yet, among men who were tested positive for HIV infection in the years 2008/09 the significant number revealed that they have had unprotected sex with sex workers.

In order to reduce harassment of sex workers by the police and developing favorable attitudes towards marginalized groups, the NSACP with support from UNFPA conducted several programmes during 2008 and 2009. Since the density of sex workers is high in Colombo 10 police stations were approached. Lecture/discussions/ questions & answers/ small group discussions were held to educate and change attitudes. Although quantitative data is not available to quantify the change, it

was observed at group discussions that the majority (>90%) did change their attitudes towards marginalized group

Clients of sex workers: According to the estimates of the expert group using BSS (06/07) data approximately 3.5% of the adult male populations (5,500,000) in the country are clients of sex workers. Since clients of sex workers are also a hard to reach group data on the demography and behaviors are lacking. Since the majority of STD clinic attendees are clients of sex workers they are being addressed at STD clinics by providing information, offering HIV testing, promoting and providing condoms. It is observed that clients are attracted to the sex trade through advertisements in print media for body massages, internet, or by word of mouth through pimps. The BSS observed that very often clients object to the use of condoms. The STD attendees were surveyed in the sero-surveillance in 2009 and the prevalence rates was 0.15% (Table 2).

3.1.2 Programme for men who have sex with men

The spread of HIV among men who have sex with men is recognized as an important source of infection in the draft national policy. Therefore targeted interventions were carried out in 2008/09. However, addressing prevention for MSM remains difficult through government programmes as well as CSO due to stigma attached to homosexuality often driven by cultural norms and punitive legislation. Thus they remain a "hidden" population. The Asia Pacific Coalition on Male Sexual Health was launched at the 8th ICAAP held in Sri Lanka and the MSM community advocacy network was launched in 2008-09. A landmark of these events is the endorsement of a comprehensive package to support HIV prevention, treatment and care among MSM. Mapping of MSM in the district of Colombo and Anuradhapura was carried out in 2009 with active participation of Companions on a Journey- one of the leading CSO working with MSM. At a population level the contribution of male to male sex to the HIV epidemic depends in part on the proportion of males in the population who have sex with men and the mapping exercise carried out in 2009 would give a more realistic figure on the density of the population of MSM. The estimate arrived by experts in 2007 was that there were 41,250 - 123,750 MSM in the country.

According to the BSS, the knowledge of MSM about HIV is inadequate. BSS and another survey carried out in Anuradhapura in 2008 among MSM reveals that MSM have both male and female partners. Their condom use is basically low and lower during sex with regular male and female partners according to results of both surveys. The same observation was made at the BSS (2006/07) survey. It may probably be due to trust in regular partners or the inability to negotiate condom use for various reasons such as generating suspicion in the regular partner. This is a researchable area. According to the BSS 13.6% MSM who took part in the survey have had a HIV test in the preceding 12 months and is aware of the result.

In 2009 with funds from AIDS Foundation Lanka, two drop in centers were established in Anuradhapura and Dankotuwa by Companions on Journey. The drop in centers were benefited by 500 MSM. Fifteen men were trained in basic peer outreach skills and communication at a two day training workshop. These peer educators have approached 195 MSM. Number of booklets and leaflets produced with community participation were distributed by peers. Peers also distributed 7200 condoms. A batch of 25 volunteer counselors was trained at an 8 day workshop covering basic counseling skills and methods. Workshops and seminars were also conducted and these activities were benefited by about 4000 gays. A telephone hot line (AIDS-LINE) was established and 498 calls were received from September 2008 to March 2009. Continuous monitoring & evaluation is necessary to observe whether the desired objectives have been achieved.

3.1.3 Programmes for drug users

It is stated in the National AIDS Policy that drug prevention programmes will include HIV/AIDS Prevention components and encourage VCT, epidemiological, social research on drug abuse and encourage different medically acceptable treatment interventions. Such interventions should also be provided in prisons for inmates and those remanded and in correctional facilities with equity. Asia Harm Reduction Network estimates that there are around 240,000 opiate users in Sri Lanka. The National Dangerous Drug Control Board estimates that around 40,000 are heroin users and the majority is inhalers or snort heroin and 2% of the illicit drug users are injectors. Although drug use is illegal there are substantial amount of drug users distributed throughout the country. The Colombo, Gampaha, Galle and Kandy districts are reported to be high prevalence areas. The BSS (2006) reported that the commonly used substance was heroin (94.7%) followed by cannabis (85.1%). In contrast another survey in 2006/2007 revealed that the widely used drug was cannabis, followed by heroin.

Only one case of HIV transmission through injecting drugs within the country has been reported, yet, attention is given to the threat of spread through this route. As shown by surveys carried out so far drug user's injectors or non-injectors are sexually active and they engage in a variety of behaviors that make them and their partners vulnerable to HIV. If it is not so then the problem of HIV remains confined among those who share needles and preventive programmes need to address only them. But the situation becomes more complex as they are involved in multiple sexual relationships, sell sex for money or other services and buy sex. Situations such as unemployment, peer pressure, poverty, mobility, displacement are factors which are closely linked with drug use. They are the very factors which promote the spread of HIV infection. BSS (2006) observes that 15% of the sexually active drug users who had sex with a woman in the 12 months preceding the survey have bought sex from female commercial sex workers and only half of them (54%) had always used a condom. The BSS has shown that many of the drug users have wives and regular girl friends and some also have non- paying casual partners. Drug users also engage in unprotected sex with other men. There is no data available for the years 2008 and 2009 in respect of some of these risky behaviors.

In Sri Lanka, The National Dangerous Drugs Control Board is complementing the National STD/AIDS Control Programme by enhancing programmes tailored to reduce risk behaviors of drug using population through its drug preventive educational activities, behavior change approaches, treatment programme for drug users, outreach activities, drug counseling and linking up with STD services.

Drug Abuse Monitoring System in Sri Lanka regularly monitors the changes in drug administration methods and purity of street level heroin. One of the main contributing factors for low demand in injecting is believed to be the high purity of street level heroin. In such a situation a drop in supply will create a breeding ground for injecting. Therefore all agencies working in the field of drug abuse and HIV/AIDS should be alerted to this fact. A sad past experience is that when there was short-supply of heroin in the market, the users turned into other alternative drugs or attempted to suicide rather than switch into injecting heroin. This surveillance system will signal a switch to injecting drug use.

3.1.4. Beach Boys

The term "beach boys" is referred to young men who work near beaches selling various accessories such as picture postcards, costume jewellery etc to tourists. They also offer sexual favors to tourists both males and females in exchange of money or other favors. They also act as pimps and support the sex trade. Some of them are associated with hotels and guest houses and is a hard to reach group. The BSS observed that beach boys have sex with female and male partners. The beach boys have sexual intercourse with more non-regular female partners than regular partners. Most of the

females were foreign than local women. The BSS observed high levels of male-male anal sex among beach boys.

3.1.5. Lesbians, gay, bisexuals and trans-genders (LGBT)

Individuals of these groups also practice high risk behaviors which put them at risk of HIV infection. This group was fairly invisible for some time but has now surfaced after the 8th ICAAP. The AIDS Foundation of Lanka has supported the CSO (Equal-grounds) which is involved with these groups to carry out awareness programmes, debates on their sexual and reproductive needs and rights. In 2009, they were able to cover 63 direct beneficiaries, 18 organizations in 20 regions of the country. Knowledge on basic facts of HIV has increased from 26.2% to 58.4% at post intervention. A telephone hotline was established and members were trained to provide information for the inquiries. Around 2096 people have been indirect beneficiaries of these programmes although most of them do not belong to this sub population.

3.1.6 HIV sentinel surveillance

In 2007, the NSACP decided to conduct the sero surveillance once in two years and the survey results of 2009 shows that among the sentinel groups (female sex workers, STD clinic attendees, TB patients, drug users, MSM, military) the prevalence continued to remained low.

In the year 2008, unlinked anonymous sero-surveillance was initiated in two groups (MSM, drug users) in order to include them together with the routine groups surveyed thus far. A total of 242 MSM were included and one tested positive for HIV. Among the drug users from the Western Province there were 256 samples and none tested positive while among a sample of 283 drug users from the Southern Province one was positive giving a prevalence of (0.4%). This activity was supported by the WHO over the years.

In the year 2009 HIV sentinel surveillance included female sex workers, men who have sex with men, drug users, tuberculosis patients, military personnel and STD clinic attendees. HIV sero-prevalence among MSM is 0.48% while STD clinic attendees gave a rate of 0.15%. Zero HIV prevalence observed in other groups surveyed (table 2).

3.2 Other vulnerable populations

3.2.1 Programmes for prisoners

The peer education programme which commenced in 2005/6 under the World Bank funded Project is now internalized into the routine education programmes of all 34 the prisons in the country. Prisoners have access to IEC material in the prison libraries. A poster competition and a walk was organized by them to commemorate the World AIDS day in 2008 and 2009.

3.2.2 Programmes for external migrants

Migrant workers contribute heavily to the country's GDP growth and this segment is one of the main foreign exchange earners. An estimated 1.8 million Sri Lankans work in the Middle East and almost 79% are unskilled women. In 2008, foreign employment placements were reported as 252,021 a small increase from 218,459 in 2007. Large numbers of women are employed in low skilled, low status jobs in the domestic sector where they are highly vulnerable to harassment, violence and

sexual abuse. The share of female migrants who left for foreign employment in 2008 was 49%. Among them 43% were housemaids. The highest number of Sri Lankan workers employed in housemaid job category is Kuwait and it was 35,677. Saudi Arabia and U.A.E are in second and third place respectively as Sri Lankan housemaid employed countries. The NSP recognizes the importance of increasing the scale and coverage of this vulnerable group for HIV related interventions.

Since the detection of the first HIV infection in Sri Lanka it was observed that a significant number of HIV infections are being diagnosed among external migrant workers. The available data revels that 40% of HIV infected females have acquired the infection probably outside the country. Although infected returning migrant workers may not be able to seed local networks and cause a chain of infections they are considered as a part of the burden of infection. While acknowledging that external migrants account for little less than half of female infections, interpretation of data should be done with caution as there is an over representation of the numbers testing positive in a background of lack of information on the total number of HIV tests done among external migrants. Data on pre departure screening is not available with the NSACP as they are carried out at the request of the destination (host) country by laboratories that do not come under the jurisdiction of the National STD/AIDS Reference Laboratory. When tests are done in the context of migration, confidentiality and counseling is routinely not applied. In an attempt to include the numbers of tests done for external migration in this report, the NSACP sent letters to the 15 GAMCA registered centers but only 7 responded and according to the submitted data in the seven centers in 2008 a total of 58,440 tests and in 2009, 65,617 tests were done.

Being away from their families and being isolated in a culturally and linguistically unfamiliar environment, free of the restrictive traditional family settings in Sri Lanka and to a certain extend the newly gained economic prosperity creates a favorable setting which foster risky sexual behaviors which lead to sexual relationships with local and foreign casual partners. In addition there were instances where such women had to provide sexual services to families that employ them and employment agents who helped them in securing jobs. There is evidence that domestic workers have been targets of sexual exploitation and violence. To avoid being abused or exploited by their employer women run away from houses of employment and fall into the hands of pimps who further abuse them. A survey carried out in 2008 among Middle East returnee's reports that 15-20% of respondents were sexually active during the course of their overseas employment, 17% were subjected to sexual harassment and 5% were raped while they were overseas. Some migrant women were even engaging in commercial sex. The migrants very often have poor access to social, health or legal services. The situation becomes grave as domestic workers fall outside the domain of local labor laws that protect the rights of migrant workers in other sectors. None of the respondents (n-160) of the survey have used condoms regularly. Over 25% did not know that condoms could provide protection from HIV.

The Sri Lanka Bureau of Foreign Employment (SLBFE) carries out a 12 day pre departure training programme for female migrants with the objective of educating female migrants to develop skills on carrying out various household chores which they are likely to perform as domestic workers. In 2006 with the assistance of the World Bank fund an addition day was included in this programme to promote Sexual and Reproductive Health and develop skills in safer sexual behaviors, negotiating skills etc. During 2008 and 2009, this programme was scaled up to cover all the 34 training centers and the SLBFE have now mainstreamed this activity and have built the capacity of trainers to conduct the 13th day effectively. The migrant worker's spouse is also involved in this training. A variety of IEC material and role plays are used during training.

In the years 2008 and 2009, the total numbers of external migrants registered with the SLBFE were 250,500 and 247119 respectively. However, it is unfortunate to note that only 14% (n= 35,043) and

16% (n=40,047) in 2008 and 2009 respectively attended the 13th day pre departure training programme. There is no structured programme available for the returning migrants. Although it is envisaged that such women could be counseled and promoted for voluntary HIV testing when they access well woman or family planning services in government sector in reality it does not take place. There are no pre departure programmes for male migrants either.

In 2009, the Family Planning Association (FPA) with the support of AIDS Foundation Lanka carried out 22 awareness programmes in Batticaloa and Ampara of the Eastern Province after being liberated from the hands of terrorists for male external migrants and in bound Middle East returnees. There were 1445 direct beneficiaries and 51,414 indirect beneficiaries. The FPA prepared a 10 minute video clip on " how to face sexual challenges" with special focus on male migrants. It is currently being used by the SLBFE and some job recruiting agencies**.**

3.2.3 Programmes for youth in schools

The Government of Sri Lanka with support from UNICEF has focused on health related programmes in schools based on the life-cycle approach. One policy of the Government is to sensitize adolescents and youth on HIV/AIDS. HIV/AIDS education is integrated into the national school curriculum to target children from Grade 6-11. The students in Grade 6-11 are given education on Reproductive Health including HIV/AIDS during hours allocated for the subjects of health and physical education. Since these subjects are compulsory only from Grade 6-9 and optional from Grade 10-11 a large number of students do not avail of this intervention. In addition the teachers were not comfortable in carrying out this work.

With the award of the 6th round of GFATM funds, in 2008, following several discussions with the Minister of Education and officials the subject of HIV/AIDS education was given a sharper focus through a life skills development approach. Given the nature of HIV and the controversies surrounding its discussion in schools, in a country which still upholds traditional and cultural norms the prevention interventions for in school youth were planned in the background of health promotion and life skills development. Five provinces (Western, southern, Uva, Sabaragamuwa and North central) were identified by the proposal. As an initial step the Minister of Education and his officials were briefed on the details of the proposed HIV/AIDS education programme in schools. The objectives and the strategies were discussed at these meetings. Advocacy meetings to cover three hundred education officers from all five selected provinces were held. Thereafter awareness programmes were held to cover 1500 school principals from four provinces (the North central Province wished to opt out). Thereafter the education programme was planned with the objective of reinforcing positive sexual health behaviors and altering the behaviors that place young people at risk through accurate knowledge and skills. The methodology to implement the programme was discussed with full participation of school principals and teachers, student leaders and students and education department officials. The preventive strategies were developed taking into consideration community norms and values.

One hundred and twenty eight In-Service- Assistants (ISA) selected from three provinces (Uva, Sabaragamuwa and Southern) were trained to train teachers. This Training of Trainers (TOT) programme was held over three days. The technical assistance was provided by NSACP. Training curricula and modules have been prepared. Thereafter 2285 teachers selected from 698 schools in the two districts (Ratnapura and Kegalle) of the Sabaragamuwa province were trained by the ISAs. The capacities of teachers to teach the subject were built through intensive 3 day training programme. The emphasis was on life-skills and attitudes, as well as biological factors. Information on identifying behaviors that place young people at risk of contracting HIV, preventive approaches such as delaying sexual debut, mutual monogamy, and where appropriate condom use were

included in a culturally acceptable manner. Skills to refuse sexual intercourse and to avoid risky sexual behaviors and safer alternatives to intercourse were also included as role play models to the higher grade students. It also addresses the human rights dimension of HIV/AIDS and the right of infected people to live, work and study without stigma and discrimination. It is expected that open discussions, peer support would help exchange health promotion information, creates groups who are able to openly discuss issues related to HIV and drug use in addition to teacher teaching method. The training programmes helped teachers to address the sensitive subject of HIV/AIDS in a comfortable manner and identify issues which merit further discussions and how to provide referral for further information and services for students. A mid-term survey showed that 45.9% of children had composite knowledge on 4 of the 5 variables of the UNGASS indicator no-13 (the question on condoms was excluded in the survey questionnaire). Since the Asia Development Bank (ADB) has come forward to assist the Ministry of Education in HIV/AIDS school education there was an agreement for them to cover the other provinces through their funds. The GFATM approval was granted for this reprogramming. The strategies adopted by the NSACP/ GFATM programme will be adopted for the ADB project.

After evaluating the Sabaragamuwa programme the Minister of Education has agreed to include HIV/AIDS education through the subject of science with the new curriculum change which will come to effect in 2012, so that all students from Grade 6-11 will be targeted. The strategy is to implement the programme on a spiral approach from Grade 6-11. The school programme reach out to a wider audience even those currently not at risk of HIV.

3.2.4 Out of school youth

Youth Friendly Health Services (YFHS) were commenced with the objective of ensuring youth have access to information and build necessary skills to maintain good sexual health and obtain health services in a supportive environment. As at end 2009, a total of 50 such centers were established in government and non government settings. The target set for universal access by 2010 was to provide one YFHS service in all districts by 2010. A comprehensive training module was developed under the regional project "Models for scaling up YFHS for prevention of HIV" with UNFPA assistance. This training module has allocated a two and a half hour session on prevention of STI/HIV among youth. A community based survey carried out in 2009, among men and women between ages 18-24 in a district called Galle along the coastal belt of the Southern Province which is a hot spot for tourists revealed that sexual debut among both males and females was at 23 years of age. Around 20% of the participants (n=812) had had sex at least once in their lifetime. The study extracted the data of those who had engaged in risky behaviors and matched with data from a control group and the case control study observed that employed youth, alcohol consumption, visiting night clubs, watching pornography on internet, having poor communication with parents and having liberal attitudes towards sex were the risk factors for engaging in risky sexual behaviors.

The Family Planning Association with support from AIDS Foundation Lanka prepared a booklet on HIV/AIDS for young people. In 2009, 50,000 booklets were printed and distributed through peer educators. A 10 minute video clip on "how to face sexual challenges by young people" was prepared and distributed.

The target set for universal access in education and behavior change was that by 2010, 80% of youth (in and out of school) are able to correctly identify modes of HIV transmission and methods of prevention. A well planned survey using sound sampling techniques should be carried out to determine whether youth have comprehensive knowledge on HIV.
According to DHS (2006/07) the composite knowledge on HIV (correctly answered all 5 questions on the UNGASS indicator 13) among 15-24 year old married women was 17.3%.

3.2.5 Tri-Forces

Although the war situation in the country escalated during 2008/09 whenever possible awareness and sensitization programmes which were commenced under the WB project were continued. The peer educators who were trained under this project were available for counseling and referral. Condoms were supplied to the tri-forces by the NSACP. Sentinel sero-surveillance conducted in Sri Lanka Army in 2009, and 1380 blood samples were collected but none tested positive. Although literature reveals that HIV prevalence increases during armed conflict situation, fortunately Sri Lanka did not witness such a scenario. The HIV sero prevalence among the Sri Lanka Army was zero.

3.2.6 Plantation workers

Health, education and social services infrastructure is provided by the Government and CSO for this sector but still some areas are underserved. However, HIV/AIDS programmes were conducted in these areas although not in a systematic manner. The target set for universal access by the NSACP is by 2010, 60% of women on estates know 3 ways of HIV transmission and 3 ways to protect themselves. The ILO implemented a well planned HIV/AIDS education programme among hotel, manufacturing and plantation sectors. A baseline survey was conducted among all three sectors in 2005. Thereafter BCC package was implemented to change knowledge, attitudes and behaviors in this workforce and the impact was measured in 2008. The success of this programme in terms of significant improvement in knowledge, attitudes and behaviors is described later under section 5. The results of the baseline and impact survey for plantation workers are described below. The survey included men and women both and the results in respect of women are given below. 86.3% women plantation workers were able to correctly identify 3 modes of HIV transmission and after the intervention this has increased to 98.8%. Similarly female workers who correctly identified 5 misconceptions regarding HIV transmission was 28.8% this had increased to 86% at the impact survey. Women who correctly identified 3 means of protection against HIV infection was 91.3% at baseline and increased to 98.8% at the impact survey. It appears that the knowledge of the women workers was good in respect of transmission and prevention of HIV even at baseline. Although considered a poorly served community with low literacy levels this community was targeted for HIV/AIDS prevention activities in 2004/05 by CSO during the World Bank Project that probably is why the baseline results were also good. The well planned and carefully implemented BCC package by the ILO was able to enhance knowledge further.

The GFATM funded programme for plantation workers was commenced in July 2008. The districts selected were Badulla, Nuwara Eliya, and Ratnapura. It consists of three components and the first is to prevent the transmission of HIV infection among plantation workers by creating awareness and behavior change, promoting health seeking behaviors among the plantation workers and strengthen plantation sector health systems to improve STI/HIV prevention and treatment services. In order to achieve these objectives, the selected CSO first had advocacy programmes for the estate hierarchy and planned out the activities with full participation of all stakeholders. A baseline survey was carried out and then trainers were selected. Five training programmes were held and 375 peer leaders were trained for outreach work. The peers were trained to have one to one counseling with workers and carry out small group discussions on safer sexual behaviors, women empowerment, identification of STI, available medical services particularly STD services, and promote and provide condoms. In 2009, eight five condom vending machines were installed for condom distribution. A total of 10 voluntary counseling and referral centers were established and trained counselors are available for counseling. Ten Estate Medical officers were trained in syndromic management of STI to manage and refer for further care. NSACP modified and reprinted Guidelines for syndromic management of STI in the plantation sector using the GFATM funds.

3.3 Blood safety

The National Blood Transfusion Service (NBTS) is the state sector organization responsible for assuring a safe supply of blood and blood products to the people of Sri Lanka. The blood safety policy introduced by the Government of Sri Lanka in 1988 is being carried out over the years uninterrupted and has helped the country to maintain the low level of HIV transmission via blood and blood products. All donated blood in the government sector is screened for HIV infection, and all blood banks do follow the Standard Operations Procedures.

The NBTS comprises of the National Blood Center (NBC) in Colombo and 74 cluster / peripheral blood banks. The cluster/ peripheral centers are associated with teaching, provincial, base and district hospitals. The annual blood collection is about 300,000 units of which about 30% is collected by the NBC and the balance by the cluster and peripheral blood banks. In 2008/09 the National Blood Transfusion Service continued its contribution to the maintenance of the low rate of transmission of HIV through blood and blood products through continuing the adoption of a system of pre donation education and counseling, adopting criteria for donor selection and deferral, discouraging paid donations and encouraging voluntary non remunerative donations, donor recruitment and retention, ensuring donor confidentiality, screening of all donated blood for HIV and other transfusion associated infections such as hepatitis B &C, syphilis and malaria, and promotion of rational use of blood.

All donations are non remunerative but replacement donations are taking place. Replacement donors are either friends/ relatives. During the year 2008 and 2009 the total numbers of non remunerative donations were 282,446 and 267,773 respectively. The replacement donors were 12% and 14% in 2008 and 2009 respectively. At present voluntary non remunerative donations are around 86% and it is expected that it would reach the target of 100% very soon. Although "guidelines for clinical use of blood" are available how best the adherence has been is not evaluated.

In 2008, a total of 320,091 blood donations were tested for HIV and 11 were confirmed to be positive. In 2009 among a total of 309,909 blood units that were tested a total of 13 were confirmed as positive. The seropositivity rates were 0.003% and 0.004% for the two consecutive years of 2008 and 2009.

The proportion among HIV infections due to blood and blood products has been extremely low (0.4% of the cumulative reported HIV infections). So far only 3 cases of transfusion related HIV infections have been reported to NSACP and all these cases were reported before year 2000. Thereafter none were reported. The blood safety policy adopted in Sri Lanka since 1988 has helped to maintain this low prevalence. Government sector blood banks carry out HIV tests as per standard operational procedures on all donated blood prior to transfusion. During the years under review (08/09), a total of 588,146 samples of donated blood in the government sector were screened for HIV antibodies and 23 of them were positive giving a seropositivity rate of 0.004%. Over the last five years the sero-positivity rate among donated blood samples has been fluctuating between 0.002-0.004 percent. Screening for other blood borne infections in donated blood has yielded very low sero positivity rates. In 2008 the sero-positivity rate for hepatitis B and C were 0.09% (300/320,091) and 0.27% (879/320,091) using the ELISA screening test as confirmatory tests are not available in the country. The corresponding figures for 2009 are 0.14% (438/309,909 and 0.31% (970/309,909). In 2008, 10 new HIV cases were detected by screening donated blood and the corresponding figure for 2009 was 13 cases. These accounted for 9.8% of total cases detected in 2008 and 9.1% cases

detected in 2009. Fortunately because of this detection transfusion related HIV infections were avoided.

In 2008, staff of the blood banks followed a refresher course in counseling. The National Blood Center participates in the external quality assessment (EQAS) programme conducted by the National Reference Laboratory in the NSACP and the National Reference Laboratory in Melbourne and Thailand. NBC is also working for ISO 15189 accreditation and expect to participate in additional EQAS programmes in transmission transmitted infections (TTI) testing in the near future.

3.4 STI services

3.4.1 Improving management of STI

On account of the proven relationship between conventional STI and HIV, the national policy recognizes the need to strengthen the existing STD services as a priority intervention for the prevention of HIV transmission. STD clinics are headed by either a consultant venereologist or trained medical officers. STD clinics carry out programmes for primary prevention in order to reduce the incidence of disease and secondary prevention to shorten the duration of disease thus minimizing the probability of complications or sequele. Primary prevention is targeted at promoting safer sexual behaviors (postponing sexual debut until marriage, avoiding extramarital sex, being faithful to one partner, condom use if engaging in risky sexual practices) and promoting and providing condoms. In addition information is provided that many STD can be treated and cured, early treatment is necessary to avoid complications and sequele, symptoms and signs may not be noticeable, descriptions of how to recognize symptoms, advice on the need of partner evaluation and assurance of privacy and confidentiality of services. A comprehensive STI care package is provided as secondary prevention which includes; correct diagnosis after obtaining a history and complete physical examination, provision of effective therapy using Guidelines for management of STI in Sri Lanka, advice on treatment compliance, promotion and provision of condoms and counseling to promote HIV testing, safer sexual behaviors, treatment adherence, and partner notification. Patient referral method is commonly used in partner tracing. The universal access target set by the country to offer HIV testing to 100% of STD clinic attendees with counseling has been achieved.

The National Reference Laboratory of the NSACP is headed by a consultant microbiologist and it supports clinical services in confirmation of clinical diagnosis, antenatal screening for syphilis and HIV, sentinel surveillance, antimicrobial susceptibility monitoring and in epidemiological and microbiological surveys. It participates in external quality assessment programmes of the WHO, CDC Atlanta and National Reference Laboratory Australia. In addition it organizers National External Quality Assessment (NEQAS) programmes for HIV and syphilis serology for the NSACP and National Blood Transfusion Services (NBTS).

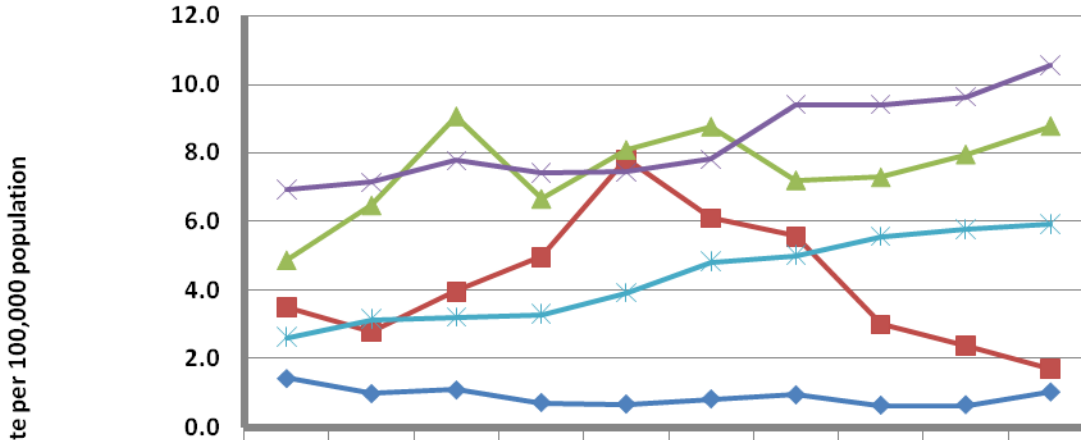
In order to provide standard treatment for STI, the College of General Practitioners has included a 2.5 hour lecture in their post graduate teaching curriculum. Distant Learning Modules on Management & Care of STI are available for them although an evaluation has not been done. Thus it is difficult to comment on the progress towards achievement of universal access targets. The NSACP functions as an undergraduate and a postgraduate training center for medical and Allied medical services. Formative and operational research is carried out by Post Graduate trainees on topics related to STI/HIV/AIDS. The National Institute of Health Services, which is the central training center of the Ministry of Health has included the subject of STI/HIV/AIDS in the training programmes and during 2008/09, a total of 60 Medical officers of Health were trained in Prevention of STI/HIV at

community level and mitigating stigma and discrimination in the Community Health Orientation Programme.

3.4.2 STI surveillance

Epidemiological and clinical data of STD attendees from all the STD clinics is sent every quarter to the NSACP for analysis. Over the years bacterial infections shows a decreasing trend while a gradual increase of viral infections is observed. In 2008, the total number of newly registered patients in all government STD clinics was 16,501. Of these new patients 8,216 patients were diagnosed with STIs. A total of 16,897 infection episodes were recorded in all patients attended to STD clinics during 2008. Of which, 59.5% were due to STI, 20.7% due to lower reproductive infections (candidiasis and bacterial vaginosis) and the balance were non-venereal. Among the STI episodes the bulk was due to herpes genitalis (18.9%) followed by human papilloma virus infection-HPV (11.3%), late latent syphilis (5.7%), gonorrhea (4.7%) and infectious syphilis (1.3%). In 2009, the total number of newly registered patients in all government STD clinics was 15,205. Of these new patients 8,986 patients were diagnosed with STIs. A total of 17,231 infection episodes were recorded in all patients attended to STD clinics during 2009. Of which, 61.2% were due to STI, 19.7% due to lower reproductive infections (candidiasis and bacterial vaginosis) and the balance were non-venereal. Among the STI episodes the bulk was due to herpes genitalis (20.5%) followed by HPV (11.5%), late latent syphilis (5.2%), gonorrhea (3.2%) and infectious syphilis (2%). The figure below demonstrates the declining trend of gonorrhea and the stable trend of infectious syphilis at a low level whereas the viral STI appears to be gradually increasing.

Figure 6. Rate of STIs per 100,000 Population in Sri Lanka 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Early Syphilis	1.4	1.0	1.1	0.7	0.7	0.8	0.9	0.6	0.7	1.0
Gonorrhoea	3.5	2.8	4.0	5.0	7.8	6.1	5.6	3.0	2.4	1.7
Non Gono. Infec.	4.9	6.5	9.1	6.7	8.1	8.8	7.2	7.3	8.0	8.8
Genital Herpes	6.9	7.1	7.8	7.4	7.4	7.8	9.4	9.4	9.6	10.6
Genital Warts	2.6	3.1	3.2	3.3	3.9	4.8	5.0	5.6	5.8	5.9

A total of 46,471 syphilis screening tests for pre employment were performed in 2008 and a total of 11 cases were positive giving a low prevalence rate of 0.02%. All eleven cases were treated according to the stage of syphilis. The low prevalence of syphilis among the pre employment

category could be considered as a proxy measure of the status of syphilis in the general population. Antenatal screening for syphilis has continued over the reporting period and 98% of mothers have been screened either in the state or from the private sector. Three confirmed cases of congenital syphilis were reported in 2008. In respect of women's health, routine cervical cytology examination is carried out at STD clinics In 2008 and 2009 a total of 720 and 779 Papanicoaloa smears were performed. The abnormal smears are managed with updated guidelines.

3.4.3 Elimination of congenital syphilis in Sri Lanka by 2015

Prevention of congenital syphilis has been a public health priority in Sri Lanka. Antenatal screening for syphilis has been a routine procedure in the country over four decades and the coverage in 2008 was 98% according to the data sent to the FHB from MOH areas. This included testing in both private and public health sectors. In keeping with the WHO initiative, the strategy for elimination of congenital syphilis (ECS) in Sri Lanka by 2015 was launched in November 2009. Goals, targets and indicators for monitoring and evaluation have been identified. In 2009, a situation analysis was carried out in six districts and the four pronged approach of the WHO strategy was commenced in six districts out of the 24 districts in the country. In 2009, district level action plans for 2010 were developed with the objective of increasing the coverage for syphilis screening. In 2010 the programme will be scaled up to cover 10 more districts and the balance in 2011. Two thousand copies of the ECS strategy were printed and distributed among stakeholders. Specific IEC material were prepared and distributed to enhance early access for antenatal care, advantages of screening and what the test entails, available services etc. IEC materials to be displayed at exhibitions were also prepared. The screening gaps due to staff shortages and other logistical issues will be overcome with the introduction of the on- site rapid Immunochromatographic strip test (ICS). The universal access target of achieving 100% coverage of antenatal screening by 2010 is expected to be achieved with the introduction of the rapid test. Test kits have been purchased already to fill the gap and a distribution plan is being prepared based on the needs. The interventions carried out in 2009 were supported by the WHO.

3.5 Condom promotion

Given the fact that almost 96% of HIV infection in Sri Lanka is through the sexual route condom promotion has been accelerated. The rates of condom use among MARPs have been studies in detail in the BSS (2006/07). High level of condom use was noted among street based sex workers (81.9%) while condom use among MSM was not favourable (63.7% used condoms during last sexual exposure with non-regular male partner). More details are included in section 5 on knowledge and behaviour change.

The use of condom for family planning purposes was taking place from far back as the nineteen sixties. Traditionally the family planning programme was promoting the use of condom through the public health midwives and public health inspectors of the primary healthcare team. According to the DHS the prevalence of condom use was 5.7%. Data were collected from married women in the ages between 15-49 years. The target set for universal access of 5% couples using condoms for contraceptive purposes by 2010 has been achieved. With the advent of HIV/AIDS, the STD programme promoted the condom as a method of dual protection; as a method to prevent a conception and against STI and HIV. The main distribution points of condoms in the government are the NSACP, FHB, and Family Planning Association and Population Services Lanka from the private sector. Condoms for the FHB are purchased by the Government Medical Services Division as per tender procedures. Specifications are given by the experts in the FHB. Quality control procedures are carried out by Sri Lanka Standards Institute (SLSI) or Industrial Technology Institute (ITI). The FHB has purchased 13,000,000 and 10,600,000 condoms in 2008 and 2009 respectively and distributed

1,500,000 and 6,500,000 condoms in the years 2008 and 2009 respectively. In 2008 and 2009, a total of 487972 & 1,310,832 condoms respectively were distributed by the NSACP to the CSOs, armed forces and STD clinics.

In an environment where discussing the use of condom is still a taboo subject, the ILO workplace project gave a booster to condom promotion. Thirteen out of their 14 enterprises set up condom distribution services and eleven were considered quality services. The plantation sector under the GFATM programme has established 85 condom vending machines and the Tri-forces continue to distribute condoms through the vending machines which were installed in 2005/06 by the World Bank project.

3.6 Voluntary counseling & testing

The national policy promotes VCT services as an important intervention which would strengthen and support prevention of HIV and protection of human rights. In addition to VCT, provider initiated counseling and testing takes place as part of standard of care to persons with symptoms or medical conditions suggestive of HIV infection. The NSACP and its 30 peripheral STD clinics serve as VCT centers. On site HIV testing facilities (enzyme linked immunosorbent assay-ELISA and particle agglutination test- PA) are available in the central and peripheral clinics. In 2009, this facility was increased from 13 centers in 2007 to 22 peripheral STD clinics. On site testing reduces the time taken between testing and release of results. ELISA screening test is available in Colombo and four other peripheral centers (Kandy, Kurunegala, Badulla and Anuradhapura) and particle agglutination test is available in 18 peripheral clinics including the clinics where the ELISA test is available. The STD clinics which do not have on site testing facilities, serve as blood collecting centers and the samples are sent to the National Reference Laboratory or to the closest STD laboratory for testing. With the increase in on site testing facilities the number of STD clinics which collected blood and sent to other facilities for testing was reduced. In 2007 there were thirteen such centers and in 2009 this was reduced to eight. Since the test is done in a different center these test results may take about 7-10 days to reach the relevant STD clinic. Tests are performed by trained MLT and in 2008 and 2009 a refresher training course was given in the center.

One objective of the NSACP is to establish a cohort of counselors in the country. In 2008/09 Counseling training workshops were held with the objectives of 1) describe the HIV/AIDS situation globally, regionally and in the Sri Lankan context 2) describe the rationale to scale up VCT 3) demonstrate that VCT is an effective HIV transmission reduction strategy 4) demonstrate the role VCT as an entry point to HIV prevention programmes 5) improve the technical capacity of health workers to provide counseling. As an outcome the counselors are able to understand the risks for HIV and prevention strategies, gender related vulnerabilities and help clients to modify the risk to HIV. In 2008, twenty staff members of STD clinics (15 medical officers, 1 PHNS, 1 PHI and 3 staff nurses) were trained in counseling. In 2009, the balance staff members (n=26) were trained in counseling. In 2009, ten, estate medical assistants were trained in counseling at a five day workshop conducted by the NSACP. Medical officers and nurses of Health Education units in tertiary and secondary level hospitals carry out health education discussions, talks, distribution of IEC material. Since they have the opportunity of promoting VCT for HIV, 24 nurses from these hospital based health education units of the Western Province were trained in counseling.

The Department of Public Health Services of the Colombo Municipal Council contributes to improve public health services such as maternal and child health including screening of antenatal mothers for syphilis, immunization, sanitation etc. In an effort to mobilize the primary health care staff of the Colombo Municipality in prevention of HIV, a five day workshop was held in 2009 to train 35 of their

staff members in counseling for HIV. The WHO Counseling Manual and the Sri Lanka Counseling Manual were used as training material. In scaling up towards universal access to HIV/AIDS prevention, treatment and care, the target was to establish 10 sexual health promotions, counseling and referral centers in non health settings.

Through the plantation sector component of the GFATM project 10 counseling and referral centers have been established and 57 counselors have been trained with technical inputs from NSACP to serve in these centers. The 57 counselors include public health midwives of the plantation health services, estate welfare officers and members of CSO working with the plantation sector in prevention of HIV. The revised target for universal access to HIV/AIDS prevention was to establish 40 VCT/VCR centers by 2010. Since all 30 STD clinics serve as counseling and testing or counseling and referral centers together with the 10 centers established in the plantation sector this target could be considered as achieved. Insert a map with project areas

3.7 Prevention of mother to child transmission of HIV

Since almost 99% of mothers access antenatal services during pregnancy, the Government of Sri Lanka considers antenatal services are an entry point for prevention of HIV. The National Strategic Plan seeks to increase quality and coverage of PMTCT services and is adopting the four prong strategy of WHO/UNICEF. A policy decision was taken to integrate PMTCT in MCH services. As a result of the integration, at the point of service delivery PMTCT interventions especially in relation to the first prong of the strategy- prevention of HIV infection among young men and women was incorporated into the pre- conception package of services and antenatal service package and is implemented by the Family Health Bureau. The pre conception manual which includes a section of STI/HIV for young married couples was published. HIV positive pregnant women will also avail of the comprehensive antenatal service package of services including regular assessments for the wellbeing of mother and baby, provision of micronutrients, screening for syphilis diabetes and pregnancy induced hypertension offered to all mothers attending government antenatal care without stigma and discrimination.

The country target set for universal access by 2010 is to conduct pilot programmes for antenatal risk screening and offer HIV testing as needed in three selected high prevalence areas, with the goal of 70% accepting testing and 60% of HIV infected mothers detected and 80% of infants born to HIV infected mothers are free of HIV. Antenatal mothers are provided with pre test information in three selected centers and acceptance was almost 100% and all positive mothers are offered ART. Since diagnosis of HIV infection is hindered by the lack of HIV-DNA test the outcome is difficult to measure.

HIV positive mothers are managed by a team of healthcare personnel including venereologists and obstetricians and supported by staff of the wards, labor room and operation theatres. The Medical Officer of Health supports follow ups. Assessment of clinical and immunological status is carried out at STD clinics and ART is initiated as prophylaxis or treatment. Planned pre labor lower segment caesarean section is the preferred mode of delivery and mothers are counseled in safer breast feeding practices. Guidelines for prevention of HIV infection in pregnancy in Sri Lanka were prepared in 2008 in consultation with an expert from the Macfarlene Burnette center in Melbourne, and were distributed among obstetricians, medical officers of health and MO-STD.

Integration of PMTCT into Maternal & Child Health (MCH) services and active involvement of obstetricians in the management of HIV positive mothers without stigma and discrimination are main achievements during the current reporting period of 2008/09. In 2009, routine HIV testing was

included in the antenatal package to fulfill standard of care in one out of the two leading maternity hospitals situated in the city of Colombo. At the De Soysa Maternity hospital for Women (DMH) all antenatal mothers are tested for HIV as a routine procedure after providing group pre test information. In addition, IEC material given by NSACP on PMTCT to all the wards in the hospital is used to educate mothers. In the year 2009, a total of 11,216 mothers were tested from DMH and two tested positive for HIV infection giving a sero positivity rate of 0.02%. Among them there were 2659 antenatal mothers in the 15-24 year age group and one was confirmed to be HIV infected. This policy was extended to the other maternity hospital in Colombo - Castle Street Hospital in December 2009 and group counseling and testing will commence in 2010 January.

The opt out testing center established in 2004, in Gampaha, was continued in 2008/09. Mothers are provided with information on HIV in a group and have the option of dropping out of the test. The opt in center established in Kalutara in 2006 for self assessment following evaluation of their own risk by mothers is continuing. During 2008 and 2009 a total of 2290 and 2259 HIV tests were done and one tested positive in year 2008.

In 2008, in the three centers a total of 12,239 antenatal samples were tested and three positives were detected giving a low sero positivity rate of 0.02%. In 2009, the grand total of 13,475 HIV tests was carried out during antenatal screening and two positive giving a prevalence of 0.02%. The estimated total number of HIV positive pregnant women is <100.

In the year 2008 and 2009 a total of 8 and 5 antenatal HIV positive mothers were reported to the NSACP (In the year 2008, three antenatal mothers were diagnosed during screening and five diagnosed mothers became pregnant despite counseling on family planning. Thus eight antenatal mothers were reported to the NSACP). Of them one ended up with an abortion, whilst one died and the other defaulted. Out of the other five, prophylaxis therapy regimen was given to four mothers and the other was already on triple therapy and continued it during pregnancy.

In 2009, a total of four mothers were on ART, two were given prophylaxis treatment as there was no indication to commence on treatment as per guidelines, two women who were already on triple ART became pregnant and ART was continued during pregnancy. The other defaulted attending HIV services and was admitted as an emergency with a history of vaginal bleeding and aborted and died adding to the total maternal deaths in the country. The commonly followed prophylaxis regimen is – prepartum ZDV from 28 weeks + ZDV+3TC and intra partum single dose NVP at delivery and ZDV +3TC postpartum tail. ZDV and NVP syrup to babies. All babies were formula fed. Formula feeds were provided by funds from the AIDS Foundation Sri Lanka. The treatment regimens will be modified now according to the new guidelines issued by WHO/CDC in December 2009.

Of the five mothers who had treatment during pregnancy in 2008, four babies have completed 18 months of age by March 2010 and all of them were HIV antibody negative, one baby is yet to complete 18 months. All these babies were not breastfed.

HIV positive women were provided with a food basket which the NSACP provides with support from World Food Programme to all PLHIV that are registered at the HIV clinic of the NSACP.

Since PMTCT is integrated in MCH services the In-service training programmes undertaken by the Family Health Bureau in 2009 for Medical Officers of Health (MOH), public health midwives (PHM) and labor room and theatre nurses had included PMTCT. The National Working Group in Reproductive Health held two workshops one in Colombo and another in Ratnapura in the Sabaragamuwa province in 2009 to train consultant obstetricians, senior registrars and senior house officers in PMTCT and provision of ART and care without stigma and discrimination. Technical

support was provided by NSACP. A total of 60 clinicians were trained. Community Home-Based Care (CHBC) is still in its infancy in Sri Lanka. There are no CSOs or CBOs, including PLHIV organizations that are involved in providing care and support for pregnant women and their newborns. The school based HIV/AIDS education through development of life-skills programme has included PMTCT to sensitize young boys and girls on the importance of preventing HIV infection in young men and women.

3.8 Post exposure prophylaxis

HIV/AIDS is an occupational hazard for healthcare workers. Therefore it is important to educate healthcare workers on practice of universal precautions to avoid needle stick or percutaneous injuries in health care settings. Counseling services and post exposure prophylaxis with antiretroviral therapy are available for such events. PEP treatment protocols are available to both public and private sector hospitals. In 2008 there were 117 healthcare workers who were counseled at the central STD clinic with needle stick injuries and following counseling 26 were commenced on dual therapy with Zidovudine and lamivudine for 28 days. Only two turned up for follow up and both were negative. The balance 24 has defaulted. A total of 121 presented to the central STD clinic and 23 were commenced on ART after counseling and assessment of the injury. None appeared for follow up. In the year 2009, three were offered triple therapy with zidovudine+lamivudine+indinavir/ritonavir and the others had dual therapy.

3.9 Universal precautions

Standard precautions and infection control procedures are integrated into medical and paramedical training courses of the Ministry of Health. In addition knowledge on infection control and standard procedures are updated at in-service training courses. However, implementation of the standard procedures is hindered by the intermittent non-availability of personal protection equipment and other resources.

During the last two years attention has been drawn to Health care waste management. A general circular was issued by the Director General of Health Services, Ministry of Health in respect of waste collection and segregation in government health facilities. However, waste disposal including infectious waste disposal has not reached expected levels**.**

3.10 Programmes for PLHIV

The draft policy endorses the need to provide treatment, care and support for PLHIV. The NSP has identified strategies to increase the quality and coverage of HIV and AIDS treatment services and home based care. The NSACP provides pre and post test counseling, treatment adherence counseling and regular follow up of PLHIV. Introduction of ART has helped PLHIV to increase survival and quality of life. Protecting the sexual and reproductive rights of HIV positive men and women has been a concern. In this direction two workshops were held by the Family Planning Association of Sri Lanka with financial support by the AIDS foundation of Lanka which was established following the 8th ICAAP in Sri Lanka and technical support from the NSACP. The workshops on sexual and reproductive health which highlighted the importance of preserving their health and rights, making informed decisions about sexual health and accessing the available state services were for both PLHIV and their families. The NSACP in collaboration with the FHB and Consultant Obstetricians & Gynecologists provides the same cafeteria of temporary and permanent methods of family planning services to PLHIV free of charge.

A programme for PLHIV called "Our Health" Empowering Communities to normalize HIV, was implemented in 2008/09 in three districts by Alliance Lanka and CSO working in the field of HIV/AIDS with funds from the World Bank. The specified three objectives of the project were to (1) Promote responsibility, respect and acceptance of HIV and AIDS by stimulating awareness of HIV and AIDS to reduce stigma and discrimination (2) Promote health as a right of every person while promoting coping skills within communities, individuals and families and (3) Develop and improve life skills of identified HIV positive persons for a better living. The goal of the project is to improve access to awareness, education and services on HIV in a non threatening environment and to prevent the spread of HIV and reduce stigma and discrimination among the general population with active participation of PLHIV. Within the framework of the stated objectives, series of activities were carried out. Developing staff training modules and IEC materials, establishing visitor friendly Peoples Centers, Voluntary Counseling and referrals, training identified persons on positive living and business planning were some of the activities carried out under the frame work of the stated objectives.

In 2008, the FPA with financial support from AIDS Foundation of Lanka developed a strategy to reach to PLHIV in the Eastern Province which was a difficult to reach area during the war. They provided support to seek medical services for 7 PLHIV. Livelihood support programmes were also initiated for these seven people.

The AIDS Foundation Lanka has opened up a fixed deposit with a leading bank with an initial deposit of U$ 100,000 for the benefit of PLHIV. The PLHIV attending the HIV clinic of the NSACP and members of Lanka plus were registered for this financial benefit. Interest which accrues from this deposit is divided among 180 PLHIV every quarter. The money is credited directly from the bank to the savings accounts of PLHIV. The money is used by the recipients for the welfare of themselves and their families. The AIDS Foundation Lanka also established another fund utilizing a donation from a benevolent Sri Lanka lady resident in UK the " Brighty Jayasekera Endowment Fund" in 2009. The proceedings of this donation are used to provide financial assistance to educate children of HIV positive parents. Three children benefited from this fund in year 2009.

3.11 Programmes at Work places

The draft National AIDS Policy has included Prevention of HIV/AIDS in the workplace. Strategies for World of Work are included in the NSP. The involvement of workplaces in HIV/AIDS related activities showed an impressive increasing trend as a result of the HIV/AIDS workplace education project launched in 2005 and carried through 2008. The three sectors selected in the formal economy were; hospitality trade, manufacturing and plantation. The two main strategies of this project were to – facilitating partner enterprises to establish their own HIV/AIDS Workplace Policies and implement a Behavior Change Communication (BCC) programme. The BCC tool kit developed jointly by ILO and Family Health International (FHI) was used to develop the BCC intervention. The project has reached almost 7,920 employees in a total of 14 enterprises. All 14 enterprises have established an AIDS policy. The impact assessment was carried out in mid 2008 showed major changes including improvement in knowledge, behavior and attitudes among employees in the target sectors. The results are given in the next section under knowledge and behavior. By 2008, thirteen out of the 14 enterprises had appointed focal points for HIV/AIDS and allocated official working hours to attend the HIV education programme. As at 2009, nine of the 14 enterprises had a collaborative agreement with an external HIV/AIDS resource person/ organization or hired a full time HIV/AIDS coordinator and integrated HIV/AIDS component into the existing Occupational Safety Health and Human Resources (OSH/HR) training programme. In 2009, nine of the 14 enterprises had allocated a specific budget for HIV/AIDS education programme.

As members of the Business Coalition several companies have taken steps to include HIV/AIDS in the workplace. In 2008, from BASF Finlays Company a total 25 senior level managers and 60 from Textred Jersey Company and 50 from Delmege Forsyth Company were trained in carrying out awareness on HIV/AIDS and skills building for behavior change. Another company - Dipped Products have trained 130 trainers to train a group of peer educators to reach out to their employees. In 2009, senior managers of Unilevers, Hayleys, Hatton National Bank, Columbia Sports, MAS Holdings, underwent a similar training programme. The minor staff of SCB Company was trained as peer educators during 2009.

The ILO Code of Practice on HIV/AIDS in the World of Work which was launched in 2004 is being continued under the leadership of EFC. Several awareness programmes which also focus on dispelling stigma and discrimination have been carried out by EFC during 2008/09. EFC has integrated HIV/AIDS modules in certificate training courses including the Supervisory Development Programme, Certificate Programme in Occupational Health & Safety and Certificate Programme in Labor Law and Industrial Relations. Nearly 500 members of the EFC receive regular updates on HIV/AIDS through their quarterly newsletters. The Ceylon Chamber of Commerce (CCC) through its CSR programme focusing on Millennium Development Goal 6, conducts awareness programmes in workplaces. The seafarers Association launched a HIV/AIDS education programme in 2009 jointly with ILO and NSACP.

3.12 Mass media

A group of media personnel were trained under the World Bank project during 2005 and 2006 and as a continuation of activity in 2009, a capacity building workshop was held for a group of 35 media personnel from print and electronic media. The objective was to promote responsible reporting without violating the rights of PLHIV, maintaining confidentiality and anonymity of those infected and affected by HIV. In 2008 and 2009 media personnel in both print and electronic media continued their support in commemoration of the World AIDS day.

3.13 Women empowerment & safeguarding rights

Several women's organizations and legal bodies are working in Sri Lanka to protect the rights of women. The issues addressed by them in addition to STD/AIDS are domestic violence, sexual violence, trafficking of women for forced or compulsory labor, sex work and other forms of sexual exploitation since all of them have a direct or an indirect impact on transmission of HIV. Prevention of Domestic Violence Act was passed in Parliament and a National Committee is appointed to implement the provision of the Act. The Family Health Bureau is training public health workers to reach out to the community and educate people on the consequences of domestic violence and methods of prevention. A training module has been developed by the FHB and it includes a section on prevention of STD/HIV. Involvement of boys and men is a step in the right direction. The Women Development Officers and Counselors attached to Assistant Divisional will be also involved. Trafficking is another phenomenon which makes women vulnerable to HIV. Since Sri Lanka is a state party to the South Asian Association for Regional Corporation (SAARC) Convention on Trafficking women and children for prostitution several awareness programmes are carried out on domestic violence and trafficking and HIV/AIDS is included in them. A CSO (Women's support group) was funded by the AIDS Foundation Lanka to empower women in rural areas on sexual and reproductive health issues. Six CSO were selected to work with them and selected members from each organization was trained in creating awareness among women on making correct decisions to improve sexual and reproductive health. They were trained to reach and address even women who

were practicing high risk behaviors. There were 190 direct and 3800 indirect beneficiaries during this intervention. The activities are ongoing.

Zonta Club -2 of Colombo was supported by AIDS Foundation for a similar project as above. The selected community was the women of the fishing-folk community in a city named Angulana in the Western Province. Peer leaders were selected and trained to conduct small group discussions, one to one counseling addressing the risks of HIV, prevention methods, consequences of STI and HIV, health seeking behaviors. BCC materials were developed with community participation. Stickers were prepared for fisherman with boats giving prevention methods. Simple culturally sensitive messages on personal sexual hygiene and reproductive health were prepared and distributed among schools. Posters with specific messages for youth were prepared and displayed in selected locations. A street drama group was created at a low cost that included young men and women, girls and boys from the community. The street drama was performed on the World AIDS day at various functions. The religious leaders in the area also participate in some activities.

Number of CSOs have carried out sensitization/awareness programmes among women, the target set by universal access that by 2010, 80% women in the general population know three ways of HIV transmission and 3 ways to protect them could be achieved only if these programmes are extended island wide.

3.14 Emergency preparedness and response

In 2009, around 350,000 people were internally displaced as a result of the war situation and immediate aftermath of the conflict in the North-East. Health, social and other services were mobilized to these areas as an emergency measure to provide care for the internally displaced people (IDP). The health services response was prompt where healthcare teams were stationed in the camps to deliver curative as well as preventive care. The Government also took steps to ensure that the rights of those displaced especially women and children were protected. The numbers of women police constables on duty were increased. Antenatal mothers were provided with optimal care and support. The medical team of the NSACP was mobilized to carry out syphilis screening among the antenatal mothers. The a total of 2963 antenatal blood samples were tested and there were 14 samples which were VDRL positive but the confirmatory test TPPA performed on these samples were negative thus there were no cases of maternal syphilis. The nearest STD clinic to the IDP camps was Vavuniya and a MO-STD was appointed promptly to take charge of the STI/HIV prevention and care. The NSACP supported to establish the clinic by providing test kits, reagents, IEC material, communication equipment and training of medical and paramedical service personnel. Rapid syphilis test kits were dispatched to Vavuniya to increase the coverage of antenatal testing.

4. Treatment, care & support

The policy of the Government of Sri Lanka is to provide ART free of charge to all eligible people living with HIV without stigma and discrimination through the NSACP. National AIDS Policy states that all HIV positive persons and AIDS patients shall have access to Government health services equally with other persons for treatment. The treatment, support and care subcommittee meets regularly to discuss the implementation of activities and make recommendations to the NAC. The NSACP and three other STD clinics (Colombo North, Colombo South, Kandy), and the Infectious Disease Hospital (IDH) provide ART. From 2004 up until December 2009, a cumulative total of 244 patients were commenced on ART. By end of 2009 a total of 196 adults and 11 children <15 years were on ART as 37 succumbed to the disease while on ART.

At post test counseling PLHIV are requested to register at the HIV clinic of the NSACP. There is no coercion for registration. In the HIV clinic trained medical officers and nurses provide counseling and patient care under the guidance of consultants. During evaluation the stage of the illness is determined following clinical and immunological assessments.CD4 test is available in the central STD laboratory and at the Medical Research Institute. It is not cost effective to have this facility at provincial level. Alternatively blood samples for CD4 count are sent to the reference laboratory and guidelines are available for collection and transport of samples. Viral load testing is not a requirement for initiating ART.

Sri Lanka Guidelines for ART is available which assist in initiating, switching, monitoring and follow up. Eligibility to initiate ART is based on clinical and CD4 counts and eligible patients are counseled and prepared for ART. Family members are counseled with the consent of the patient. In preparation for ART, baseline hematological, biochemical investigations are carried out at the National STD laboratory. All patients are screened for STI and opportunistic infections and are managed accordingly. Cervical cytology screening is available for women. Since some tests are not available in the STD laboratory the patients are requested to get them done in the private sector. The first line drugs as well as second line drugs for substitution or failure of treatment is available. When PLHIV need special services they are referred to other units such as psychiatry, gyn & obs, ENT, eye etc. In 2008, a total of 23 males and 07 females were commenced on ART (n=30), in 2009 a total of 45 males and 26 females (n=71) were commenced on ART. The estimated total number of people in need for ART during 2008 was 817 and the same value was used as the estimate for 2009. Thus as at end December 2009, nearly 30% of the total estimated number who need ART had started ART. During the years 2009 the following drugs were added to the armamentarium of drugs- tenofovir, emtricitabine, abacavir, liponavir/ritonavir. A total of 16 patients were using second line drugs by end 2009. Drugs are procured by the NSACP and distributed by the Pharmacy of the NSACP. In year 2008 and 2009, the GFATM funds were used to purchase drugs. Patients are followed up regularly and clinical and immunological follow ups are done as per country guidelines. Continuous counseling and comprehensive care has helped to keep defaults at a very low level. Lanka plus PLHIV group also carry out adherence counseling. Two training programmes were conducted by Lanka plus for members and their families on sexual and reproductive health for people living with HIV.

The Clinton Foundation has facilitated the procurement process of ART drugs directly from the manufacturer at a very low price since 2008.

In 2009, under the GFATM programme six provincial level treatment, support and care teams were trained. The Provincial Director Health Services gives leadership to the team and pediatricians, obstetricians, medical laboratory technicians, nurses, was included in the team. The objective was to provide continuum care and treatment in local settings.

The College of Physicians of Sri Lanka carries out training programmes with the objective of improving quality care for PLHIV and minimizing stigma and discrimination in health care settings. Four two day workshops were held in 2009. 197 healthcare workers including hospital Matrons, Ward Sisters, Principals and Tutors of Nursing Schools were the beneficiaries of this intervention. The NSACP provides technical support.

Two consultant Venereologists from NSACP attended the ART cohort analysis programme organized by the WHO in November 2009.

TB & HIV

During 2008/09 there were 3 with advanced HIV infection who were on ART. Since March 09 some TB physicians have commenced Provider initiated testing for HIV. In 2009, from the Colombo clinic a total of 943 tests were done and only one became positive. HIV testing of all TB patients was carried out in the Chest Clinic Badulla and in 2008 and 2009, a total of 286 and 268 samples were tested and none were positive. The estimated HIV positive incident TB cases that received treatment for TB and HIV in 2009 was 10%. Promoting the offer of HIV testing for high risk TB patients is not easy. Achieving the target set for universal access seems difficult in this scenario.

5. Knowledge & behavior change

5.1 Female sex workers

A definite trend in condom use among female sex workers cannot be determined since the type of sex workers, locations and methodologies adopted in surveys are different. Results of a survey carried by CSDF, postgraduate medical officers and BSS are given below.

In 2008, the CSDF carried out a behavior change intervention among 438 female sex workers registered in their Drop in Center. The baseline survey was done in January and impact survey results are given below:

Knowledge

- At baseline 89% had the misconception that HIV is transmitted via mosquitoes. Later this misconception was corrected and the post intervention survey results revealed only around 13% had such a misconception.
- Knowledge on HIV transmission through sexual intercourse increased from 17% at baseline to 84% at the post intervention survey
- Knowledge on mother to child transmission improved from 20% at baseline to 91% at the post intervention survey
- Knowledge that a HIV positive person could look healthy was 20% at baseline and increased to 91% later

Attitude

Only 19% were willing to keep an HIV infected family member at home at the baseline survey. This increased to 89% later

Behavior

- At baseline consistent condom use with paid clients was 24%, and later increased to 88%.

- Only 6% have had voluntary counseling & testing at baseline survey and a marked increase to 56% was observed following the intervention

Survey-2 a brothel based survey carried out among 340 female sex workers in 2005 observed that 65% always use condoms with clients. This trend in using condoms by sex workers improved substantially during the period 2006/2007. 39.4% of casino workers, 62.9% and 62.5% of brothel and casino workers, respectively, 70.4% of massage parlor workers and 81.9% of street workers were reported to have used a condom every time during this period.

Results of the BSS survey in respect of risk behaviours during last 12 months and most recent are given below:

Behavior

Consistent Condom use with clients during the last 12 months prior to the survey

- 62.9% among brothel workers and 39.4% among casino workers (only 87.5% of casino girls have had sex during this period)
- 70.4% among massage parlor workers (only 72.1% massage parlor girls have had sex during this period)
- 81.8% among street based sex workers

Last exposure

Overall 90.5% of all sex workers surveyed had used a condom with their most recent paying client. The variation between the types of sex workers was small.

HIV testing

There were 42.6% of sex workers who admitted that they had an HIV test 12 months prior to the survey and knew the result (BSS 06/07). The majority among this group were over 25 years of age (46%).

5.2 Men who have sex with men

It has been observed that MSM groups operate in Anuradhapura in the North Central Province. In order to capture data on knowledge, attitudes and behaviors of this group a research was carried out in 2008 among 225 MSM selected using the respondent driven sampling technique in the district of Anuradhapura. Data were collected using an interviewer administered questionnaire after obtaining consent. The results of this survey is compared with the findings of the BSS (2006/07)

Knowledge

- The majority (93.7%) were aware that HIV is transmitted through unprotected sex, whilst 95.1 % knew that HIV is transmitted through transfusion of contaminated blood and 90.6% had the knowledge that HIV is transmitted by contaminated needles. Transmission of HIV from mother to child was known by 79.4%.
- 55% knew that a HIV positive person could look healthy. BSS data shows that almost similar percentage (51.7%) had this knowledge in years 06/07
- Only 57.8% were aware that condoms could protect from HIV. The corresponding result from the BSS was 66%
- 26.9% had the misconception that HIV could be transmitted while sharing a meal, 34.1% believed that HIV could be transmitted by mosquitoes, 17% thought that the virus is transmitted by sharing a toilet
- Only 66% knew that they could prevent HIV infection by using a condom. There were 32% who believed that one could get HIV from mosquito bites. Only 65% knew that a HIV positive person could look healthy. Although the above findings cannot be generalized it has thrown some light on the risky behaviors which would sow seeds for spread of HIV infection in this community.

Attitudes

- 47.1% had said they were not willing to work with a HIV positive co-worker
- 51.1% did not want to live in the same house with a HIV positive person

Behaviors

in respect of anal intercourse

Last exposure with a male partner

- 41.2% had used a condom with regular male partner at the most recent sexual exposure.
- 25.6% had used a condom with the non regular partner at the most recent sexual exposure

Sexual exposure with another male 12 months prior to survey

- 38.2% had never used a condom with regular partners and 55.3% with the non-regular partner during the last 12 months
- the average number of non regular partners for the whole sample was 6.8 in the previous 12 months
- 14.9% have had coercive sex in the previous 12 months

The BSS (06/07) observed that MSM have regular and casual partners and condom use is low particularly with regular partners. The results of the 302 MSM who participated in the study are given below:

Sexual exposure with another male 12 months prior to survey

- 67.5% had anal sex with a regular male partner and 80.9% with non regular partners. This amounts to a total of 92.4% having had anal sex with male partners.
- Only 25.9% had had always used condoms with regular male partners and the corresponding figure for casual sex was higher 46.5%

Last Sexual exposure with another male

- 34.9% used a condom with regular male partners and 63.7% with the non- regular male partners

Although the BSS and the MSM survey data cannot be compared in a scientific manner it appears that there is an increase in consistent condom use among MSM during anal intercourse with regular partners, although the level of condom use stagnates at same levels where only a little less than half those surveyed used condoms always in both surveys.

Sexual exposure with a female 12 months prior to survey

23% have had sex with women (14.7% were with their regular partner, 12.2% with casual partners). 18.2% used condoms always with regular partners and 36% with non regular female partners.

On the last occasion a MSM had sex with a regular female partner 29.5% always used condoms and 61.1% with non regular female partners.

HIV testing

- 13.6% MSM who took part in the survey have had a HIV test in the preceding 12 months and is aware of the result.

5.3 Drug users

Since data for 2008/09 period is not available, the results of the BSS 2006/07 carried out among 779 drug users are given in this report.

Behaviors

Sexual exposure 12 months prior to survey & consistent condom use & number of partners

- 49.7% of the male drug users have had sex with their regular female partner and only 1.1% used condoms always

- 27.3% have had sex with casual female partners and 18.8% used condoms always
- 15.6% had had sex with female sex workers and 47.4% used condoms consistently

- Nearly 6% of drug users have had anal sex with a male partner and over 90% have never used condoms consistently
- Male drug users have had more female commercial partners (mean of 3) than non regular female partners (mean of 2).
- The males who had sex with male partners had on average 4 non regular partners.

Condom use at last occasion with male sex partner

The situation is even more dangerous when drug users engaged in anal sex.

- Almost 98% of drug users did not use a condom during their last anal intercourse

As indicated above men discriminate between different partner types when they decide whether or not to use condoms. In general consistent condom use among men has been low. The drug users who buy sex from sex workers and have sex with marital or regular girlfriends or casual female partners will be a vector carrying HIV between populations.

Injecting behavior

- According to the BSS (2006/07) injecting drug use was low with only 34 (4.4%) drug users admitting to have injected 12 months prior to the survey while 14% had ever injected. Among this small group sharing needles was common, with 42.3% of injectors offered the same used needle to someone during the last occasion they injected and 51.1% have received a used needle for re-use.

The more sex partners drug users have injectors or non-injectors the more likely it is that an HIV infection takes root among such communities. Frequency of partner turnover and low condom use emerge as critical risk factors for transmission of HIV infection as per the results above. .

5.4 Beach boys

The BSS 06/07 was carried out among 553 beach boys selected using the Respondent Driven Sampling (RDS) technique. The results revealed that beach boys have regular and non regular male and female partners and condom use is low. Most of them have sex with male and female foreign partners and most often have unprotected sex.

Knowledge

- Almost all knew that HIV is transmitted sexually during unprotected sex
- 34% believed that HIV could be transmitted by mosquitoes
- 74.9 % had the misconception that by using a condom correctly and always would protect themselves from HIV
- 44.2 % had the correct knowledge that a healthy looking person could be infected with HIV

Attitudes

- 52.9% were not willing to work with a HIV positive person
- 70.4% were not willing to live in the same house with an infected person

- 34.3% held the view that a student should not continue school education if infected and although not sick

Behaviors

Sex with females 12 months prior to survey & condom use

- 70.7% have had sex with casual partners. 47.2% always used a condom, only 8.2% never use condoms
- 53.3% had sex with a regular partner and 74.1% never used a condom

condom use during the last exposure was also similar to what was reported during 12 months prior to the survey

Sex with males 12 months prior to survey & condom use

- 18.7% have had anal sex with a regular partner and only 12.6% used condoms
- 18.9% had anal intercourse with non regular local male partners
- 45.9% always used condoms with their male partners
- 44.5% had anal intercourse with Condom use on last occasion during anal sex
- 39.6% used condoms with regular partners
- 68.5% used condoms with casual partners

HIV testing

18% had tested for HIV and 79% underwent the test voluntarily

5.5 Antenatal mothers

The results of a study was carried out in 2008 among 371 antenatal mothers in the district of Ratnapura in the Sabaragamuwa Province are given below;

Knowledge

- 62.8% were aware that a HIV positive person could look healthy
- 61.5% rejected two common misconceptions (sharing toilets and meals could transmit HIV)
- 94% were aware that having one uninfected sexual partner can reduce the risk of HIV infection
- 70% were aware that condoms could prevent HIV infection

Attitudes

- The majority did not like to buy food from a boutique owned by a HIV positive person
- 98.4% preferred to keep the HIV status of a family member as a secret

5.6 World of work

A baseline survey was carried out in 2005 to determine the knowledge, attitudes and practices among a sample of workers selected from manufacturing, hospitality and plantation sectors. Hundred workers from each sector were selected using the systematic sampling technique. The impact survey was carried out six months after the BCC intervention package was introduced to assess the changes in the variables under study. The comparison of the results of the baseline survey (2005) and impact survey (2008) are given below when all three sector employees were taken together.

Knowledge

- Knowledge of the three modes of transmission of HIV increased from 82% in 2005 to 98%

- An increased amount of 85.3% were able to correctly identify misconceptions regarding transmission of HIV compared with 22% in 2005
- 99.3% were able to correctly identify three means of protection from HIV as against 86.3% at the baseline survey in 2005
- In 2005, only 78% had the knowledge that a person may get HIV by having unprotected sex even with a person who looks healthy. In the impact survey almost 98% had this correct knowledge.
- At the baseline survey in 2005, nearly 30% believed that a physically fit HIV positive worker would be denied opportunities in the workplace but in the impact survey a marked improvement in the correct knowledge that employers would not embark on such a step was observed.
- In 2005, only 61% recognized that intoxication as a contributing factor to HIV/AIDS. In 2008, almost 91% were able to recognize this fact with more females being able to do so in the impact survey.
- Currently almost 98% are aware that HIV/AIDS services are available in their workplace

A remarkable observation of the impact of the BCC intervention was that there was no statistically significant difference in the advanced knowledge across all groups in respect of age, gender and education level although the plantation workers are considered a less advantaged group in terms of education and access to services.

Attitudes

- By 2009, the number of employees with a supportive attitude towards HIV positive co-workers increased by 60.7%
- The belief that their employer would dismiss a physically fit HIV + person had reduced from 27% in 2005 to only 2.7% now.

Behaviors

- By 2009, the use of condoms during risky sexual behaviors increased by 33% (from 48% in 2005 to 81% in 2008)

- An increased percentage has also intentionally limited the number of partners other than their spouse within the last 6 months in order to reduce the risk of HIV/AIDS. This indicates that the interventions have been able to change the behaviors of workers towards safer sexual behaviors in order to protect themselves from the risk of HIV infection.

5.7 Youth between 18-24 years

A study on risky sexual behaviors and substance abuse was carried out among youth in the district of Galle in the Southern Province along the coastal belt in the country in 2009. Due to its strategic geographical location with sea beaches it has become a haven for tourists. The second highest drug related police arrests were reported from this district in 2005/06. Closer to Galle, in Habaraduwa and Koggala a large number of garment factories were set up which accommodates a large youth population. The sample consisted of 812 young men and women between the ages 18-24 who lived in the area for over 3 months prior to the survey were selected using the cluster sampling technique. Cannabis was the popular drug used by 14.9%, followed by heroin. Cocaine was never used by 98.6%. Only three had ever injected drugs but none had shared needles and none were current injectors as they had given up the habit.

Knowledge

- 36.6% knew from where to purchase a condom

- Only 13.7% men and women were able to correctly identify two methods of preventing sexual transmission and rejected three misconceptions on HIV transmission

Behaviors

- For both sex groups the average age at first sex was 23 years
- 27.2% (n=110) males and 11% (n=35) females had experienced sex at least once in life
- 2.8% men and women had intercourse before the age of 15
- 8.3% had had sex with more than one partner 12 months prior to the survey
- Only 2.6% of men reported the use of a condom the last time they had anal sex with a male partner

5.8 In school youth

The results of a survey carried out among 6007 school children in the Sabaragamuwa Province in October 2009 are given below.

Knowledge

Correct knowledge on transmission methods

- 94.2% had the knowledge that unprotected sexual contact with a PLHIV
- 89.7% had the knowledge that HIV is transmitted through blood and blood products
- 80.7% had the knowledge that an infected mother could transmit HIV to the baby
- 80.7% had the knowledge that transmission could occur through infected persons with no symptoms

Correct knowledge on non- transmission methods

- 100% had the knowledge that sharing cups and meals with a HIV infected person is not a method of HIV transmission
- Only 65% had the correct knowledge that HIV is not transmitted by mosquito bites
- Only 61.5% had the knowledge that sharing toilets with an infected person is not a method of HIV transmission
- Only 41% had the correct knowledge that HIV is not transmitted by sharing razors

Composite knowledge on four variables of the UNGASS indicator – 45.9%

V. Best practices

Tracking the epidemic

Unlinked sentinel surveillance was first introduced in 1993 to track the level of HIV infection in different sub populations and provide information for policy and programmes development. Several stakeholders from the health, and CSO assist the NSACP to conduct this annual event. The data collected from sentinel surveillance was used to track the epidemic, make estimates of MARP in the country.

Supply of HIV free safe blood

Sri Lanka is one country in the South Asia region which has been able to keep the spread of HIV by transfusion of contaminated blood at an extremely low level. The success is due to the blood safety policy adopted in 1988. A policy decision was made by the Government of Sri Lanka to screen all donated blood collected in the government blood banks for HIV and other transfusion related infections. The National Blood Policy of Sri Lanka was presented to the Parliament and the Transfusion act has been enacted. A private Medical Institutions Bill that incorporates legislative powers to the Ministry of Health in respect of private health care facilities to regulate private sector blood banks has also been approved by Parliament.

Initially the HIV screening test was carried out by the NSACP but gradually over the years the capacity of the National Blood Transfusion Service was developed to take over this intervention completely. The NBTS through the adoption of a system of pre donation education and counseling, adopting criteria for donor selection and deferral, discouraging paid donations and encouraging voluntary non remunerative donations, donor recruitment and retention, ensuring donor confidentiality, screening of all donated blood for HIV and other transfusion associated infections such as hepatitis B &C, syphilis and malaria, and promotion of rational use of blood has helped in maintaining the low HIV prevalence situation in the country. The sero positivity among blood donors has been maintained between 0.003- 0.004%. There were no reported blood transfusion related HIV infections since year 2003.

Provision of STI services

The STI services in Sri Lanka was established in 1952 and since then control and prevention interventions have been taking place in a systematic manner. The NSACP consists of an administrative wing and treatment and care service which is supported by the National Reference Laboratory and it networks with 30 island wide STD clinics. All STD clinics are manned by a trained medical officer. The other medical staff is also trained in various aspects including delivery of clinical care without stigma and discrimination, counseling, laboratory services. Primary prevention activities are carried out by a public health care team and are assisted by primary health care staff in the respective areas, CSOs and PLHIV. The roles and responsibilities of the primary health care providers such as MOH, PHMW, PHNS, PHI were revisited and confirmed by the Deputy Director General of Public Health Services in 2009. The public health team carries out awareness, behavior change communication programmes for MARP and the general public. Comprehensive management of STI is done on an etiological or syndromic basis depending on the availability of laboratory facilities. Treatment protocols for etiological and syndromic management of STD in Sri Lanka are available in all centers. Drugs for STI treatment including ceftriaxone, cefuroxime, doxycycline, metronidazole, acyclovir are available in all STD clinics. STD services are available to all and are free of charge in the government sector. Counseling, partner notification, condom promotion and

provision are included in the package of services. All STD attendees are offered HIV testing and counseled before testing. Confidentiality is maintained during pre and post test counseling and examination for STI. STD clinics serve as VCT centers. The STD services play an integral part in screening antenatal mothers for syphilis. All mothers diagnosed with syphilis are treated and followed up at STD clinics and the management of infants is carried out in coordination with the pediatrician. The antenatal screening programme is monitored at the monthly MOH conference. With the launch of the ECS programme the RDHS is responsible in the smooth delivery of this service at district level.

Data from STD Clinic are collected using standard formats and is entered into various registered by trained staff. Quarterly returns are submitted to the center where data are analyzed and used for policy and programme planning. The STI data over the years shows a declining trend of bacterial infections with an increase in viral STI.

Mapping and size estimation of key populations at risk (FSW and MSM) in Sri Lanka

As yet, evidence suggests that the HIV epidemic in Sri Lanka remains at a relatively low level. However, experience from other countries in South Asia have shown that concentrated HIV epidemics involving vulnerable key populations can expand quickly within those sub-populations and affect the wider population through "bridge populations" (usually men who have sexual partnerships with both members of higher risk key populations and lower risk partners).
Therefore, to prevent the establishment and potential expansion of an HIV epidemic in Sri Lanka a key strategy will be to reduce the potential for transmission in important networks of vulnerable key populations, particularly where such networks are large and dense and therefore prone to rapid HIV transmission within and from these networks. The first key step in developing targeted interventions for vulnerable key populations is assessing their location, size and basic operational characteristics. Experience in diverse settings of South Asia has shown that structured mapping can provide accurate estimates of the size and location of key populations and thereby provide guidance for the scoping and targeting of HIV prevention programs and services.

At the request of the National STD/AIDS Control Programme (NSACP) in late 2008 the UN Joint Team on AIDS in Sri Lanka supported the development of a methodology for the mapping of most-at-risk populations, a precursor to effective prevention interventions with most-at-risk populations. Until now, estimates of the number of sex workers in the country ranged from anything, between 5,000 to 30,000, while there are no estimates for MSMs.

The National STD/ AIDS Control Programme established a steering group to guide this initiative with membership drawn from the NSACP, senior ranking law enforcement agents, the two implementing community based organizations (Companions on a Journey and Community Strength Development Foundation) and the UN system. Technical assistance was provided by the World Bank through the University of Manitoba, who provided experienced staff from both India and Pakistan. The two key community based organizations received a comprehensive training, where a pilot methodology was field tested.
Hot spots for Men who have sex with men and female sex workers have now been mapped in 4 of the 25 districts across the island. Initial results from the mapping exercise will provide clearer estimates of numbers and locations making at-risk populations easier to reach with prevention services. The methodology has been adopted by the NSACP for scale-up to further 10-13 districts under the Global Fund round 9 interventions with implementation starting in late 2010.

VI. Major challenges and remedial actions

To convince some leaders and policy makers of the importance of addressing issues on HIV/AIDS is a challenge due to current low HIV prevalence in the country.

Only a handful of CSOs are working with MARP especially female sex workers and MSM. It is difficult to convince some CSOs that at present the interventions should be targeted for MARP based on evidence. Policies on SWs, MSMs and LGBT population groups should be seriously considered with a greater political commitment. A more conducive, non stigmatizing and non discriminating legal and policy environment should be created by revisiting the current penal code laws for SWs, IDUs and MSMs need review/removal as they present barriers to prevention.

The national drug policy has not adequately considered the risk of HIV transmission through IDU and with the next revise this issues should be given due consideration. Harm reduction practices need to be introduced and if the policy environment is conducive this intervention could be introduced overcoming stigma and discrimination.

Sri Lanka is a high labor exporting country. Evidence shows that external migrant workers are importing the infection to Sri Lanka and steps should be taken to minimize their vulnerabilities in destination countries and also adopt a mechanism to promote VCT for the returnees. Currently migrants are not considered as MARPS. Less prominence is given to this group as they are not considered as a group which would ignite a chain of infections.

Currently routine data are collected only from public STD clinics on a quarterly basis. However this data is collected and submitted manually. STD clinics have no IT facilities. Capacity should be built to collect and analyze data in a less cumbersome manner and facilitate timely dissemination of data smoothly to all stakeholders. There is a scarcity of data at the national level particularly from the CSO and other stakeholders and steps should be taken to establish a system of flow data to the National programme from all stakeholders.

Most of the data from surveys cannot be used for national planning and implementation as they are conducted on selected populations and using sampling methods which cannot be generalized to the specific populations.

Need to build the capacity of M&E unit to overcome some of the constraints described above. Need have uninterrupted and sufficient funds and personnel with IT experience to carry out M&E activities. However amid these constraints HIV and STI surveillance data are disseminated by annual reports and through the web site of the national programme whenever possible.

It is necessary to integrate management of HIV/AIDS patients to the existing healthcare setting. Addressing this issue through respective academic Colleges should be strengthened.

Although the NSACP is able to carry out the baseline basic tests some tests are not available in the central laboratory. Since the numbers of samples are also small purchasing equipments for such tests is not feasible. As an alternative the private sector hospital laboratories should support the NSACP in carrying out some of these tests. Although it is necessary to scale up treatment, care and support and establish ART centers at Provincial Hospitals it may not be effective if facilities are not available.

As a policy decision has been made to integrate HIV/AIDS education into the national school curriculum in 2012, it is necessary to make available enough resources for curriculum development

and capacity building in terms of teacher training, development of training modules and relevant IEC material to reach out as a national programme which covers all schools.

Reducing stigma and discrimination is a challenge especially because the problem of HIV/AIDS is invisible in the low prevalence situation. Media communication strategy should be planned with the relevant stakeholders.

The National AIDS policy is in a draft stage for number of years and to date it is not endorsed..

Although sentinel surveillance has been an ongoing activity STD staff fails to enroll the identified sample size of most of the sentinel groups especially female sex workers and MSM. The CSO should support the government sector as the link between MARP and the STD clinics in some areas is not strong. Capacity building opportunities for the STD clinic staff should be explored as it is mandatory to work with the MARPs. Special training on novel methodologies on MSM/FSW/DU networking and strategies which can be adopted in winning the confidence of MARPs should be considered.

Improve the funding for the sentinel surveillance. CSOs working with the MSM and FSW provide monitory or materialistic incentives for the MARPs members. As such it is very difficult for the government STD clinic staff to work with those groups as they expect similar incentives from the government sector for their participation. Due to insufficient funding incentives were not provided to date. Further, some payment should be allocated for STD clinic staffs who work after normal working hours.

CSOs have limited technical capacity in programme planning and implementation. Capacity building is vital. Need to strengthen networking and linkages of the few CSOs working on HIV. Need to create and strengthen additional civil society groups led by MARPS. Establishment of an effective coordinating mechanism between government and civil society is necessary to enrich further the national response. Lack of in-country financial commitment to continue the prevention progammes will jeopardize the existing prevention interventions.

Taking into account the above challenges in the implementation of the well formulated National Strategic plan 2007-2011 to reach the goal of maintaining the low prevalence, the round 9 HIV dual track proposal for the next five years (2011-2015) was formed to overcome the identified gaps and weaknesses and unmet need. It is proposed that two principle recipients, ministry of health as government principal recipient (PR) and a leading CSO as the nongovernmental PR will implement the project at a cost of USD 12 million in a participatory, collaborative and coordinated manner.

The round 9 proposal address 3 strategic areas prevention, care treatment and support and generating strategic information.

Focus on the prevention strategy of "Increased scale and quality of comprehensive interventions for most at risk populations: female sex workers and clients, men who have sex with men, drug users, and prisoners" and generating strategic information including planning administration and M&E are given a high priority as reflected in the budgetary allocation of 49% and 21% respectively.

The scaling up of treatment, care and support activities is addressed through the proposal to complement those that are being implemented currently with Global Fund Round 6 grant resources component with the first two key care strategies of the National HIV/AIDS Strategic Plan 2007 – 2011: Increased quality and use of voluntary confidential counselling and testing services and increased quality and coverage of HIV and AIDS treatment services.

Prevention

Prevention efforts will be the responsibility of the Nongovernmental PR a leading CSO through 3 sub Recipient(SR) CSOs with experience in working with MARP (MSM, CSW, DU) with technical support and procurement of commodities and pharmaceuticals by NSACP.

Targeted Interventions

A comprehensive package of services to deliver targeted interventions for MARP were agreed upon based on strategic evidence (BSS, research and programme records) and experience of organisations working with MARP during several stakeholder consultations (CSOs working with MARP, members of key populations, NSACP, academics & professional bodies). Peer led education on safe sex/drug using practices, condom promotion, STI services and VCT will be an effective intervention. Action will be taken to monitor drug using behaviour and setting environment for harm reduction interventions for IVDU if the need arise.

Advocacy at two levels to create enabling environment to implement these activities are planned. At the central level for hierarchy, political leaders, policy makers etc and local advocacy for the law enforcement officers, authorities, local administrators ,community leaders and gate keepers etc.

Capacity building of civil society

Strengthening of the capacity of CSOs currently working with MARP ,and development of civil society groups composed of key populations at higher risk to lead the response to HIV in their own communities is given attention .This includes establishing networks for organizations and agencies who work, or want to work, with key populations at higher risk. Technical assistance in institutional development of small CSOs also been proposed.

Mapping and size estimations

A major gap in strategic information, social mapping and reliable population size estimates that can be agreed upon by consensus in order to determine coverage of prevention services were listed as a priority activity covering 13 districts. The mapping exercise commenced in 2009 in 5 districts will provide methodology and implementing issues.

Strategic information, monitoring and evaluation

Due attention is given for strengthening second generation surveillance (conducting IBBS) national size estimation of key populations, estimating PLHIV and formative and operational research.

Strengthening of M&E system is identified as a key area to meet the gaps identified. A a comprehensive M&E plan including time bound targets, set of indicators and data collection strategy and tools agreed upon by the implementing partners is developed. A specific budget for M&E activities is identified for strengthening of the SIM unit, human resource development, program and project monitoring system and a joint monitoring mechanism is proposed for better coordination of the implementing partners and the PR and sub recipients.

Care and support to PLHIV

Further donor support is necessary to continue ART programme without interruption. It is estimated that those who need ART will increase from current 510 to 1467 by the year 2015 (according to HIV estimations done in 2009 using Spectrum). However it is assumed that 80% of the estimated population will access treatment. Round 6 grant resources for care and support will be consolidated with activities in this proposed Round 9 grant. The total budget for care represent 29.4% of total budget.

Participation of PLHIVs in provision of care and support to target population is encouraged in this proposal through engaging them in developing and delivering a package of services including counseling and advice on treatment preparedness, nutrition, spiritual matters, and sexuality.

Provision of supportive environment to PLHIVs and MARPs seeking care at STD clinics will be addressed through training of health care workers on informed consent, confidentiality and non discriminating attitudes towards the target populations.

Key strength of the proposal is that a participatory approach was used involving key stakeholders (government, CSOs ,private sector, professional associations, PLHIV and their organizations, members of high risk populations, bilateral donors and UN agencies) in every step of developing the proposal including prioritizing of strategic areas, preparation of work plans, developing the monitoring and evaluation plan and costing in a transparent manner giving ownership to all for better coordinated action.

VII. Support from the country's development partners

a) Key support received

Over the last reporting period the principle support for the response to AIDS in Sri Lanka, came through a grant from the World Bank between 2003 -2007 for US$ 12.6 million. This grant came to a close in June 2008. Almost 64% of the total funds were utilized for implementation.

Additional key support has come from the Global Fund on AIDS, Tuberculosis and Malaria through a Round 6 grant for HIV for US$ 1.8 million. In the 2008 to 2009 period US$ 302,000 had been disbursed. Phase II implementation is ongoing for 2010-2012.

In 2009 Sri Lanka put together a successful round 9 proposal for US$ 10.8 million which will support implementation around three priority areas of the National Strategic Plan on HIV and AIDS; 1: To increase the scale and quality of comprehensive interventions for most at risk populations (to implement the first prevention strategy of the National Strategic Plan); 2: To provide care, treatment and support for people living with HIV and AIDS; 3: To generate and use strategic information. Grant negotiations are currently underway and implementation is expected to start before the end of 2010.

Sri Lanka was also included in a successful Global Fund regional proposal on HIV and men who have sex with men covering South Asia. Again implementation of this which complements the country proposal will begin in late 2010.

Individual UN agencies brought strategic support throughout this period in terms of awareness and programmatic support largely in the form of technical assistance. The UN Joint Team on AIDS in Sri Lanka supported the government through a Joint Programme on AIDS. The major focus of the programme in 2008-09 was for the development of a mapping methodology for most-at-risk groups (SW, MSM) with technical assistance provided by the World Bank and UNFPA; undertaking a survey of stigma and discrimination with people living with HIV through UNDP; a HIV risk assessment of conflict affected populations through UNHCR; a risk assessment of fishing communities through ILO; development of a national policy on HIV prevention in the World of Work through ILO; HIV prevention interventions for both internal and external migrants through ILO and IOM and strengthening of surveillance and estimates through WHO.

b) Actions that need to be taken by development partners to ensure achievement of the UNGASS targets

Prevention - scaling up of quality prevention programmes for most-at-risk populations (SW, MSM, DU, prisoners and beach boys)

Care and Treatment - expansion of care and treatment for PLHIV with a focus on strengthening referral and improving quality of services

Management - strengthening of coordination and management capacity of the national response through the national AIDS committee and the NSACP

Policy - strengthening of the legal and policy framework

Strategic information – continued strengthening of the monitoring and evaluation capacity of the NAC, NSACP and civil society, with a particular focus on an integrated behavioural and sentinel survey and coverage of interventions with most-at-risk. Development of resource tracking system to assist in ensuring that resource allocations are in line with national priorities

VIII. Monitoring and evaluation environment

During the year 2008 a separate Strategic information & Management Unit (SIM Unit) was established for the first time in the National STD/AIDS Control programme to coordinate monitoring and evaluation activities of the national response. World Bank funds were used to develop the infrastructure of this unit. Six full-time staff were recruited to this unit from the permanent staff of NSACP. This was a major achievement during the reporting period in monitoring and evaluation area. The objectives of Strategic Information Management in NSACP are to provide an overall picture of HIV and AIDS scenario in the country and national response to HIV and AIDS, to provide accurate, timely and stakeholder-friendly information, to enable planning, learning and effective decision making at various levels using evidence, to address accountability in the program, to meet various national and international reporting needs and to provide an effective system for bringing together information from multi-sectoral agencies to address information needs at various levels.

The draft M&E plan was developed with the identification of appropriate indicators which would help in local and international reporting.

However there is no routine budget allocation identified for monitoring and evaluation activities from the government. Funding depend mainly on donor funds. Limited donor funds were available during 2008 and 2009 for M&E activities. As a result there were no funds to sustain some of the activities such as software and web updates, professional IT and statistician's services. However amid these constraints some HIV and STI data are collected, analysed and disseminated by annual reports and quarterly reports through the web site of NSACP and used for programme planning and resource allocation. It is expected that the round 9 GFATM proposal would fill in the gaps of the SIM unit.

ANNEX I

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Which institutions /entities were responsible for filling out the indicator forms?		
a) NAC or equivalent	Yes	No X
b) NAP	Yes X	No
C) Others	Yes	No X
2) with the inputs from		
Ministries:		
Education	Yes X	No
Health	Yes X	No
Labor	Yes X	No
Foreign affairs	Yes	No X
Others	Yes X	No
Civil society organizations	Yes X	No
People living with HIV	Yes X	No
Private sector	Yes X	No
United Nation Organizations	Yes X	No
Bi-lateral	Yes X	No
International NGOs	Yes X	No
Others	Yes X	No
3) Was the report discussed in a large forum?	Yes X	No
4) Are the survey results stored centrally?	Yes X	No
5) Are data available for public consultation?	Yes X	No
6) Who is responsible for submission of the report and for follow-up if there are questions on the country progress report?		

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ANNEX 2

National Composite policy index questionnaire - Part A

[Administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes **X**	No	Not applicable

Period covered: *[write in]* ***2007-2011***

IF NO or NOT APPLICABLE, briefly explain why.

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy?
Number of Years: *[write in]* ***since 1995 (over 14 years)***

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
Health	Yes **X**	No	Yes **X**	No
Education	Yes **X**	No	Yes	No **X**
Labour	Yes **X**	No	Yes **X**	No
Transportation	Yes	No **X**	Yes	No **X**
Military /police	Yes **X**	No	Yes	No **X**
Women	Yes	No **X**	Yes	No **X**
Young people	Yes **X**	No	Yes	No **X**
Other	Yes **X**	No	Yes	No **X**

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

World Bank Grant (2003-2008 only)
GFATM round 6 (Education and Plantation sectors)
ADB funds to education sector
UN agencies (WHO, UNAIDS, UNFPA)

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting
issues?

Target populations		
a. Women and girls	Yes **X**	No
b. Young women/young men	Yes **X**	No
c. Injecting drug users	Yes **X**	No
d. Men who have sex with men	Yes **X**	No
e. Sex workers	Yes **X**	No
f. Orphans and other vulnerable children	Yes **X**	No
g. Other specific vulnerable subpopulations* Beach boys, prisoners	Yes **X**	No
Settings		
h. Workplace	Yes **X**	No
i. Schools	Yes **X**	No
j. Prisons	Yes **X**	No
Cross-cutting issues		
k. HIV and poverty	Yes **X**	No
l. Human rights protection	Yes **X**	No
m. Involvement of people living with HIV	Yes **X**	No
n. Addressing stigma and discrimination	Yes **X**	No
o. Gender empowerment and/or gender equality	Yes **X**	No

1.4 Were target populations identified through a needs assessment?

Yes **X**	No

IF YES, when was this needs assessment conducted?
Year: *[write in]* ***2006***

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?
*[write in]****Commercial sex workers, clients of sex workers, MSM including beach boys, youth, drug users (including injecting), prisoners, migrant workers.***

1.6 Does the multisectoral strategy include an operational plan?

Yes **X**	No

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes **X**	No
b. Clear targets or milestones?	Yes **X**	No
c. Detailed costs for each programmatic area?	Yes **X**	No
d. An indication of funding sources to support programme implementation?	Yes **X**	No
e. A monitoring and evaluation framework?	Yes **X**	No

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement **X**	Moderate involvement	No involvement

IF active involvement, briefly explain how this was organized:

There were series of workshops with the involvement of civil society organizations during the development of the national strategic plan in 2006. They were PLHIV organizations, young people, human right organizations, workers organizations, and organizations of key affected groups such as MSM, sex workers, drug users.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals,
multi-laterals)?

Yes **X**	No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners **X**	Yes, some partners	No

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes **X**	No	Not applicable

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes **X**	No	NA
b. Common Country Assessment / UN Development Assistance Framework	Yes **X**	No	NA
c. Poverty Reduction Strategy	Yes **X**	No	NA
d. Sector-wide approach	Yes **X**	No	NA
e. Other: *[write in]* ***(government manifesto)***	Yes **X**	No	NA

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	Yes **X**	No
Treatment for opportunistic infections	Yes **X**	No
Antiretroviral treatment	Yes **X**	No
Care and support (including social security or other schemes)	Yes **X**	No
HIV impact alleviation	Yes **X**	No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes **X**	No
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or support	Yes **X**	No
Reduction of stigma and discrimination	Yes **X**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes **X**	No
Other: [write in]	Yes	No **X**

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No **X**	NA

3.1 IF YES, to what extent has it informed resource allocation decisions?

Low	0	1	2	3	4	5	High

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes **X**	No

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes **X**	No
Condom provision	Yes **X**	No
HIV testing and counselling	Yes **X**	No
Sexually transmitted infection services	Yes **X**	No
Antiretroviral treatment	Yes **X**	No
Care and support	Yes **X**	No
Others: [write in] Capacity building	Yes **X**	No

If HIV testing and counseling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counseling (e.g. indicate if HIV testing is voluntary or mandatory etc):

a) Voluntary counseling and testing for members and family of Army personnel
b) Mandatory testing at recruitment
c) Mandatory testing for UN peace keeping force members
d) Mandatory for Army members going for overseas courses

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes **X**	No

5.1 ***IF YES,*** for which subpopulations?

a. Women	Yes **X**	No
b. Young people	Yes **X**	No
c. Injecting drug users	Yes	No **X**
d. Men who have sex with men	Yes	No **X**
e. Sex Workers	Yes	No **X**
f. Prison inmates	Yes	No **X**
g. Migrants/mobile populations	Yes	No **X**
h. Other: *[write in]*	Yes	No **X**

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Existence of a child protection authority with law enforcement powers. Child Protection Authority has law enforcing rights to protect the rights of children.
Help Centers run by CSO's for women- in- need for reproductive issues, sexual and physical violence.
Legal acts against domestic violence and sexual abuse of women.

Briefly comment on the degree to which these laws are currently implemented:

Laws for protection of women and young people are effectively implemented.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes **X**	No

6.1 ***IF YES,*** for which subpopulations?

a. Women	Yes	No **X**
b. Young people	Yes	No **X**
c. Injecting drug users	Yes **X**	No
d. Men who have sex with men	Yes **X**	No
e. Sex Workers	Yes **X**	No
f. Prison inmates	Yes **X**	No
g. Migrants/mobile populations	Yes	No **X**
h. Other: *[write in]*	Yes	No **X**

IF YES, briefly describes the content of these laws, regulations or policies:

Drug users- Selling, possessing and using hard drugs are illegal.
MSM- Sections 365 and 365A of the penal code criminalize sexual acts between two consenting adults of same sex.
Sex worker- According to the vagrant ordinance soliciting for sex is illegal.

Briefly comment on how they pose barriers:

Reaching target populations for preventive activities is difficult due to above laws as these groups operate in a clandestine manner are hid.
Prison inmates – homosexuality is illegal therefore condom promotion is not allowed in prisons.
However, there is no discrimination for accessibility and availability of HIV preventive treatment and care services for these high risk groups

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes **X**	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes **X**	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes **X**	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs **X**	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes **X**	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes **X**	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes **X**	No

IF YES, for which population groups?
Sex workers
MSM
Drug users
Prisoners
Migrant workers, ANC antenatal mothers , Youth
Briefly explain how this information is used:

This information is used for planning of preventive programmes. E.g. an advocacy programme for police officers was commenced to reduce obstacles for condom promotion and to reduce harassment of sex workers.
To decide on priority areas for action when developing the proposal for global fund Round 9 grant

(c) Is coverage monitored by geographical area?

Yes **X**	No

IF YES, at which geographical levels (provincial, district, other)?

Provincial and district levels

Briefly explain how this information is used:

Plan provincial preventive programmes, advocacy for district and provincial AIDs committees, allocate resources, capacity building of staff

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes **X**	No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?

Very poor	0	1	2	3	4	5	6	7	8 **X**	9	10	Excellent

Since 2007, what have been key achievements in this area:
Training of healthcare workers in counseling, behavior change communication
Improvement of clinic space in the main ART center in Colombo
An ART monitoring system is being updated based on WHO ART monitoring system.

What are remaining challenges in this area:

Establishment of ART centers in other provincial hospitals as stipulated in targets, provision of ART, management of STI , screening o antenatal mothers for syphyles, prevents M-T-C-T
Establishment of diagnostic tests for monitoring clinical status including opportunistic infections in ART centers

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes **X**	No
Other high officials	Yes **X**	No
Other officials in regions and/or districts	Yes **X**	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes **X**	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 ***IF YES***, when was it created?
Year: **1988** *[write in]*
2.2 ***IF YES***, who is the Chair?
Name: **Dr Nihal Jayathilake** Position/Title: **Acting Secretary of Health**
2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes **X**	No
have active government leadership and participation?	Yes **X**	No
have a defined membership? ***IF YES***, how many members? *[write in]* ***35***	Yes **X**	No
include civil society representatives? ***IF YES***, how many? *[write in]* ***10***	Yes **X**	No
include people living with HIV? ***IF YES***, how many? *[write in]* ***2***	Yes **X**	No
include the private sector?	**Yes X**	No
have an action plan?	Yes	No **X**
have a functional Secretariat?	Yes **X**	No
meet at least quarterly?	Yes	No **X**
review actions on policy decisions regularly?	Yes **X**	No
actively promote policy decisions?	Yes **X**	No
provide opportunity for civil society to influence decision-making?	Yes **X**	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes **X**	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes **X**	No	NA

IF YES, briefly describe the main achievements:

National strategic plan was approved , Identified key policy measures to target MARP and to deliver ART. Appointed subcommittees for prevention , care support and treatment(laboratory, counselling and testing), policy law and ethics, communication and advocacy, multisectoral response (including civil society and other sectors, strategic information (research , surveillance and M&E) to make recommendations to the NAC

Briefly describe the main challenges:

A major Challenge is to continue participation of all stakeholders, overcoming the complacency while targeting high risk populations due to prevailing Low prevalence.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?
Percentage: *[write in] To complete after financial assessment*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes **X**	No
Technical guidance	Yes **X**	No
Procurement and distribution of drugs or other supplies	Yes **X**	No
Coordination with other implementing partners	Yes **X**	No
Capacity-building	Yes **X**	No
Other: *[write in]* ***(engaging in National AIDS events)***	Yes **X**	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No **X**

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Overall, how would you rate the *political support* for the HIV programme in 2009?

Very poor	0	1	2	3	4	5	6	7	8 **X**	9	10	Excellent

Since 2007, what have been key achievements in this area:

-Ministers of Education, Minister of Plantation sector, Governor and Chief Minister of Sabaragamuwa province have given their full commitment for the implementation of the STI/HIV/AIDS prevention programmes in schools through life skills from Grade 10-13 under the GFATM round 6 in the Sabaragamuwa province since 2008. This was achieved through the advocacy role played by the Minister of Health and his high ranking officer and the NSACP.

- The Minister of Education has agreed to revise the school curriculum in relation to HIV/AIDS with the next curriculum change in 2012. Currently, the STI/HIV/AIDS school education programme through life skills development is taking place through the health and physical science stream in all the state sector schools from Grade 6-11. Since these are not compulsory subjects (optional), around 60% of school children will not benefit from this approach. In 2012 the STI/HIV/AIDS education through life skills development will be addressed through the subject of science as it is a compulsory subject from Grade 6-11. This was achieved during the negotiations made by the Minister of Healthcare & Nutrition and officials.

- Minster of Labour has given leadership to prepare a tripartite declaration on HIV/AIDS in the world of work with the aim of trade unions to provide advocacy, create awareness and to launch campaigns offering solidarity and provide care and support to affected families and build partnership with local and international institutions as part of the national response.

- Minister of Foreign Employment and Promotion has agreed to continue pre-departure HIV AIDS knowledge and skills development programme through its 34 training institutes.

- Influence of the Minister of Finance has expedited the procurement of antiretroviral drugs.

What are remaining challenges in this area:

-To convince other political leaders of the importance of addressing issues on HIV/AIDS.

-To make available enough resources for curriculum development and capacity building in terms of teacher training, development of training modules and relevant IEC material to reach out as a national programme which covers all schools.

-To advocate returning migrant workers to undergo voluntary HIV testing (significant number of reported HIV cases has a history of working in Middle Eastern countries)
-Secure funds to continue to provide ART with prolonged survival of patients and increased detection of new patients as the policy is to provide ART to all eligible persons with HIV , and for prevention of MTCT and for PEP

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes **X**	No	NA

1.1 ***IF YES***, what key messages are explicitly promoted?

 Check for key message explicitly promoted

a. Be sexually abstinent	**X**
b. Delay sexual debut	**X**
c. Be faithful	**X**
d. Reduce the number of sexual partners	**X**
e. Use condoms consistently	**X**
f. Engage in safe(r) sex	**X**
g. Avoid commercial sex	**X**
h. Abstain from injecting drugs	**X**
i. Use clean needles and syringes	-
j. Fight against violence against women	**X**
k. Greater acceptance and involvement of people living with HIV	**X**
l. Greater involvement of men in reproductive health programmes	**X**
m. Males to get circumcised under medical supervision	-
n. Know your HIV status	**X**
o. Prevent mother-to-child transmission of HIV	**X**
Other: *[write in]* -	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes **X**	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes **X**	No	NA

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes	No **X**
secondary schools?	Yes **X**	No
teacher training?	Yes **X**	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes **X**	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes **X**	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes **X**	No

IF NO, briefly explain:

3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?
 Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations *(write in)
Targeted information on risk reduction and HIV education	**X**	**X**	**X**	**X**	**X**	Beach boys, External migrant workers
Stigma and discrimination reduction	**X**	**X**	**X**	**X**	**X**	,,
Condom promotion	**X**	**X**	**X**	**X**	**X**	,,
HIV testing and counselling	**X**	**X**	**X**	**X**	**X**	,,
Reproductive health, including sexually transmitted infections prevention and treatment	**X**	**X**	**X**	**X**	**X**	,,
Vulnerability reduction (e.g. income generation)	NA	NA	-	NA	NA	-
Drug substitution therapy	-	NA	NA	NA	NA	-
Needle & syringe exchange	-	NA	NA	NA	NA	-

IDU*=injecting drug users MSM**=men who have sex with men

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?

Very poor	0	1	2	3	4	5	6	7	8	9 **X**	10	Excellent

Since 2007, what have been key achievements in this area:
Increase coverage of preventive activities
Promoting HIV testing and accessing treatment and support.

What are remaining challenges in this area:

To develop a policy or strategy for IDU. However, currently estimated IDU population size is small.

4. Has the country identified specific needs for HIV prevention programmes?

Yes **X**	No

IF YES, how were these specific needs determined?

Recommendations of external review of national HIV response in 2006
Series of consultations with all stakeholders prior to the development of national strategic plan.
Epidemiological data
Programme data
Special surveys

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety	*Agree* **X**	*Don't Agree*	*NA*
Universal precautions in health care settings	Agree **X**	Don't Agree	NA
Prevention of mother-to-child transmission of HIV	Agree **X**	Don't Agree	NA
IEC* on risk reduction	Agree **X**	Don't Agree	NA
IEC* on stigma and discrimination reduction	Agree **X**	Don't Agree	NA
Condom promotion	Agree **X**	Don't Agree	NA
HIV testing and counselling	Agree **X**	Don't Agree	NA
Harm reduction for injecting drug users	Agree	Don't Agree	NA **X**
Risk reduction for men who have sex with men	Agree	Don't Agree **X**	NA
Risk reduction for sex workers	Agree	Don't Agree **X**	NA
Reproductive health services including sexually transmitted infections prevention and treatment	Agree **X**	Don't Agree	NA
School-based HIV education for young people	Agree **X**	Don't Agree	NA
HIV prevention for out-of-school young people	Agree	Don't Agree **X**	NA
HIV prevention in the workplace	Agree	Don't Agree **X**	NA
Other: *[write in]*	Agree	Don't Agree	NA

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

Very poor	0	1	2	3	4	5	6	7	8 **X**	9	10	Excellent

Since 2007, what have been key achievements in this area:

- 100% screening of donated blood for HIV in a quality assured manner.
- Opt-out HIV testing commenced for all antenatal mothers in one of premier maternity hospitals in the capital city.
-Expansion of drug rehabilitation centers by National Dangerous Drug Control Board.
- HIV prevention programmes were commenced for drug users via civil society involvement under the UNODC project.
- Condoms were distributed free of charge to MARPS at drop-in-centers
- Voluntary counselling and referral centers were established in the plantation sector under GFATM round 6.
- National consultation on MSM needs held in 2009.
- HIV prevention programme in schools in Sabaragamua province commenced under GFATM round 6.
-Production of -IEC material , leaflets, videos, documentaries for target populations and general population on safe sex, ABC of prevention .
-Community participation (slum population, prisoners , youth) in world AIDS day activities for delivering key messages.

What are remaining challenges in this area:

Introducing harm reduction practices.
Dealing with legal barriers for prevention efforts addressing MARPs

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes **X**	No

1.1 IF YES, does it address barriers for women?

Yes **X**	No

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes **X**	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes **X**	No

IF YES, how were these determined?

The care and treatment subcommittee of the NAC identified major policy issues and addressed them through National AIDS committee. HIV/AIDS patients are provided ARV, depending on the medical eligibility criteria. Positive patient associations are empowered and actively involved in provision of care. Clinicians were trained to be on alert to identify symptomatic patients in healthcare settings.

HIV surveillance and case reporting system were strengthened to assess the treatment and care needs.

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree **X**	Don't Agree	N/A
Nutritional care	Agree **X**	Don't Agree	N/A
Paediatric AIDS treatment	Agree **X**	Don't Agree	N/A
Sexually transmitted infection management	Agree **X**	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree **X**	Don't Agree	N/A
Home-based care	Agree **X**	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree **X**	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree **X**	Don't Agree	N/A
TB screening for HIV-infected people	Agree **X**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree **X**	N/A
TB infection control in HIV treatment and care facilities	Agree **X**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree **X**	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree **X**	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A **X**
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree **X**	N/A
Other: [write in]	Agree	Don't Agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes **X**	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes **X**	No

IF YES, for which commodities?: [write in]

ARV, Condoms

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

Very poor	0	1	2	3	4	5	6	7 **X**	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

-Supply of uninterrupted line of ARV drugs to provinces has been ensured.
-Expansion of ARV centres into the provinces.
-Empowerment and capacity building of positive people groups have been strengthened.
-Dissemination of knowledge and increase of clinical alertness among clinicians and health care professionals were carried out since 2007 and as a result diagnosis of HIV infections among the patients who are in symptomatic stages has been satisfactory.
- Introduction of second-line drugs and increase the number of first-line drugs in ART centres.

What are remaining challenges in this area:

-Expansion of ARV centres to remaining provinces.
-Reduction of stigma and discrimination.
-Integration of management of AIDS patients to the existing healthcare setting.
- Continuous update of knowledge of health care providers in management of HIV/AIDS patients

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	NA **X**

5.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No **X**

5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? % [write in]

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

Very poor	0	1	2	3	4 **X**	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

Few CSOs have come forward to take care of these children. At present it is at a manageable level as the number of affected children are few.
More paediatric formula are available

What are remaining challenges in this area:

Lack of proper statistics about OVCs
Capacity building of CSOs who are willing to provide care for OVCs.
Some PLHIV do not like CSOs visiting for home based care.

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes **X**	In progress	No

IF NO, briefly describe the challenges:

1.1 IF YES, years covered: [write in] **2007-2011**

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes	No **X**

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes **X**	No

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners **X**	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy		
IF YES, does it address:	Yes **X**	No
routine programme monitoring	Yes **X**	No
behavioural surveys	Yes **X**	No
HIV surveillance	Yes **X**	No
Evaluation / research studies	Yes **X**	No
a well-defined standardised set of indicators	Yes **X**	No
guidelines on tools for data collection	Yes	No **X**
a strategy for assessing data quality (i.e., validity, reliability)	Yes	No **X**
a data analysis strategy	Yes	No **X**
a data dissemination and use strategy	Yes	No **X**

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No **X**

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M& E activities? % [write in]

3.2 IF YES, has full funding been secured?

Yes	No

IF NO, briefly describe the challenges:

No routine budget allocation from the ministry of health funds for monitoring and evaluation activities.
Funding depend mainly on donor funds. However, there are limited donor funds in the reporting period. Lack of sustainability of the activities initiated for M & E. e.g. No funds available for software and Web updates, no funds to get professional services, e.g. IT professional and Statistician's services.
To streamline flow of data from CSOs and donor agencies to the national programme.

3.3 IF YES, are M&E expenditures being monitored?

Yes	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes **X**	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:
During external reviews.

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes **X**	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit?

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	No **X**
in the Ministry of Health? **(National STD/AIDS Control Programme)**	Yes **X**	No
Elsewhere? [write in]	Yes	No **X**

5.2 IF YES, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: **5**		
Position: [write in] **Coordinator**	Full time/part time? **Full time**	Since when ? **2009**
Position: [write in] **Medical officer**	Full time/part time? **Full time**	Since when ? **2008**
[Add as many as needed] **Public Health Nursing officer** **Public Health Inspector x2**	 **Full time** **Full time**	 **2008** **2008**
Number of temporary staff:		
Position: [write in]	Full time/part time?	Since when ?
Position: [write in] **GFATM M&E officer**	Full time/part time? **Full time**	Since when ? **2008**
[Add as many as needed]		

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No **X**

IF YES, briefly describe the data-sharing mechanisms: What are the major challenges? **-Currently routine data are collected only from public STD clinics on a quarterly basis. However this data is collected and submitted manually. STD clinics have limited IT facilities.** **-Need to establish a system to get down essential data from CSOs and other stakeholders.** **-Need to build the capacity of M&E unit.** **-Need to have uninterrupted and sufficient funds to carry out M&E activities.** **- Private Hospitals Act yet to be approved by the Cabinet. So it is difficult to get health related data from private sector institutions.**

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No **X**	Yes, but meets irregularly	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

7. Is there a central national database with HIV- related data?

Yes **X**	No

7.1 IF YES, briefly describe the national database and who manages it [write in]
SIM unit and the epidemiologist of National STD/AIDS control programme maintain a simple database for HIV and STIs.

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?
a. Yes, all of the above
b. Yes, but only some of the above: [write in] **X Some of the target populations and some of geographical areas.**
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes **X**	No
At subnational level IF yes , at what level(s) **MOH level (medical officer of health) and district level**	Yes **X**	No

(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No **X**

9. To what extent are M&E data used
9.1 in developing / revising the national AIDS strategy?

Low	0	1	2	3	4 **X**	5	High

Provide a specific example:

To prepare National strategic plan 2007-2011
To write proposal for GFATM grants.
To project HIV epidemic in the country
The strategic area of Prevention - Prevention interventions aimed at target populations (MSM, CSW, Prisoners) as a priority area in under
Under care and treatment -To strengthen VCT to increase uptake of testing and identify HIV positives early by training doctors to have a high index of suspicion and secure funds for ART
Strategic information – Carry out size estimations of risk populations to set targets to increase the coverage

What are the main challenges, if any?

Lack of data flow to the National programme from all stakeholders,
Surveys conducted on selected populations and using sampling methods which cannot be generalised to the specific populations, and thus data cannot be used for national planning and implementation.
-Lack of data use, in the absence of a standard system for dissemination even the available data cannot be accessed by the relevant stakeholders.

However amid these constraints HIV and STI surveillance data are disseminated by annual reports and quarterly reports through the web site of the national programme whenever facilities to update the website are available Maintaining the website is a challenge with lack of continuing funds and professional services.

9.2 for resource allocation?:

Low	0	1	2	3 **X**	4	5	High

Provide a specific example:

To prepare GFATM proposal, projections and estimates of PLWHA , programme routine data on PMTCT, Survival , defaulters and morbidity , side effects and drug resistance (clinical failure) for estimating budget for ART needs – prevalence data and size of populations were used to plan targets and coverage for MSM and sex workers
Data gaps identified and future design of strengthening strategic information IBBS, operational research and mapping of target populations, and in M&E
Financial analysis – to guide resource allocation
What are the main challenges, if any?
Financial gap analysis –No up-to-date national health accounts /provincial level spending
Lack of data on funds spent on specific areas of prevention especially by civil society

9.3 For programme improvement?:

Low	0	1	2	3 **X**	4	5	High

Provide a specific example:

Strengthening human resource
To restructure the NAC and its subcommittees
Streamlining of staff needs –on the recommendation of function task analysis
New cadre projections were identified
Training needs identified

What are the main challenges, if any?

Certain activities were commenced however sustaining these are a challenge due to lack of funds and manpower.
The existing provincial health information systems are not linked to the central M& E unit. The peripheral STD clinics do not have a proper M&E system
To have a simple national accounting system, that enables tracking expenditure by strategic areas from all partners, government /non government to evaluate the cost effectiveness and cost-benefit.

10. Is there a plan for increasing human capacity in M&E at national, sub national and service-delivery levels?:
a. Yes, at all levels **X**
b. Yes, but only addressing some levels: [write in]
c. No

10.1 In the last year, was training in M&E conducted

At national level?	Yes **X**	No
IF YES, Number trained: [write in] 20		
At subnational level?	Yes **X**	No
IF YES, Number trained: [write in] 60		
At service delivery level including civil society?	Yes	No **X**
IF YES, Number trained: [write in]		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes	No **X**

IF YES, describe what types of activities: [write in]

Overall, how would you rate the M&E efforts of the HIV programme in 2009?

Very poor	0	1	2	3	4	5	6	7 **X**	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

Allocation of a physical area and provision of infrastructure for a Strategic Information Unit
Identification of full time staff for the unit.
Training of staff
Preparation of a draft M&E plan
Population size estimation by mapping initiated.
Existing M&E system for the network of STD clinic updated.
What are remaining challenges in this area:

Allocation of sufficient funds for M&E area
Need to prioritize M&E activities
Getting financial and professional support for software updates and web development and maintenance

Annex 3

National Composite policy index questionnaire - Part B

[Administered to representatives from civil society organizations, Bilateral agencies and UN organizations]

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	**X** No

1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision: [write in]

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

X Yes	No

2.1 IF YES, for which populations?

a. Women	**X** Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	**X** No
d. Men who have sex with men	Yes	**X** No
e. Sex Workers	Yes	**X** No
f. Prison inmates	Yes	**X** No
g. Migrants/mobile populations	**X** Yes	No
h. Other: [write in]	Yes	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

1. Sri Lanka is a signatory to the CEDAW (Convention Against the Elimination of All Forms of Discrimination Against Women) that is bound to follow the reporting procedures in relation to non discrimination/protection of women.
2. The labor migration law provides for the protection and rights of all migrant workers and their families. However being HIV negative is a prerequisite for employment abroad largely due to host country regulations.
3. young people: The current Health policy includes the health of young persons, however, no separate youth policy exists. There is also a policy on the health of young person's currently in draft form. This policy outlines the need for compressive sexual and reproductive health education including HIV, access to youth friendly health services for young people as well as increased youth participation.

Briefly describe the content of these laws:

1. The constitution of Sri Lanka-fundamental rights provides for affirmative action through laws for women, children and disabled persons.
2. The policy states that migrant workers are entitled to a variety of fundamental human rights, migrant specific rights and labor rights in the workplace as articulated in the ILO multilateral framework on labor migration.

Briefly comment on the degree to which they are currently implemented:

1. CEDAW is integrated through enforcing legislation such as the Domestic Violence act, Women's Charter
2. One day training for migrant domestic workers is provided by the national body, Sri Lanka Foreign Employment Bureau which can be availed by those who register through the bureau. Male migrants departing to South Korea also received one day training. However there a large number of documented, undocumented and sponsored migrant workers who do not receive any training what so ever.
3. The ILO code of practice relating to HIV and AIDS at the workplace is enforced through the collaboration with the Employers Federation of Ceylon (EFC) trade unions and ministry of labor
4. Unfortunately the Population and Reproductive Health Policy is yet to be implemented successfully.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

X Yes	No

3.1 IF YES, for which subpopulations?

a. Women	**X** Yes	No
b. Young people	Yes	**X** No
c. Injecting drug users	**X** Yes	No
d. Men who have sex with men	**X** Yes	No
e. Sex Workers	**X** Yes	No
f. Prison inmates	**X** Yes	No
g. Migrants/mobile populations	Yes	**X** No
h. Other: [write in]	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies:
Women
As per the vagrants ordinance the police has the authority to arrest sex workers.

Men who have sex with men
1. Homosexuality is a criminal offence under Section 365 and 365A of the penal code.
2. Section 365 and 365A of the penal code criminalizes sexual acts between 2 consenting adults of the same sex.

Sex Workers
Under the brothel house ordinance criminalize the sex work

Migrant workers
The Sri Lanka government does not impose mandatory HIV testing to migrant populations. However, since GAMCA is the only body designated by the Gulf States to conduct medical examinations, a mandatory HIV test is conducted for all migrant workers to the Gulf violating international conventions.

Briefly comment on how they pose barriers:

1. Although, the relevant penal provisions are rarely used, their existence contributes to the ongoing stigma and discrimination these groups face in the community and harassment in the hands of law enforcement agents.
2. Legal provisions drive the MSM community and commercial sex workers underground.
3. The sweeping statements of the penal code address alleged 'indecency' of 'unnatural' sex leads to criminalize the LGBTIQ community.
4. As sex workers find 'quick and easy' ways to avoid the police, they do not want to keep condoms with them as it proves their status. It de-motivates condom use among sex workers.
5. If one is found to be HIV positive during the testing process she/he is terminated from employment in the Gulf and that prevents a person to motivate for VCCT.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

X Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

1. **The National AIDS Strategic Plan 2007-2011 clearly outlines the following four guiding principles which apply to each of the strategic areas of the strategy and affect national planning and service delivery equally as cross cutting concerns;**

i) Strategies based on evidence
ii) Respect for human rights
iii) Gender considerations
iv) Involvement of communities and people living with HIV

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes	**X** No

IF YES, briefly describe this mechanism

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

X Yes	No

IF YES, describe some examples:

1. The National HIV/AIDS Strategic Plan was developed by involving key members and vulnerable communities and organizations as well as other CSO's working on the HIV response including faith based organizations, trade unions etc.
2. The national labor migration policy and national tripartite declaration on HIV was also developed by involving tripartite representatives as per the ILO process.
3. . However, the outcome and implementation of such strategic plans and polices are not always shared and discussed in an inclusive way.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	**X** Yes	No
b. Antiretroviral treatment	**X** Yes	No
c. HIV-related care and support interventions	Yes	**X** No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations: **1. Even though the national policy on HIV is not endorsed, the National Strategic plan states services are provided free for charge by government. However, some of these services are confined to Colombo and have not been decentralized.** **2. CSOs are not empowered to conduct many services relating to HIV care and support.** **3. Most HIV related care and support interventions are conducted by positive network organizations and not by the government though the infectious disease hospital has a dedicated section for PLHIVs.**

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

X Yes	No

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

X Yes	No

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

X Yes	No

IF YES, briefly describe the content of this policy: **1. The National HIV/AIDS Strategic Plan 2007-2011 states in section 5 .2 and 5.3 that MARPs have access to prevention, treatment and care programs.**

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	**X** No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?

X Yes	No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	**X** No

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	**X** No

IF YES, describe the approach and effectiveness of this review committee:

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	**X** No

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	**X** No

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	**X** No

IF YES on any of the above questions, describe some examples:

13. In the last 2 years, have members of the judiciary (including labor courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes	**X** No

14.Are the following legal support services available in the country?
– Legal aid systems for HIV casework

Yes	**X** No

– Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV

Yes	**X** No

– Programmes to educate, raise awareness among people living with HIV concerning their rights

X Yes	No

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

X Yes	No

IF YES, what types of programmes?

Media	**X** Yes	No
School education	**X** Yes	No
Personalities regularly speaking out	**X** Yes	No
Other: **[Workshops, seminars and lecturers] Law enforcement agents: police**	**X** Yes	No

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

Very poor	0	1	**X** 2	3	4	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

1. A new labor migration policy was introduced.
2. Workplace education program facilitated development of 14 company policies on AIDS based on ILO code of practice in the private sector.
3. National Tripartite Declaration on HIV and AIDS and Trade Union policy on HIV and AIDS were launched.
3. A sex workers mapping exercise was carried out in four main districts of the country for policy interventions.
4. The school education program has been implemented with training of teachers.
5. A MSM mapping exercise was carried out in two districts

What are remaining challenges in this area:

1 The national AIDS policy is not endorsed yet.
2. Sri Lanka is a high labor exporting country. Evidence shows that there are growing numbers of HIV positive migrant workers in the country due to their vulnerabilities. Currently migrants are not considered as MARPS. This fact itself of giving less prominence to this group leading to greater risk and vulnerability.
3. Issues of IDUs are not adequately considered in national drug policy.
4. Policies on SWs, MSMs and LGBT population groups should be seriously considered with a greater political commitment.
4. the current penal code laws for SWs, DUs and MSMs need review/removal as they present barriers to prevention.
5. Civil society engagement in planning and implementation of national HIV policies and programme should be further strengthened.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

Very poor	0	1	2	**X** 3	4	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

The national labor migration policy is been put to practice and key stakeholder partners educated about its relevance.

What are remaining challenges in this area:

A national youth policy with a rights based SRH and HIV

II. CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low	0	1	2	**X** 3	4	5	High

Comments and examples:
CSOs are progressively engaged in policy formulation but their voices to be further strengthened. However, the access to change political will is limited as there is indecision in government to change some policy interventions for fear of reprisal. Furthermore, civil society lacks the dynamism seen in other parts of south Asia mainly because of the general mistrust and anti NGO sentiments of certain factions

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low	0	1	**X** 2	3	4	5	High

Comments and examples:

There is limited involvement by CSO representatives including MARPs in planning, budgeting and reviewing drafts due to the power imbalance between government and civil society. Barriers include: language and stigma

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

Low	0	1	2	**X** 3	4	5	High

b. the national AIDS budget?

Low	0	**X** 1	2	3	4	5	High

c. national AIDS reports?

Low	0	1	**X** 2	3	4	5	High

Comments and examples:

Services provided by the civil society is not adequately recognized by government and national budget has limited contribution to services provided by civil society

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

Low	0	**X** 1	2	3	4	5	High

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low	0	**X** 1	2	3	4	5	High

c. M&E efforts at local level?

Low	**X** 0	1	2	3	4	5	High

Comments and examples:

Transparency in M&E process is limited and CSOs do not have adequate opportunity to engage in the M&E process. However UNGASS working group has equal representation from civil society and government

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low	0	1	2	**X** 3	4	5	High

Comments and examples:

There is a diverse group of CSOs who are working on the AIDS response but the involvement of faith based organizations is still limited

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low	0	1	**X** 2	3	4	5	High

b. adequate technical support to implement its HIV activities?

Low	0	1	**X** 2	3	4	5	High

Comments and examples:

1. Funds released through the Global Fund and World Bank through the government has been limited during the past two years.
2. CSOs rely mostly on multilateral agencies and other INGOs for funding their HIV intervention programs.
3. UN agencies provide some technical assistance for specialized projects by way of hiring technical experts and in country training or seminars.
4. Capacity of civil society was developed through foreign and local training and providing expertise on organizational management.
Civil society member participated in regional police meeting
Two civil society members participated in CAA recommendation launch and local CSO consultation held in Sri Lanka. CAA report was translated to local languages.
World Bank supported Lanka Plus to conduct income generation activities through marketplace programmes. Lanka Plus participated in capacity development programme
CSO strengthening project was initiated through ICOMP and selected three CSOs from Sri Lanka.
CSO team was sent on a study tour on sex work to India (UNFPA)
Civil society member was trained on UNGASS reporting and engage in organizing civil society response in UNGASS reporting process
UNFPA supports a network of 7 CSOs engaged in HIV prevention in sex work. The support includes the funding of a drop in centre for sex workers in Colombo, outreach workers for condom promotion and clinic referrals.
Law enforcement agents such as the police are also being sensitized by the NSACP with support from UNFPA.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	**X 51-75%**	>75%
Prevention for most-at-risk-populations				
- Injecting drug users	**X <25%**	25-50%	51-75%	>75%
- Men who have sex with men	<25%	**X 25-50%**	51-75%	>75%
- Sex workers	<25%	**X 25-50%**	51-75%	>75%
Testing and Counseling	**X <25%**	25-50%	51-75%	>75%
Reduction of Stigma and Discrimination	<25%	**X 25-50%**	51-75%	>75%
Clinical services (ART/OI)*	**X <25%**	25-50%	51-75%	>75%

Home-based care	**X <25%**	25-50%	51-75%	>75%
Program for OVC** - Not applicable	**X <25%**	25-50%	51-75%	>75%

*ART = Antiretroviral Therapy; OI=Opportunistic infections
**OVC = Orphans and other vulnerable children

Overall, how would you rate the efforts to increase civil society participation in 2009?

Very poor	0	1	2	3	**X** 4	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

1. Involvement of the civil society in national level activities – Mapping and size estimations of MSM and Sex workers in 4 districts across the island, conduct stigma index on HIV related stigma and discrimination
2. Significant representation of civil society in national level planning and strategy development.

What are remaining challenges in this area:
1. Lack of participation of rural based CSOs.
2. Need to strengthen networking and linkages of CSOs working on HIV.
3. Need to create and strengthen additional civil society groups led by MARPS.

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

X Yes	No

IF YES, how were these specific needs determined?

National strategic plan on HIV in Sri Lanka was developed with the broader consultation with all stakeholders including civil society organizations working with most-at-risk and vulnerable populations.

IF NO, how are HIV prevention programmes being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	**X** Agree	Don't Agree	NA
Universal precautions in health care settings	**X** Agree	Don't Agree	NA
Prevention of mother-to-child transmission of HIV	**X** Agree	Don't Agree	NA
IEC* on risk reduction	**X** Agree	Don't Agree	NA
IEC* on stigma and discrimination reduction	**X** Agree	Don't Agree	NA
Condom promotion	**X** Agree	Don't Agree	NA
HIV testing and counseling	**X** Agree	Don't Agree	NA
Harm reduction for injecting drug users	Agree	**X** Don't Agree	NA
Risk reduction for men who have sex with men	Agree	**X** Don't	NA

		Agree	
Risk reduction for sex workers	Agree	**X** Don't Agree	NA
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	**X** Don't Agree	NA
School-based HIV education for young people	Agree	**X** Don't Agree	NA
HIV Prevention for out-of-school young people	Agree	**X** Don't Agree	NA
HIV prevention in the workplace	Agree	**X** Don't Agree	NA
Other: [write in]	Agree	Don't Agree	NA

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

Very poor	0	1	2	3	**X** 4	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area?

1. GFATM proposal was well focused that targeted prevention activities among MARPS
2. UN agencies have provided technical and financial support for targeted prevention programmes of MARPs.
3. UN Cares programme was implemented in the UN system.
4. Other at risk population groups such as migrant workers, women and youth have been included in HIV interventions by CSOs.
5. More CSOs have successfully been able to work with MARPs

What are remaining challenges in this area?

1. Encourage the State to recognize fundamental rights of MARPs that will be useful in prevention efforts.
2. Establish an effective coordinating mechanism between government and civil society.
3. Lack of in-country financial commitment to continue the prevention progammes
4. Prevention programmes for youth and women are not adequate
5. Limited technical capacity of CSOs in programme planning and implementation

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	**X** No

IF YES, how were these specific needs determined?

IF NO, how are HIV treatment, care and support services being scaled-up?
There is hardly any strategic information available on the specific needs of HIV treatments care and support in Sri Lanka. But ARV and medical treatment is dispensed free of charge by the government health sector at present.

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	**X** Agree	Don't Agree	NA
Nutritional care	Agree	**X** Don't Agree	NA
Paediatric AIDS treatment	**X** Agree	Don't Agree	NA
Sexually transmitted infection management	**X** Agree	Don't Agree	NA
Psychosocial support for people living with HIV and their families	Agree	**X** Don't Agree	NA
Home-based care	Agree	**X** Don't Agree	NA
Palliative care and treatment of common HIV-related infections	**X** Agree	Don't Agree	NA
HIV testing and counseling for TB patients	**X** Agree	Don't Agree	NA
TB screening for HIV-infected people	**X** Agree	Don't Agree	NA
TB preventive therapy for HIV-infected people	Agree	**X** Don't Agree	NA
TB infection control in HIV treatment and care facilities	**X** Agree	Don't Agree	NA
Cotrimoxazole prophylaxis in HIV-infected people	**X** Agree	Don't Agree	NA
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	**X** Don't Agree	NA
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	**X** Don't Agree	NA
HIV care and support in the workplace (including alternative working arrangements)	Agree	**X** Don't Agree	NA
Other programmes: [write in]	Agree	Don't Agree	NA

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

Very poor	0	1	2	3	**X 4**	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

1. Emergence of new local STI clinics in a few districts with facilities.
2. ARV is dispensed free of charge

What are remaining challenges in this area:

1. Ensuring quality and quantity of palliative care facilities.
2. In-country financial resource mobilization ARV and care and support for PLHIV
3. Prevention actions are not sufficiently focused on behavior change of PLHIV
4. Information on HIV prevention and service are not adequately penetrated to the workplace.
5. GIPA training for PLHIV communities and affected families have not been adequately provided

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	**X** No	NA

2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? % [write in]

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

Very poor	0	1	2	3	4	5	6	7	8	9	10	Excellent

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area: