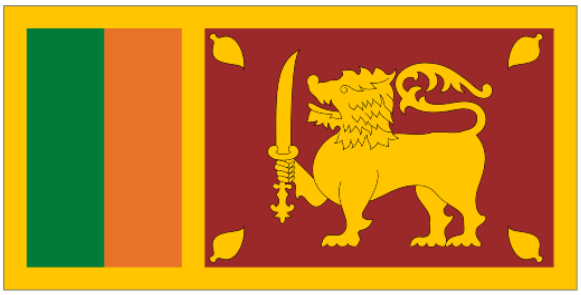
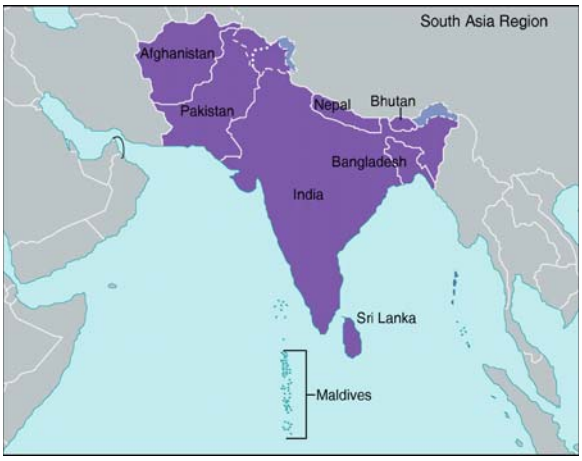
# HIV/AIDS in Sri Lanka

THE WORLD BANK August 2006






## The World Bank in South Asia

**Afghanistan**
**Bangladesh**
**Bhutan**
**India**
**Maldives**
**Nepal**
**Pakistan**
**Sri Lanka**

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Sri Lanka has a relatively small number of people living with HIV/AIDS, but high-risk behaviors that contribute to the spread of HIV are prevalent, making the country vulnerable to an increase in infections. Sri Lanka has a narrowing window of opportunity to forestall the spread of HIV among high-risk groups.

## STATE OF THE EPIDEMIC

According to UNAIDS, Sri Lanka has a relatively small number of HIV-infected people—about 5,000 adults. Since 1986, only 712 cases have been officially reported, with underreporting due mainly to limited availability of counseling and testing, fear associated with seeking services as well as the stigma and discrimination associated with being identified as HIV positive.

Of the total number of HIV cases reported from 1987 to 2000 in which the mode of transmission is known, 98 percent were sexually transmitted. Only a few cases of HIV transmission from mother to child and through blood transfusions have been reported and transmission through intravenous drug use has not yet been reported.

Because a large number of women travel to work in the Middle East, for which HIV testing is mandatory, more women than men have tested positive in Sri Lanka. The current ratio of HIV-positive men to women in Sri Lanka is reportedly 1.4 to 1, although in reality, there are probably far more men infected then women as in most early phase HIV epidemics.

## RISK AND VULNERABILITY

Despite an estimated low prevalence rate, there are mounting concerns because of the significant presence of risk factors and vulnerability.

L**ow Condom Use**: Although research on sexual behaviors has been limited, a few studies conducted suggest low condom use among men. For example, in 1997, only 4.7 percent of men between the ages of 15 and 49 in the rural area of Matale and 9.6 percent of men in the capital of Colombo reported ever using condoms, although about two thirds of them had heard about them. Among men who stated that they have had sex with casual partners during the last year, only 26.3 percent in Matale and 44.4 percent in Colombo reported using a condom.

**Commercial Sex:** It is estimated that about 30,000 women and girls and 15,000 boys work in the commercial sex industry in Sri Lanka. The risk of HIV spreading among sex workers is heightened by low condom use and high prevalence of sexually transmitted infections (STIs), which make a person more susceptible to contracting HIV. In one study, 45 percent of female sex workers had experienced multiple STIs, and 70 percent of male patients at STI clinics had reported frequenting sex workers. In addition, women and children in prostitution are considered most vulnerable to HIV infection because they often lack the ability or power to negotiate condom use with clients or to seek STI treatment. They are often "hidden," making it a challenge for HIV prevention services to reach them.

**Sexually Transmitted Infections (STIs)**: Every year, estimates of detected STI cases in Sri Lanka vary from about 60,000 to 200,000, of which only 10 to 15 percent are reported by government clinics. STIs facilitate the spread of HIV infection and serve as indicators for low condom use and other high-risk sexual behaviors.

There are significant structural and socioeconomic factors which put South Asia at risk for a full-blown AIDS epidemic.

More than 35 percent of the population lives below the poverty line;

Low levels of literacy;

Porous borders;

Rural to urban and intrastate migration of male populations;

Trafficking of women and girls into prostitution;

High stigma related to sex and sexuality;

Structured commercial sex and casual sex with non-regular partners;

Male resistance to condom use;

High prevalence of sexually transmitted infections (STIs);

Low status of women, leading to an inability to negotiate safe sex.

HIV/AIDS is a challenge that goes beyond the health sector. What is needed is the strategic involvement of all sectors – poverty reduction, education, transport and roads, urban and rural sectors, gender, social development and public health.
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**High Mobility**: Migration within Sri Lanka and emigration to the Middle East and neighboring countries is necessary for the economic survival of many households in both rural and urban areas. Thousands of women and men live away from their families as migrants abroad and as workers in Sri Lankan Free Trade Zones. Removal from traditional social structures, such as family and friends, has been shown to foster unsafe sexual practices, such as having multiple sexual partners and engaging in casual and commercial sex, as well as to increase vulnerability of women and girls to sexual abuse. An estimated 1.2 million Sri Lankans work in the Middle East and 79.1% of unskilled migrants are women. International female migrants account for more than 40% of reported HIV infections among females.

**Injecting Drug Users (IDUs)**: Sri Lanka has an estimated 30,000 drug users, of whom about 2 percent inject drugs. Although there have been no reported cases of HIV in this group thus far, its members are at high risk because of needle sharing. Drug users also often experience difficulty accessing information and services for both prevention and treatment.

**Low Levels of Awareness among Poor People**: HIV awareness and knowledge levels in underserved communities remain drastically low. Only 40 percent of women working in rural tea estates, for example, have even heard of HIV/AIDS, as compared to 90 percent of women in other rural and urban areas.

## NATIONAL RESPONSE TO HIV/AIDS

**Government.** In 1992, the Government of Sri Lanka initiated HIV prevention and control efforts through the National STI and AIDS Control Program (NSACP) of the Ministry of Health under the Director General of Health Services. In addition, the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis and Chest Diseases (NPTCCD) are strengthening their responses to reduce transmission and prevent further spread of HIV. These services are provided in collaboration with eight Provincial Directors of Health Services and the respective District staff. The NSACP in collaboration with the Provinces has made remarkable progress in institutionalizing HIV prevention activities and in providing care and treatment to people living with HIV. Some of these activities include a mass media communications strategy to improve the knowledge and awareness of HIV among the general population. In addition, Sri Lanka has a well established sero surveillance system and work is underway to establish second generation surveillance (behavioral) among vulnerable groups. The first round of the survey is expected to start by March, 2006. Furthermore, a Management Information System is being established currently linking all STI clinics in the country to the central NSACP based on a Monitoring and Evaluation Framework for HIV.

The NSACP has made significant progress in improving STI services by refurbishing STI clinics, providing equipment, and facilitating HIV prevention work conducted through contracted NGOs and through the Government Provincial and District Health authorities to reach vulnerable groups. The NSACP has also engaged 12 line Ministries including National Institute of Education, Ministry of Labour, Foreign Employment Bureau, Vocational Training Authority, Ministry of Fisheries, National Child Protection Authority, National Youth Services Council, Army, Navy, Air Force and the Police. This work includes advocacy, improving HIV prevention awareness and knowledge of facilities available, encouraging condom use in the military and introducing VCT facilities.

In addition, the program has helped to ensure blood safety by increasing the voluntary blood donation rates toward a 100 percent goal and through upgrading blood banks and transfusion screening for HIV. Furthermore, the NBTS has initiated a Communication Program through mass media to increase voluntary blood donation in the country and raise the level of awareness and knowledge of HIV/AIDS among the general population.

In addition to these primary prevention efforts initiated by the NSACP through the National HIV Prevention Project, the NSACP has now established Care and Treatment resources needed to make treatment available to the HIV positive patients who need treatment. In 2004, it was estimated that 100 people needed treatment and currently 62 people are registered and receiving care and treatment through the national Program.

**Nongovernmental Organizations (NGOs)**. Work of both local and international NGOs in the area of HIV/AIDS prevention in Sri Lanka has been limited, unlike that of other neighboring countries, such as India, Bangladesh, and Nepal. The NGO work remains largely uncoordinated, and its program coverage of high-risk populations is estimated to be less than 10 percent. Efforts are being undertaken to improve NGO collaboration and coordination with the government. Key actions needed are to increase the capacities of NGOs to work with vulnerable groups and of the government to systematically contract and fund NGOs.

## ISSUES AND CHALLENGES: PRIORITY AREAS

**Stigma and discrimination abound.** Reducing the stigma associated with HIV/AIDS in Sri Lanka will require greater involvement of civil society organizations, businesses, the entertainment industry, religious leaders, and the medical community. As respected opinion leaders, they can play an effective role in reducing harassment of groups promoting positive attitudes toward people with HIV and creating an enabling environment for prevention efforts. Training police to reduce harassment of vulnerable groups and engage HIV-positive groups are central to these efforts.

**The Health Ministry cannot do it alone.** Scaled-up prevention efforts require a multisectoral approach, involving other ministries and departments covering finance, education, agricultural extension, transportation, the police force, and the military, as well as partnering with NGOs, the private sector, and civil society organizations, such as trade unions. These organizations and institutions are better placed to mobilize and provide services to at-risk groups. As focusing on HIV prevention is relatively new, the capacity of these institutions needs rigorous strengthening.

Shift focus from inputs to outcomes. Monitoring and evaluation, including surveillance systems, need to be improved, particularly in collecting data, using such data for policy and program management decisions, and disseminating it. Reliable data on coverage and the impact of interventions on behavioral and biological outcomes is critical for mounting an effective nationwide response. Following WHO's guidelines to tailor surveillance activities according to the country-specific epidemic, Sri Lanka, with its low-level epidemic, is further expanding coverage of high-risk groups.

## WORLD BANK RESPONSE

From 1998 to 2002, the World Bank provided about $1 million of support each year to Sri Lanka's HIV/STD program through the Health Services Project, adding to the financial and technical assistance being provided by other multilateral and bilateral agencies, such as WHO and other UN agencies and the Japan Bank for International Cooperation.

The Government of Sri Lanka asked the World Bank to support strengthening the national program to control HIV/AIDS and STIs and in December 2002, the Bank's International Development Association (IDA) provided a $12.6 million grant to help finance the National HIV/AIDS Prevention Project. The Bank's support focuses on improving prevention efforts for highly vulnerable subpopulations and the general population, in particular youth; enhancing surveillance and monitoring and evaluation systems; reducing stigma and discrimination against people living with HIV and groups at highest risk; and addressing the synergy between tuberculosis and HIV.

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