

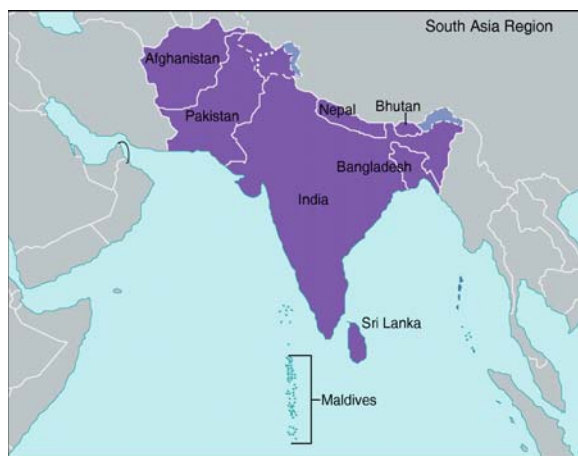
# HIV/AIDS in Sri Lanka

THE WORLD BANK

August 2008



Sri Lanka continues to have very low HIV prevalence. In low prevalence settings, the focus of HIV prevention programs should be the most-at-risk populations (MARPs). Data on HIV prevalence amongst MARPs in Sri Lanka is limited, with the exception of female sex workers. Prevalence among the latter is also low. However, data collected in the first Behavioral Surveillance Survey (BSS) of October 2006 through March 2007 indicate relatively high levels of risk behavior amongst MARPs. If these groups are not adequately addressed, Sri Lanka will be vulnerable to an increase in HIV infections. Sri Lanka has a narrowing window of opportunity to forestall the spread of HIV among high-risk groups.



## STATE OF THE EPIDEMIC

UNAIDS estimates that about 3,800 Sri Lankans were living with HIV at the end of 2007, yielding prevalence of less than 0.1 percent. As of December 2007, 957 reported cases of HIV in the country (an increase of 71 cases reported since June 2007) out of which 177 have died. Sixty percent of reported HIV cases are males, and more than half are from Colombo. Underreporting of cases is mainly due to low knowledge about how HIV is spread and barriers to seeking services due to stigma and discrimination. Most transmission is sexual, 4 percent is perinatal transmission, and only 1 percent through blood transfusion. Only one case of HIV acquisition through injecting drug use has 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 (1987-1991) to 42 percent (2007), in part because of increased testing of women over the last few years.

## The World Bank in South Asia

Afghanistan  
Bangladesh  
Bhutan  
India  
Maldives  
Nepal  
Pakistan  
Sri Lanka

\*This map was produced by the Map Design Unit of The World Bank. The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.

## RISK AND VULNERABILITY

Despite the low HIV prevalence, the presence of important risk factors in Sri Lanka suggests it may not be maintained if action is not taken. The key risk factors are:

**Low Condom Use:** The recent BSS noted condom use among most-at-risk groups is generally low (except among some subgroups of female sex workers when engaging in commercial sex). Men who have sex with men also have low condom use, as do drug users (although very few inject drugs).

**Commercial Sex:** Estimates of the number of female sex workers in Sri Lanka vary from 5,000 to 50,000 although the more likely number is around 30,000. In addition, there are networks of men who have sex

with men who have multiple partners including paying clients and women. Preliminary findings from the 2006 BSS suggest that STIs and HIV among female sex workers are relatively low, as they see few clients per day and have relatively high condom use. However, while reported symptoms of STIs were low, only about one-third knew women could be asymptomatic, and knowledge about how HIV is transmitted was low. 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:** Every year estimates of detected STI cases in Sri Lanka vary from about 60,000 to 200,000, of which only 10-15 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 rural and urban households. Thousands of women and men live away from their families as migrants abroad and as workers in Sri Lankan Free Trade Zones. An estimated 1.2 million Sri Lankans work in the Middle East and 79 percent of unskilled migrants are women. Removal from traditional social structures is believed 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. Very few, however, have tested positive.

**Injecting Drug Users (IDUs):** Current estimates of opiate users range from 30,000 to 240,000 out of which only 2 percent inject. However, an increase in drug injection could spark an epidemic. The BSS found that both knowledge about HIV transmission and that condom use were low among drug users. In addition, drug users often experience difficulty accessing information and services for both HIV prevention and treatment.

**Low Levels of Knowledge about how HIV is Transmitted:** Knowledge about HIV transmission was low among the populations surveyed in the BSS. This increases the potential for HIV to spread as the groups surveyed are the populations engaging in riskier behavior.

**High Levels of Stigma associated with PLWA:** The survey also indicated high levels of stigma towards PLWA among all groups. Stigma and discrimination discourage PLWA and others who fear they may be infected from seeking health care or from being tested. Moreover, they result in poor quality of care by health care workers.

## 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) strengthened 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 undertook HIV prevention activities (e.g., a mass media communications strategy to improve knowledge and awareness of HIV) and provides care and treatment to people living with HIV. In addition, Sri Lanka has a well established sero surveillance system, and second generation surveillance (behavioral) among vulnerable groups was conducted in 2006. 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 improved STI services by refurbishing STI clinics, providing equipment, and facilitating HIV prevention work conducted through contracted NGOs and through the Government Provincial and District Health authorities to reach vulnerable groups. The NSACP 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 among the armed services, and introducing voluntary counseling and testing (VCT) services.

The program has helped to ensure blood safety by increasing the voluntary blood donation rates, upgrading blood banks, and increasing transfusion screening for HIV. In addition, the NBTS has initiated a Communication Program through mass media to increase voluntary blood donation 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 established Care and Treatment resources needed to make antiretroviral therapy (ART) available to the HIV-positive patients who need treatment. As of April 2008, the NSACP Central STD Clinic followed up 423 patients (just over half of those currently infected), of whom 113 receive ART.

**Nongovernmental Organizations (NGOs):** Work of both local and international NGOs in the area of HIV 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

**Increase efforts to reach MARPs.** Sri Lanka continues to have very low HIV prevalence. In a low-prevalence context like Sri Lanka, programs must focus a large share of their efforts on prevention activities for the most at-risk populations, if an epidemic is to be averted. Most efforts to date have focused on the general population among whom transmission is low. Prevalence data on MARPs is also limited, but data collected through the BSS indicate these groups do engage in risky behavior and thus need to be reached. Coverage of key populations (female sex workers, men who have sex with men) with targeted prevention programs need to be prioritized.

**Stigma and discrimination must be reduced.** Stigmatization and discrimination discourage demand for counseling, testing, and treatment. Reducing the stigma associated with HIV and 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 towards 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.** Most at-risk groups are not likely to seek MOH services; therefore, the Ministry needs to partner with NGOs, some line ministries, such as armed forces and prisons department; private sector; and civil society organizations, such as trade unions to reach the at-risk populations. Although these organizations and institutions are better placed to mobilize and provide services to at-risk groups, their capacity needs strengthening.

**Shift focus from inputs to outcomes.** Monitoring and evaluation, including surveillance systems, need to be improved, particularly in collecting data, using data for policy and program management decisions, and disseminating it. Strengthened 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.

## 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 focused on improving prevention efforts for highly vulnerable subpopulations and the general population, 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. The project closed in June 2008.

Sri Lanka  
Ms. Chulie De Silva  
☎ 9411-5561-323  
✉ cdesilva@worldbank.org

Washington, DC  
Mr. Erik Nora  
☎ 1-202-458-4735  
✉ enora@worldbank.org

[www.worldbank.org/lk](http://www.worldbank.org/lk)  
[www.worldbank.org/sar aids](http://www.worldbank.org/sar aids)