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 had about 5,000 people living with HIV at the end of 2005. Officially reported cases are far fewer, with underreporting due mainly to limited availability of counseling and testing, fear associated with seeking services, and the stigma and discrimination associated with being identified as HIV positive. Of the reported HIV cases, the majority were transmitted through heterosexual sex (85 percent), although some transmission was reported through homosexual sex and through peri-natal transmission and blood products. Transmission through intravenous drug use has not yet been reported.

The ratio of HIV-positive men to women in Sri Lanka is 1.4 to 1. The proportion of women infected with HIV has been rising, from 21 percent (1987-91) to 47 percent (2002-05). Part of this increase is probably due to the increased testing of women over the last few years.

**RISK AND VULNERABILITY**

Despite the low HIV prevalence, there are concerns because of the presence of risk factors and vulnerability.

**Low Condom Use**: Although research on sexual behaviors has been limited, a few studies conducted suggest low condom use among men.

**Commercial Sex**: It is estimated that there are between 3,000 and 50,000 female sex workers in Sri Lanka. In addition, there are networks of men who have sex with men, who have multiple partners including paying clients. Preliminary findings from the 2006 BBS suggest that STIs among sex workers are relatively low, they see few clients per day, and there is reasonable condom use. Women and children engaged in sex work 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.

**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 percent of unskilled migrants are women.

**Injecting Drug Users (IDUs):**
According to UNAIDS, Sri Lanka has a high number of heroin users, and, although few of them currently inject drugs, if there were a substantial change in drug-use patterns to more injecting drug use, this would result in the increase in the number of people who are likely to be exposed to HIV. In addition, drug users often experience difficulty accessing information and services for both HIV 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 STD and AIDS Control Program (NSACP) of the Ministry of Health under the Director General of Health Services. In addition, the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis and Chest Diseases (NPTCCD) 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 undertaken HIV prevention activities (for example, a mass media communications strategy to improve the knowledge and awareness of HIV among the general population) and provides care and treatment to people living with HIV. In addition, Sri Lanka has a well established sero surveillance system, and second generation surveillance (behavioral) among vulnerable groups was conducted in 2006. Furthermore, a Management Information System is being established 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 established Care and Treatment resources needed to make treatment available to the HIV-positive patients who need treatment. UNAIDS estimates that 6 percent of HIV-infected women and men in Sri Lanka are receiving antiretroviral therapy.

**Nongovernmental Organizations (NGOs).** Work of both local and international NGOs in the area of HIV/AIDS prevention in Sri Lanka has been limited. 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.** Stigmatization and discrimination discourage demand for counseling, testing, and treatment. 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 AIDS 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. 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. Strenthened surveillance will be vital to detect potential changes in HIV prevalence and risk practices. Reliable data on coverage and the impact of interventions on behavioral and biological outcomes is critical for mounting an effective nationwide response. Coverage of key populations (female sex workers, men who have sex with men) with targeted prevention programs has remained very low. Prioritizing targeted interventions for people whose behavior puts them most at risk of exposure to HIV is crucial, and coverage of these groups with prevention efforts must be increased.
WORLD BANK RESPONSE

From 1998 to 2002, the World Bank provided about US$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 requested 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 US$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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