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11/06/2003

Executive Director/UNAIDS
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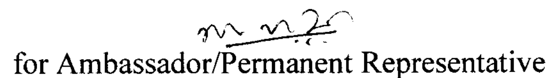
Attention: Mr. Tyszko
External Relation Officer

United Nations General Assembly Special Session (UNGASS) on HIV/AIDS

Please find enclosed, a copy of the Sri Lanka Country Report on follow up to the Declaration on Commitment on HIV/AIDS (UNGASS) received from the Director, STD/AIDS Control Programme of the Health Ministry of Sri Lanka.



for Ambassador/Permanent Representative

COUNTRY REPORT – SRI LANKA

ON

FOLLOW-UP TO THE DECLARATION ON COMMITMENT

ON

HIV/AIDS (UNGASS)

(Reporting Period: January – December 2002)

PREAMBLE

At the UN General Assembly Special Session (UNGASS) on HIV/AIDS held in June 2001, Sri Lanka was one of the 189 participating countries, which committed themselves to a comprehensive programme to fight HIV/AIDS, adopting a Declaration of Commitment. The Declaration established goals to achieve targets including the reduction of HIV infection among infants, young adults, and improvements to HIV/AIDS education, health care and treatment and orphan support. The declaration also included a pledge by the UN General Assembly to prepare a report from each participating country as well as guidelines on indicator construction, information on measurement tools, methods of measurement and reporting procedures.

Sri Lanka received the information regarding the report preparation very late and, therefore had only a short time frame for finalisation. The process to prepare the report was done through UNAIDS and its partners, and the National STD/HIV/AIDS Control Programme (NSACP), Ministry of Health. National information was collected in accordance with the procedures provided for reporting, based on the standard forms made available. However, it needs to be stated that much of the data needed was not available in the format required for the report in the current reporting system off the NSACP. Some of the information was not available as surveys needed to be carried out to gather such data. Obtaining financial data was limited by problems to collect such information from provinces and districts. Collection of such data will also need more financial resources. However, the preparation of the report was useful in that it served to identify certain gaps in the reporting system and database at the NSACP, which have been identified as a need, which should be addressed early to facilitate data collection for the proposed follow-up survey in 2005.

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Annex 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

The report was compiled with the concurrence of the UNAIDS Working Group, and partners under the chairmanship of the Director, National STD/AIDS Control Programme. Sri Lanka.

Attention

The nine forms relating to the National Programme and Behaviour Indicators could not be completed due to unavailability of data in the required formats and constraints in time. At present, the information system does not provide for the computation of indicators as requested in the UNGASS Declaration of Commitment document. In addition, select policy indicators are not relevant at present to the country. As an alternative, the current status of policies, strategies, activities, constraints in computing indicators and explanatory notes on separate policy indicators are provided.

I STATUS AT A GLANCE

NATIONAL COMMITMENT AND ACTION	
	1. National Composite Policy Index **78.9%**
	2.Government funds spent on HIV/AIDS **US$ 0.18 million (2002)**
NATIONAL PROGRAMME AND BEHAVIOUR	
Prevention	
	3. % of schools with teachers who have been trained in life skills based Education and who taught it during the last academic year. *
	4. % of large enterprises /companies that have HIV/AIDS workplace Policies and programmes *.
	5. % of HIV + pregnant women receiving a complete course of ARV Prophylaxis to reduce the risk of MTCT*
Care/Treatment	
	6. % of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled **100%**
	7. % of people with advanced HIV infection receiving ARV therapy *
Knowledge / Behaviour	
	8. % of respondents 15-24 years of age who both correctly identify ways of prevention the sexual transmission of HIV and who rejected major misconceptions about HIV transmission ** **(Target : 90% by 2005; 95% by 2005)**

Key : ** No data available. See explanatory notes*
*** Limited data available. See explanatory notes for each policy indicator*

Knowledge/ Behaviour	
	9. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner **
	10. % of injecting drug users who have adopted behaviours that reduce transmission of HIV - **not applicable to Sri Lanka at present**
Impact alleviation	
	11. Ration of orphans to non-orphaned children aged 10-14 years of age who are currently attending school - *
	12. % of young people aged 15-24 years of age who are HIV infected)* **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010**
	13. % of infants born to HIV infected mothers who are infected * **(Target: 20% reduction by 2005; 50% reduction by 2010)**

Key : * *No data available. See explanatory notes*
** *Limited data available. See explanatory notes for each policy indicator.*

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

The first case of HIV/AIDS in a Sri Lankan was reported in 1987 and the first indigenous transmission of HIV was reported in 1989. The National Working Group on HIV Estimates convened by the National STD/AIDS Control Programme (NSACP) estimates the current burden of disease as between 4700 (low) to 7200 (high). The corresponding UN estimates for Sri Lanka is around 4700. At end December 2002, the cumulative total of HIV positive persons reported to the NSACP was 455 (Table 1). Heterosexual transmission remains the dominant mode of spread (82%)

Table 1 – Country situation- reported HIV/AIDS cases at 2nd December 2002

Cumulative HIV cases end Dec2002	Cumulative HIV cases by sex		Cumulative AIDS cases	Cumulative AIDS deaths	Male: Female ratio of HIV cases
	Male	Female			
455	278	177	139	108	1.6:1

(Source – NSACP 2002)

Sri Lanka is considered a low prevalence country for HIV/AIDS but at high risk for a potential epidemic due to the following reasons : emerging sexually active youth population (young people aged 15-24 will represent about 16% of the total projected population of 20 million in 2005), increasing numbers of sex workers (currently estimate 30,000) an open economy (that has created large industrial zones with a estimated work force of over 100,000) overseas migration for employment (annually nearly 180,000 and mainly to the Middle Eastern countries), and large contingents of armed forces personnel consequent to the civil war in the North and East for nearly two decades and child exploitation and abuse. Injecting drug use is at present not reported as a problem in the country.

Since 1993, the NSACP has monitored the geographical temporal and demographic spread of HIV infection in the population through the annual HIV sero-sentinel surveillance survey. The survey adheres to the standard recommended WHO protocol for HIV sero-sentinel surveillance. Like in previous years, in 2002, three sentinel groups male and female STD clinic attendees, female sex workers and patients newly diagnosed as having TB were screened. In 2002 the number of sentinel sites was increased from 8 to10 to provide wider coverage of the population. In all three groups, persons aged 15 to 49 years were screened

Table 2 – HIV sero –sentinel surveillance 2002 - NSACP

Sentinel groups	**No. tested**	**No. positives**
Sex workers	1547	2
STD clinic attendees	5237	6
Diagnosed TB patients	1392	0
Total	**8176**	**8**

(Source – NSACP 2002)

There was no major change in trend, which is compatible with the low prevalence status of the country. In all three sentinel groups the prevalence among young people 15-24 years was zero. Antenatal clinic attendees were not a sentinel group in 2002.

Screening of antenatal clinic attendees as a sentinel group in the annual HIV sero-sentinel surveillance was discontinued as advised by the WHO since repeated surveys yielded zero prevalence. The NSACP carries out unlinked anonymous screening of VDRL samples from antenatal clinic attendees at the two premier maternity hospitals in Colombo. (Table 3)

Table 3 – Prevalence of HIV among antenatal clinic attendees at the two premier maternity Hospitals in Colombo

Year	**Number of VDRL samples screened**	**Number positive**
1999	14000	-
2000	30,906	2
2001	20,409	-
2002	17,601	-

Ad hoc surveillance of select vulnerable groups such as armed force, police personnel and prisoners have yielded negative results.
The implementation of behavioural surveillance commencing 2003, will complement the data obtained through HIV sero-sentinel surveillance and provide a more realistic understanding of the HIV status of the country.

HIV prevalence at a glance

% of young people 15-24 years of age who are HIV infected – **0% prevalence in 2002**

% of infants born to HIV infected mothers who are infected – no data available.

Source - NSACP

III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC.

1. National commitment and action

The Government of Sri Lanka (GoSL) is fully committed to the prevention and control of HIV/AIDS and will accord the highest priority to this goal not only within the health sector but also in other key sectors.
The National STD/AIDS Control Programme (NSACP), which comes under the purview of the Ministry of Health, is the key state programme spearheading the government thrust against HIV/AIDS. Other sectors such as labour, tourism education etc. are additional stakeholders in the multi-sectoral strategies being implemented at a national level for the prevention and control of HIV/AIDS.

The strategic response of the GoSL to the threat of HIV/AIDS has been the early adoption of the multisectoral approach that expands partnerships, facilitates policy development and utilisation of resources of the partner sectors. The partner sectors include the following - Education, Labour, Tourism, Armed Forces, Law enforcement, Justice, Media Information and Broadcasting, Policy planning and Implementation, External Resources, Social Services, Youth affairs, Non-governmental Organisations and Community based organisations, Public Administration Provincial Councils and Home Affairs, and the private enterprise sector. Representatives from these sectors are members of the National AIDS Committee (NAC) the policy formulating body of the Ministry of Health on HIV/AIDS.

The first Medium Plan (MTPI) and the National AIDS Committee (NAC) was formed in 1988 and was followed by the MTP II in 1994, the formation of the UN Theme Group in 1996 and the National Integrated Work Plan in 1998. Implementation of the second National Strategic Plan for 2002-2006 has commenced.

Some of the key achievements during the last five years have been; participation of other sectors such as labour, youth and education and military in the national prevention efforts, expansion of STD facilities through the construction of new clinics, meeting staffing and equipment norms and establishment of outreach programmes, upgrading of blood banks providing for HIV screening of all donated blood in the state sector is screened for HIV, syphilis and Hepatitis B and the formulation and approval of a National Blood Policy. Voluntary donations currently represent 81% of total donations.

Amount of national funds spent by the government on HIV/AIDS

Funds for HIV/AIDS prevention and control activities are committed by the government and donor agencies.
Allocations from the consolidated fund is utilised for infrastructure
(Physical facilities, drugs, other consumables and recurrent expenditures) and salaries of health staff at central and provincial levels. There is no disaggregating of consolidated funds for expenditure on HIV/AIDS as distinct from STD services.
In 2002, a total of Rs.17, 576,000.00 (approximately US$ 0.175 million) was allocated to the Central STD Clinic for infrastructure costs and salaries, an increase of more than 10% from the previous year's allocation. These monies were allocated as: salaries and emoluments Rs.1564800.00; Transport Rs.112, 000.00; Supplies and consumables Rs.520, 000.00; overheads and maintenance Rs.44, 200.00; utilities Rs.754,000.00 and Miscellaneous Rs. 88,000.00.
The IDA/World Bank Loan of approximately US $ 8.1 million for the period 1997 - 2002, was used to expand STD services at a national level in all programme areas - Infrastructures development, IEC, STD care, HIV/AIDS Care and counselling, Laboratory and safe blood, prevention of perinatal transmission and training. Some proportion of monies allocated annually for curative services is also expended for the in -ward care of HIV/AIDS patients. Since the numbers of affected patients is still low, this cost at present is small.
For the second 5-year cycle 2002 to 2007, the World Bank has pledged US $ 10.55 million and the allocation from the Government is US $ 1.98 million.

Following devolution of power to the provinces, the earlier vertical NSACP has been decentralised and individual provinces are responsible for implementing HIV/AIDS related activities with technical resource from the centre. The decentralised health budget is a common budget that does not identify a separate allocation for STD/HIV/AIDS. Considerable variation exists therefore in prioritising HIV/AIDS related activities and in allocations and utilisation of funds at provincial level.

At all levels procedural delays in disbursement and utilisation of funds within the health services hampers the timely implementation of activities and reduces expected outcomes and impacts. Strategies to improve the financial flow are among the critical health reforms identified in the new Health Sector Strategy due to be implemented shortly.

2.National Programmes and behaviour

ANNEX 2 - NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

The background to and the constraints faced in construction each policy indicator are listed accordingly.

Total score = 15/19. Score % = 78.9% Mean score = 15/4 3.75

The overall score of 78.9% (15/19) could be regarded as satisfactory but the interpretation may be queried since there are no guidelines provided for this purpose. The separate scores of the broad policy areas indicates that performance has been better in the areas of Strategic plan, Prevention and Human rights than Care and Support.

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS?
(Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

Yes X	No	N/A
Comments : Though a mult-isectoral strategy has been initiated, the mobilising of the sectors outside health has not been as effective as required. Greater emphasis and advocacy among the stakeholders is essential to optimise the national thrust against HIV/AIDS. This requires that the National AIDS Committee fulfils its mandate as the policy formulating think tank of the Ministry of Health.		

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Yes X	No	N/A
Comments: The GoSL is firmly committed to and accords the highest priority to the prevention of HIV/AIDS as a critical strategy for the alleviation of poverty. This is reflected in the Poverty Reduction Strategy Papers and the National Development Plan.		

3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes X	No	N/A
Comments: This function is fulfilled by the National AIDS Committee (NAC). In the past, the NAC has tended to concerned itself more with implementation of activities rather than policy development. Steps have been taken to reconstitute the NAC under the chairmanship of the Secretary, Ministry of Health, Nutrition and Welfare with senior policy makers of the various sectors as members in order to make it a more dynamic and cohesive body capable of fulfilling its mandate.		

The NAC is the functional national multisectoral co-ordination body mandated to define policy and co-ordinate activities implemented by the health sector (state and private), other sectors and civil organisations. Policy interventions are directed towards overcoming social and cultural barriers that foster discrimination and stigmatisation, in order to create an enabling environment that provides for the integration of HIV/AIDS affected persons into society and the widespread adoption of responsible sexual behaviours including safer sex practices and use of condoms. However this is an area that needs much greater emphasis and focus.

The Terms of Reference of the NAC are: To advise the GoSL on policy regarding prevention and control of HIV/AIDS; To facilitate inter-sectoral co-ordination; Monitor the implementation of activities related to the NSACP and bring to the notice of the National Health Council (NHC) difficulties in implementation of any activities with respect to changes in the prevailing situation. The NAC meets once in three months. The NAC has 5 sub-committees viz. Clinical care and counselling; Legal and Ethical Issues; Non Governmental Organisations; Laboratory and Surveillance and Information, Education and Communication who are responsible for implementation of activities.

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes X	No	N/A
Comments: The NAC through its 5 sub-committees promotes interaction among the government, private and civil organisation sectors. A senior administrators chair each subcommittee and the membership is representative of the spheres of activity undertaken inter-sectorally. .		

5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes X	No	N/A
Comments: This is the responsibility of the NGO Sub-committee.		

6. Has your country evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes?

Yes X	No	N/A
Comments: The conclusions of the impact study (1996) may not be currently relevant. A timely and in-depth study is needed to re-assess the socio-economic impact of AIDS in view of the rapidly changing socio-economic conditions in addition to the post-conflict environment and new challenges faced in reconstruction and rehabilitation.		

Evaluation of the Socio-economic impact of HIV/AIDS
This UNDP assisted study (1996) provided three estimates of considerable divergence regarding the socio-economic impact of HIV/AIDS at that time. The estimates of the first two methods namely the cost of illness method, and the Willingness to pay method, indicated moderate and high adverse impact. In contrast, the third method which assessed the impact on growth and development on the Human Development Index (HDI), a broader measure of economic well being, indicated that the impact would be negligible as the low prevalence status of the country will protect against substantial depression of the HDI and cost Sri Lanka just 3 months of progress between 1994 and 2005. Among the other noteworthy findings of the study were the following;

- *The relatively high literacy rate in Sri Lanka (88% in 1992) may prove invaluable as a "Social vaccine" against HIV transmission provided that the effectiveness of the Family Life Education programme in schools is increased.*
- *Indirect costs of the epidemic will be borne by people with HIV/AIDS and their families due to the lack of social welfare insurance and life insurance. The economic burden of the AIDS epidemic will be spread unevenly among the taxpayers in the country.*
- *There is likely to be an uneven impact across sectors. Tourism is unlikely to be affected greatly as tourists will continue to visit countries of low HIV prevalence. On the other hand, the health sector will be adversely affected due to the need to expand its infrastructure to cope with the increasing numbers of AIDS patients.*

Overall, the serious reservations expressed about the study methodology and wide variation in its predicted outcomes reduces its value in influencing the formulation of policy and strategy. There is a need for a more in-depth study of the socio-economic impact of HIV/AIDS in the face of new developments since 1996, mainly the implementation of the Poverty Reduction Strategy

(PRS), the post –conflict situation in the country and the apparently greater acceptance and tolerance of HIV/AIDS affected people in general.

7. Does your country have a strategy that addresses HIV/AIDS issues among its national Uniformed services, including armed forces and civil defence forces ?

Yes X	No	N/A
Comments: The National Strategic Plan identifies activities for the Uniformed services personnel The Army Medical Corps with technical guidance from the NSACP conducts programmes on HIV/AIDS related issues among armed personnel.		

Nearly two decades of war in the Northern and Eastern provinces of the country has given rise to large contingents of uniformed services personnel in transit camps, an influx of sex workers, the establishment of many brothels and lodges to cater to their needs. Uniformed personnel have thus been identified as a highly vulnerable population for HIV/AIDS requiring targeted interventions - IEC activities, provision of condoms and screening facilities for STD and HIV testing. As considerable numbers of forces personnel will continue to serve in these areas despite the changing political scenario, it is expected that aggressive strategies to promote behaviour change for adoption of safe sex practices, acceptance of voluntary counselling and testing will be implemented in the near future.
Civil defence forces are smaller in number in comparison to the uniformed personnel. No specific activities are implemented in respect of them.
Various donor agencies also assist in the implementation of select activities for the uniformed personnel in collaboration with the Army Medical Corp.

Prevention
Overall performance is satisfactory.

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

Yes X	No	N/A
Comments: IEC activity is a key strategy of the NSACP. It is accorded great emphasis in all National Strategic Plans and Action Plans at national and sub national levels. . The NSACP, Health Education Bureau and NGOs are the key providers of IEC activities. The NSACP provides technical resource for development of IEC material.		

IEC activities target the general public, decision makers and opinion leaders, Youth- in- school and out of school, high risk behaviour groups - sex workers, STD clinic attendees, , highly vulnerable groups- military personnel, migrant workers both internal and external;, 3-wheel taxi drivers and antenatal clinic populations etc.

IEC material is developed using target audience approaches with a sensitivity to the cultural sensibilities of a multi- ethnic multi-religious multi-cultural society .Both interpersonal and mass media approaches, television, radio and newspapers, as well as brochures, leaflets, pamphlets, and drama and films and one–to one efforts are used are used to deliver information. Material is produced mainly in Sinhala and Tamil and to a lesser extent in English. IEC interventions for youth aim to promote abstinence, delayed first intercourse, protected sex and empower young men and women to assume responsibility for their reproductive and sexual health. World AIDS Day is y commemorated annually by activities at national and regional level by the NSACP and non-governmental organisations.

The favourable outcome of the intense IEC activities has been the considerable increase in the awareness among the general public and an increase in the demand for voluntary confidential testing for HIV. Advocacy and IEC has fostered the emergence of a societal and cultural environment that has lessened the stigma and discrimination against people living with HIV/AIDS making it possible to promote other critical health interventions such as safer sexual practices and condom promotion, which have been identified as major strategies

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Yes X	No	N/A

Comments:

The existing strategy to promote reproductive and sexual health for Adolescents and youth is implemented through two state sectors, Health and Education and through NGOs. Reproductive and sexual health information is provided through the schools health and Life Skills based education. Policy and strategies to formalise the provision of RH related information and services for out of school is a felt need.

Adolescence being a dynamic phase of physical sexual and psychosocial maturation, young people are at greater risk of unwanted pregnancy, sexually transmitted diseases including HIV/AIDS and induced abortions. The Population and Reproductive Health Policy formulated in 1998 by the Task Force on Population and Reproductive Health aimed at achieving a higher quality of life for its people by providing for quality reproductive health information services, achieving gender equality, economic benefits of migration and urbanisation while controlling their adverse social and health effects. The eight medium term goals were translated into strategies and activities to be implemented at the central and peripheral levels.

The national reproductive health programmes give very high priority to the provision of both education and services to adolescents. The National Institute of Education (NIE) implemented the UNFPA funded Population Project in the mid-seventies. Reproductive and sexual health inputs were provided gradually in a stepwise manner, with the introduction of Family Life Education through the Adolescent Reproductive Health project in 1993, the Accelerated AIDS Education Programme in 1995 and the teaching of Life competencies in 2000.The multidisciplinary approach broad based the teaching of reproductive health in secondary schools through the subjects of Health and Physical training, Science and Technology and Social

studies. The activity targeted 1.2 million students in over 600 secondary schools and 52,500 teachers and 400 In-service Advisors (ISAs).
The teaching of 10 life competencies, viz. self-awareness, empathy, communication, interpersonal relationships, decision making, problem solving, creative thinking, critical thinking, coping with stress and coping with emotions, is intended to equip youth to cope with emerging issues of sexual harassment and abuse, gender inequalities, violence and substance use and abuse
While the curricula are satisfactory, among the many policy and administrative problems that have perennially constrained the project have been, the lack of a focal point for RH education in the Ministry of Education; delay in providing teaching training materiel to schools; inadequacies in training and commitment of the ISAs and a marked absence of adequate monitoring and supervision.

In the health sector, the National Steering Committee on Adolescent Health was established in 1993 to co-ordinate adolescence health activities and develops new initiatives. In 1998, a directorate for youth was established in the Ministry of Health for promotion of life skills education as an important element to reduce adolescent health problems including RH issues. There is now further emphasis on adolescence through the National Committees and greater efforts to plan and implement programmes while supporting the establishment of " Youth friendly Services".
Out of school youth in contrast to those in-school are not yet a group for targeted interventions. Many NGOs conduct ad hoc RH and counselling programmes for this category. As the majority of these out-of-school youth are school drop-outs who have been deprived of adequate RH inputs, they are more likely to be vulnerable to the problems of adolescence including STD and HIV/AIDS. There is a need to provide them with "Youth friendly services ". One such centre is been established.

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

Yes X	No	N/A
Comments: Subgroups demonstrating high risk behaviour such as sex workers and highly vulnerable populations, in particular the armed forces personnel, free trade zone workers and external migrant workers are the focus of IEC activities by the NSACP and NGOs. .		

Strategies are available for the provision of information about drug abuse and sex related problems in workplace, Free Trade Zones and institutions of higher learning. Counselling services and a legal framework to protect against sexual harassment is identified. The National Action Plan identifies the roles and responsibilities at national and sub-national levels of the state and non-governmental organisations and the mechanism for co-ordination and flow of resources.

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

Yes	No	N/A **X**
Comments: This category is not applicable to Sri Lanka. However, it may be an emerging issue in relation to refugees returning from South India because of the on-going " peace process" and post-conflict reconstruction and rehabilitation.		

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

Yes X	No	N/A
If yes, please list		
Groups:		Commodities:
STD clinic attendees including sex workers		Voluntary confidential testing; condoms
Armed forces personnel		- as above-
Free trade zone workers		- as above -
Comments: The NSACP and NGOs are involved in the above activities. Injecting drug use is not a problem at present in Sri Lanka and as such there is no distribution of sterile needles. There is an on-going community based condom social marketing programme. Strategies to expand the availability of VCT facilities and condoms have been incorporated into the national programme for the period 2003-2007.		

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

Yes X	No	N/A
Comments: Select strategies have been already implemented. As heterosexual transmission is the dominant mode of spread, more cases of MTCT can be expected in the future		

To date, 8 HIV infected children have been detected. As heterosexual transmission is the dominant mode of spread, a rise in number of HIV infected children due to increased MTCT is to be expected in the future. The strategic responses include: the establishment of VCT facilities for antenatal clinic attendees, educating ANC field and clinic staff, distribution of IEC material, training of obstetricians and paediatricians in the management of HIV in pregnancy and infancy and providing anti- retroviral therapy for the prevention of MTCT to needy pregnant women.

Human Rights

Many delays have been experienced in initiating action to draft legislation relevant to HIV/AIDS. Some of these issues have related to the constituting and functioning of the Legal and Ethical Issues Subcommittee. With the Ministry of Justice and Constitutional Affairs assuming chairmanship of the Committee, steps have been taken to initiate action with respect to many outstanding issues. Among these, the Ministry of Justice is awaiting concurrence of the Ministry of Health to proceed with consideration of the need for HIV /AIDS legislation related to all aspects of protecting the rights of the individual.

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

Yes X	No	N/A
Comments: At present, all rights are as enshrined in the Constitution and applicable to all persons irrespective of their HIV status. It is intended to formulate laws to protect persons living with HIV/AIDS from discriminatory events and occurrences.		

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

Yes	**No X**	N/A
If yes, please list groups:		
Comments: This is currently lacking but steps are being taken to address the issue.		

3. Does your country have a policy to ensure equal access, for men and women, to prevention and care, with emphasis on vulnerable populations?

Yes X	**No**	N/A
Comments: All persons, irrespective of gender and their state of vulnerability to HIV/AIDS are entitled to equal access to preventive and curative car. At present policy is being framed as a basis to formulating laws relevant to vulnerable groups.		

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

Yes	**No X**	N/A
Comments: The National Strategic Plan identified the need for all research pertaining to HIV/AIDS and HIV/AIDS related persons to be ethically approved by a duly constituted ethical review committee such as the Ethical Review Committee of the Faculty of Medicine, Colombo.		

Care and support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes X	No	N/A
If yes, please list Groups:	Commodities:	
Comments: Policy at present is restricted to providing routine in ward medical care for the HV/AIDS patients. Policy needs to be strengthened and expanded to provide comprehensive HIV/AIDS care and support to the needy. NGOs and Community Based Organisations (CBOs) may need to be strengthened and encouraged to undertake the care of HIV/AIDS patients at community level.		

The policy decision of the Ministry of Health, to admit patients to general medical wards for treatment is being implemented. At present, the numbers of terminally ill patients requiring in-ward care is relatively low and there has been little pressure on the State to expand facilities for HIV/AIDS patients. While the State is committed to providing affordable care, it currently excludes the routine provision of anti-retroviral therapy due to its current costs and constraints in within the free health service particularly in a long-term perspective. In-ward care provides for management of common opportunistic infections, counselling etc. However, reported data points to a rising trend in the number of HIV cases being detected annually. Currently the State is reconsidering the issues of providing ARV therapy to HIV/AIDS affected persons. At present, the burden of care rests mostly with the families. Among the many NGOs and CBOs, only three are known to provide care at community level.

There is a clear need to develop policy relevant to the provision of care and support for HIV/AIDS affected people.

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretroviral and drugs for the prevention and treatment of opportunistic infections and palliative care.)

Yes	**No X**	N/A
If yes, please list Groups:	Commodities:	
Comments: See earlier.		

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

Yes	**No X**	N/A
Comments: Orphans (due to one or both parents dying of HIV/AIDS) is an emerging concern in Sri Lanka. The National Child Protection Authority, a new body addressing the issue of child abuse and violation and neglect of child rights including the impact of HIV on children.		

National programmes at a glance

The National STD/AIDS Control Programme is responsible for providing preventive and curative services. in addition to counselling it engages in advocacy and IEC activities to foster an enabling environment that facilitates the implementation of critical interventions such as condom promotion and behaviour change strategies.

Prevention

% of schools with teachers who have been trained in life skills based education and who taught it during the last academic year is not known

% of large enterprises /companies that have HIV/AIDS workplace policies and programmes is not known.

% of HIV + pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT not applicable at present.

Care/Treatment

% of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled **100%**

% of people with advanced HIV infection receiving ARV therapy - **not available.**

Source- NSACP

2. National programme and behaviour indicators.

1. LIFE SKILLS BASED HIV/AIDS EDUCATION IN SCHOOLS

% of schools with teachers who have been trained in life skills based education and who taught it during the last academic year.

Although exact percentages of schools with teachers who have been trained in Life Skills Based Education (LSBE) is not available, LSBE is a component of the current Educational Reforms which were introduced in 1997 to all state schools (10,000) where over 93% of children (aged 5-18 years) receive free education. However, intensive training in LSBE for teachers has been done in selected areas through a programme in 2002, which reached 1000 to 1200 teachers and 100,000 adolescents (aged 12-15 years) in all schools in five districts. This is yet to be evaluated. National Policy Guidelines on LSBE are being developed and a manual for Training of Trainers (TOT) has been completed. Components of LSBE have now been introduced into activities related to reproductive health promotive programmes through schools. However, many of these institutions have yet to be evaluated in terms of behaviours.

2. WORKPLACE HIV/AIDS CONTROL

Percentage of enterprises and companies that have HIV/AIDS policies and programmes

There is no stated policy regarding HIV/AIDS in the workplace in the state or in private enterprise sectors.

In the State sector, the Worker Education Unit (WEU) of the Ministry of Labour conducts programmes for the general health and welfare of the 96,000 men and women workers employed in the three main Free Trade Zones in the country and another 200,000 workers who are employed in 121 industrial parks and towns. However, the WEU has no mandate to influence policy pertaining to HIV/AIDS in the workplace.

In the Private sector, The Federation of Chambers of Commerce and Industry Sri Lanka (FCCISL), which is the apex, organisation for the private sector has very recently convened a Committee to address the issue of HIV/AIDS in the workplace.

3. SEXUALLY TRANSMITTED INFECTION: COMPREHENSIVE CARE

% of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed ,treated and counselled

Total number of new episodes of STI in 2002 was 11893 of which 8436 were diagnosed as venereal.

The 4 steps, history taking, examination, diagnosis and treatment and counselling covering partner notification condom use and HIV testing is standard procedure that is routinely carried out for all STD clinic attendees. HIV testing is done only with informed consent. Case management adheres to nationally developed and approved treatment protocols and uses both the etiological approach (STD clinics with well equipped laboratories) and Syndromic approach according to standard algorithms (majority of peripheral clinics).

Trained medical officers provide services at all clinics supported by public health staff trained in counselling.

The Private sector is estimated to cater to 70% -80% of the demand for STD services. Thus standard treatment protocols have been used to train General practitioners in Syndromic management of STIs using the distance education approach.

Additional indicator
Percentage of public STI clinics where VCT services for HIV are provided and/or referred to
(Data source - Central and peripheral STD clinics of the NSACP)

4. PREVENTION OF MTCT : ANTIRETROVIRAL PROPHYLAXIS
% of HIV + pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
Current policy provides anti retroviral treatment with AZT according to the WHO protocol, to all pregnant women detected as infected. Drugs are provided according to the standard country protocol -

300 mg AZT twice daily from the 36th week of pregnancy up to onset of labour, followed by 300 mg of AZT 3 hourly during labour and up to delivery.

No antiretroviral drugs are administered to the baby. No estimates are available of the number of pregnant women seeking treatment in the private health sector.

Additional indicator
This is not applicable as there is no generalised epidemic in Sri Lanka at present.

4. HIV TREATMENT: ANTIRETROVIRAL COMBINATION THERAPY
% of people with advanced HIV infection receiving ARV therapy
Even though no antiretroviral combination therapy is available currently in the state sector, its provision is under policy consideration because of the long term cost implications.

Additional indicator
Percentage of health facilities with the capacity to deliver appropriate care to people living with AIDS
All base, provincial and teaching hospitals are equipped to provide routine in -ward medical care and management of common opportunistic infections to all HIV infected persons.

6. INJECTING DRUG USERS : SAFE INJECTING AND SEXUAL PRACTICES
Percentage of IDUS who have adopted behaviours that reduce transmission of HIV - both avoidance of sharing injecting equipment and use condoms

Injecting drug use has not been established as a mode of transmission if HIV/AIDS in Sri Lanka at present. It is estimated that among the 40,000 heroin users in this country, approximately 1% -

2% are injecting drug users. However it is an area where the situation needs to be monitored closely.

7. YOUNG PEOPLES KNOWLEDGE ABOUT HIV PREVENTION

Percentage of young people aged 15 to 24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

In the absence of data from national level surveys, data from the Priority Prevention Indicator Survey (PPI) of 1997-1998 and more recent select research studies is quoted

The PPI survey conducted in two areas, urban (Colombo) and rural (Matale) used the standard WHO protocol and targeted 1600 men and women, aged 15-49 years and used a standardised questionnaire focusing knowledge about HIV/AIDS, sex with non-regular partners, condom usage with non-regular partners and reported STD incidence in men during the previous 12 months. Persons aged 15-24 constituted 82 % of the sample.

Table 4 – Knowledge of urban and rural youth on 3 selected topics related to HIV/AIDS (PPI Survey, SL. 1997-1998)

Topic	Urban		Rural	
	Number	%	Number	%
HIV can be avoided by having sex with only one faithful uninfected partner	1440	90	1240	85
HIV can be avoided by using condoms	816	51	736	46
A healthy looking person can have HIV	832	52	688	43

No current data is available on this indicator.

8. YOUNG PEOPLES CONDOM USE WITH NON-REGULAR PARTNERS

Percentage of young people aged 15-24 years reporting the use of condoms during sexual intercourse with a non-regular sex partner.

Data from the 1997/1998 PPI survey showed that less than 5% of urban and rural males and less than 1 % of urban and rural females reported sex with a non-regular partner during the 12 months preceding the survey.
The main reasons for not using condoms was quoted as " males dislike condoms (urban, 70%; rural 64%), unavailability of condoms (rural 21%) and objections by partner (urban 20%).

Additional indicators

- Median age at first sex*: Urban: Males = 24 yrs Females = 23 years
  Rural: Males = 23 years Females = 20 years.

- Higher risk sex in the last year* (separate data is not available to the specified age group)
  Urban Males - 4.5%: Females - 0.6%
  Rural Males - 4.3% Females - 0.2%
  * (*Source – PPI survey, 1997/1998)*

- Condom use during last commercial sex -
  A study on the preventive aspects of sexual transmission in a high risk population of males in a tourist resort area, 225 respondents of whom 64% were youth aged 15-24, 35% reported condom use at last sexual exposure. A study on Estimation of HIV infections using sexual behaviour patterns among selected highly vulnerable groups, reported that 66.8% of female sex workers used a condom at last sexual exposure.

- Condom use during last anal sex with men
  The study on Estimation of HIV infections using sexual behaviour patterns among selected highly vulnerable groups, insertive anal sex was reported by more than 80% of men who have sex with men (MSMs) and 31.6% reported condom use at last anal sex.

ORPHAN SCHOOL ATTENDANCE

No data available probably since there are no known orphans as a result of HIV infection as yet.

National behaviours at a glance

% of respondents 15-24 years of age who both correctly identify ways of prevention the sexual transmission of HIV and who rejected major misconceptions about HIV transmission - limited data.

% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner – limited data

% of injecting drug users who have adopted behaviours that reduce transmission of HIV - not applicable to Sri Lanka at present

Source – PPI Survev 1997/1998 and select studies.

IMPACT INDICATORS

No data available for computation of impact indicators.

Impact alleviation at a glance

% of infants born to HIV infected mothers who are infected - no data available*

IV. Major challenges faced and actions needed to achieve the goals and targets

Data collection plan (2005 reporting)	2003*	2004*	2005*
Household surveys		X	
Health facility surveys			X
School based surveys		X	
Workplace surveys		X	
Desk review	X		

The lack of policy in many areas: delays in disbursement and utilisation of funds; lack of uniformity in implementation of prevention and control activities subsequent to decentralisation ; problems in monitoring and supervision of the peripheral clinics are select constraints impeding the timely implementation of preventive and control activities. Strategies to overcome /mitigate the above constraints have been identified in the second 5 year HIV/AIDS Prevention programme.

****Will be undertaken based on availability of resources.***

V. Support required from country's development partners

Greater commitment and more emphasis on HIV/AIDS related activities within sectors other than health and greater co-ordination among NGOs to optimise the national effort for the prevention and control of HIV/AIDS. This would also include technical expertise where relevant based on need.

VI Monitoring and evaluation environment

Monitoring and evaluation is in-built in to the implementation strategies of the NSACP. The National AIDS Committee under the chairmanship of the Secretary, Health reviews overall progress of activities. In addition, the select subcommittees review activities relevant to each broad programme area. Both internal and external reviews of the programme are conducted and the recommendations are taken into consideration when formulating National Strategic plans. Donor agencies conduct independent review of activities supported by them.
Overall monitoring and evaluation needs to be strengthened with the construction of a database that will facilitate extraction of data to determine whether programme goals and objectives are being met.