

Let Us Know About HIV and AIDS

Achieving Triple Zeros

Handbook on HIV & AIDS for Primary Health Care Workers



ISBN:

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Original Forum

National STD/AIDS Control Programme, Ministry of Health, Nutrition & Indigenous Medicine, in Partnership with the United Nations Population Fund

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“The world has delivered on halting and reversing the AIDS epidemic. Now we must commit to end the AIDS epidemic by 2030 as part of the Sustainable Development Goals”

Ban Ki - Moon
UN Secretary General

“Everyone has the right to live a long and healthy life. We must take HIV services to the people who are most affected, and ensure that these services are delivered in a safe, respectful environment with dignity and free from discrimination.”

“The power of prevention is not being realized. If there is a resurgence in new HIV infections now, the epidemic will become impossible to control. The world needs to take urgent and immediate action to close the prevention gap.”

Michel Sidibe
Executive Director, UNAIDS

National STD/AIDS Control Programme

Vision

Quality sexual health services for a healthier nation

Mission

Contributing to a healthier nation through sexual health promotion, emphasizing the prevention, control and provision of quality services for sexually transmitted infection including HIV

Objectives of National STD/AIDS Control Programme

1. Prevention of transmission of Sexually Transmitted Infections (STIs) including HIV.
2. Provision of care and support for those infected and affected with STIs including HIV.

The National STD/AIDS Control Programme (NSACP), Ministry of Health, spearheads the national response to HIV/AIDS in Sri Lanka. NSACP is the focal point for planning and implementation of HIV/AIDS National Strategic Plan and AIDS Policy together with all stakeholders. The headquarters of the NSACP is situated at 29, De Saram Place Colombo 10, Sri Lanka and it networks with 30 full-time STD clinics and 23 branch STD clinics.

Message from the Director General of Health services

“Let us know about HIV & AIDS - Achieving Triple Zeros” Handbook on HIV & AIDS for Primary Health Care Workers with new knowledge is a great aid for all Primary Health Care Workers in achieving Sustainable Development Goals adopted by United Nations in 2015.

Further, the lessons learnt in responding to HIV will play an instrumental role in the success in achieving many of the Sustainable Development Goals, notably, good health and well-being.

The aim of ending new HIV infections by 2030 will be commenced with fast track targets by 2020 and in achieving these targets, Primary Health Care Workers should be equipped with knowledge, skills and positive attitudes. It will be impossible to end the epidemic without developing the capacity of Primary Health Care Workers. Continued investments will be needed to build the capacity of health and community systems to reach the ambitious goal of ending the AIDS epidemic by 2030. Importantly, quickening the pace of scaling up essential HIV treatment and prevention services will, in and of itself, result in substantial benefits to health systems. In addition to help in sustaining the AIDS response, investments in HIV programmes will have the potential to transform national capacity to address other health priorities, such as non communicable diseases, maternal and child health, emerging diseases and outbreaks of infectious diseases.

This handbook is an essential reading material for Primary Health Care Workers and the authors have responded to the need very efficiently.



Dr. Palitha Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine

Message from the Deputy Director General - Public Health Services

I extend my heartiest congratulations for the publication of “Let us Know about HIV&AIDS” - Achieving Triple Zeros” Handbook on HIV & AIDS for Primary Health Care Workers .

Publication of this handbook is very timely and significantly important , as the world has committed to end the AIDS epidemic by 2030, as part of the sustainable development goals, which United Nations member states adopted unanimously in 2015. AIDS investments will also dramatically reduce future burdens on health systems associated with HIV. Investments to achieve ambitious new global AIDS targets in the post-2015 era will further enable to develop the capacity of Primary Health Care Workers .

The book provides all the necessary information for Primary Health Care Workers regarding each and every aspect of the disease such as theoretical perspectives, stigma & discrimination, and laws affecting key populations.

As this handbook showcases innovative thoughts and approaches related to halting the AIDS epidemic by 2030, it will be an essential reading material for all Primary Health Care Workers.



Dr. Sarath Amunugama
Deputy Director General - Public Health Services - 1
Ministry of Health, Nutrition & Indigenous Medicine

**Message from the UNFPA Representative,
Mr. Alain Sibenaler**

**Mr. Alain Sibenaler
UNFPA Representative, Sri Lanka**

Preface

The AIDS epidemic has had a huge impact over the past 35 years. Since the start of the epidemic, 35 million people have died from AIDS-related illnesses and an estimated 78 million people have become infected with HIV.

I applaud the great effort of publishing this useful handbook on “Let us Know about HIV&AIDS” - Achieving Triple Zeros” Hand book on HIV & AIDS for Primary Health Care Workers.

Currently Sri Lanka is experiencing a low level of HIV epidemic with a prevalence rate of less than 0.1% in the general population, as well as in the key population groups.

The United Nations Member States unanimously adopted to end the AIDS epidemic by 2030, as part of implementing the Sustainable Development Goals. The world is embarking on a Fast-Track strategy to end the AIDS epidemic by 2030. To reach this visionary goal after three decades of the most serious epidemic in living memory, countries will need to use the powerful tools available, hold one another accountable for results and make sure that no one is left behind. The ultimate target is to end the AIDS epidemic by 2030, which is the goal of the National STD/AIDS Control Programme as well. These targets aim to transform the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths into concrete milestones and end-points.

The government of Sri Lanka recognizes that HIV/AIDS is not only a public health concern but also a social and developmental challenge. Therefore, the national strategic plan of 2013-2017 has been implemented by the government and civil society, under the guidance of the National STD/AIDS Control Programme.

Stigmatizing attitudes and behaviours on the part of health workers have been widely documented and found to constitute an important barrier for seeking, using and adhering to HIV prevention services and treatment, as well as disclosure of HIV status. This handbook markedly attempts to raise the knowledge, skills development and changing attitudes among Primary Health Care Workers. Thus they can work together to end the AIDS epidemic by 2030. The capacity building of Primary Health Care Workers are essential to provide preventive services and promotion of HIV tests while changing the positive attitudes towards key populations.

I highly acknowledge Dr. Janaki Vidanapathirana, Consultant Community Physician, Dr. Prageeth Premadasa, Senior Registrar in Venereology, Dr. Nirosha Dissanayake, Registrar in Community Medicine, Dr. Nimali Wijegunawardena, Registrar in Community Medicine, Dr. Darshani Mallikarachchi, Consultant Venereologist, for their commendable contribution in writing this valuable book. Special thanks go to the team of the Multi-Sectoral unit of the NSACP for their commitment and support during this whole process.



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Clerical Support

Nishadhi Tharuka - Management Assistant, National STD/AIDS Control Programme

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Abbreviations

ART	Anti Retro Viral Therapy
ARV	Anti Retro Viral
BB	Beach Boys
BCC	Behaviour Change Communication
CMV	Cytomegalovirus
CSF	Cerebro Spinal Fluid
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio Behavioral Survey
IDUs	Injecting Drug Users
KPs	Key Populations
LFT	Liver Function Tests
MOH	Ministry of Health
MSM	Men who Have Sex with Men
NAC	National AIDS Committee
NRL	National Reference Laboratory
NSACP	National STD/AIDS Control Programme
NSP	National HIV Strategic Plan
OI	Opportunistic Infections
PE	Peer Educators
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PR1	Principal Recipient 1
PR2	Principal Recipient 2
PreP	Pre Exposure Prophylaxis
RFT	Renal Function Tests
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

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About HIV and AIDS

What is HIV?

The letters HIV stand for Human Immunodeficiency Virus. There are two types of HIV: HIV-1 and HIV-2.

HIV-1 is responsible for vast majority of infections globally, including in Sri Lanka. Only certain types of body fluids (Eg: blood, semen, pre-ejaculatory fluid, rectal secretions, vaginal secretions, CSF, breast milk etc.) of an HIV-infected person carry higher concentration of the virus which is adequate for effective transmission to another person following an exposure. Followed by a significant exposure, these high risk body fluids must come into contact with a mucous membrane, damaged tissue or else directly enter into the bloodstream (from a needle or syringe) for HIV transmission to occur. Rectum, vagina, glans penis and the oral cavity are lined by mucous membranes.

When a person has a sexually transmitted infection (STIs), he or she has a higher risk of acquiring the HIV infection via unprotected sex, in comparison to a person without an

When a person has a STI, he or she has a higher risk of acquiring HIV infection via unprotected sex

STI. This can be explained by two methods; Firstly, if the STI causes irritation or ulcerations (eg: syphilis, herpes or human papillomavirus), HIV can be effectively transmitted during sexual contact. Secondly, even when STIs do not cause ulcerations (e.g., chlamydia, gonorrhoea, trichomoniasis) HIV transmission is still enhanced as the local inflammation can increase the number of cells that can serve as targets for HIV.

HIV attacks the immune system of the body. Once the HIV enters the body, it attacks the CD4 receptor bearing cells (T helper cells and monocytes), which help the immune system to fight against infections. CD4 cells are a type of white blood cells that play a major role in protecting the body from infections. CD4 cell count of a normal individual ranges from 500 and 1,600 cells/mm³. HIV gradually invades the immune system by attacking and killing CD4 cells during its multiplication and spreading throughout the body. Thus, gradually, the number of CD4 cells are depleted in the body, making the person vulnerable for opportunistic infections and malignancies. The symptomatic stage of the infected individual due to opportunistic infections or malignancies, is known as AIDS.

Immune system is significantly damaged when the individual develops AIDS and becomes vulnerable to opportunistic infections and malignancies

What is AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome. AIDS is the final stage of HIV infection, but everyone who has HIV does not advance to this stage. Usually it takes 8-10 years to develop AIDS after acquiring the HIV infection. However, it depends on the strength of the individual's immune system.

In the stage of AIDS, the immune system is significantly damaged, thus the individual becomes vulnerable to opportunistic infections and malignancies. AIDS is defined immunologically as a depletion of CD4 cell count below 200 cells per cubic millimeter of blood (200 cells/mm³). However, if an HIV infected person has developed one or

more opportunistic infections, he or she will be diagnosed to have AIDS, regardless of the CD4 count.

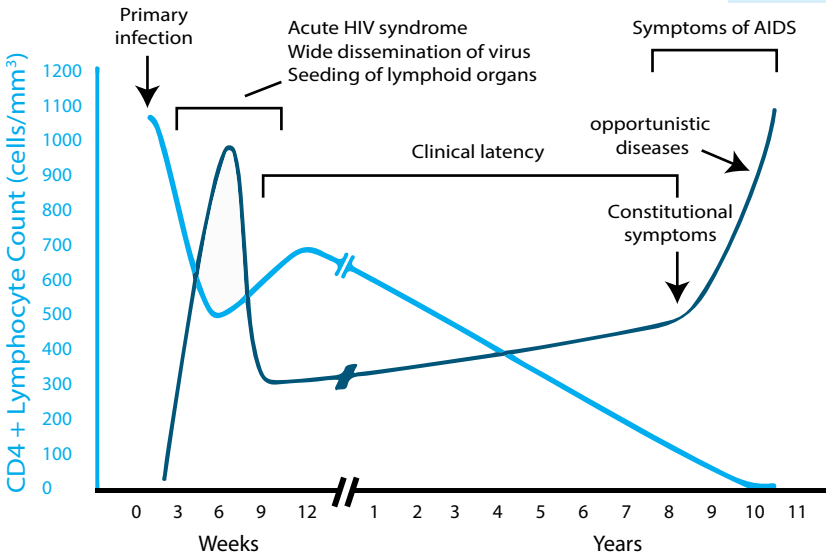
Without treatment, the prognosis of people who are diagnosed with AIDS is bad. People with AIDS need comprehensive and aggressive treatments to improve the survival.

What is Acute HIV Infection (Acute Retroviral Syndrome or Primary HIV Infection)?

Acute HIV infection is a symptomatic stage of the disease which occurs after two to four weeks following the acquisition of HIV. Acute HIV infection is also known as primary HIV infection or acute retroviral syndrome. It is the primary stage of infection and lasts until the body creates antibodies against HIV. During this stage 50% to 90% of HIV infected patients may show symptoms such as fever, swollen lymph nodes, inflammation of the throat, rash, muscle pain, malaise, and mouth and oesophageal sores.

Acute HIV infection or primary HIV infection can be undetectable

Figure 1 - Natural history of HIV; symptoms, CD4 and viral load changes



Where Does HIV Live?

Body fluids which contain a high concentration of HIV;

- Blood
- Semen and pre ejaculatory fluid
- Vaginal secretions
- Breast milk
- Cerebro Spinal /pleural/ peritoneal/pericardial/ amniotic fluids

Other body fluids like saliva and urine have a very low concentration of HIV and no risk of transmission even following an adequate exposure. HIV can penetrate the mucous membranes but cannot penetrate the keratinized skin. The virus can only survive for a short period of time outside the body.

How Does HIV Transmission Occur?

HIV is transmitted mainly by;

- **Having unprotected sex with someone who is infected with HIV.**
Anal sex carries the highest-risk of transmission with regard to sexual transmission of HIV whilst vaginal sex bears the second highest-risk. Receptive anal sex has a greater risk of acquiring HIV. This is because the lining epithelium of the rectum is less lubricated and micro abrasions created during anal sex facilitate the entry of the virus more efficiently. HIV transmission risk through vaginal sex is moderate, while from oral sex it is minimal. Through having multiple sex partners or having other STIs, the risk of infection through sex can increase.
- **HIV can be transmitted from the infected mother to the infant during pregnancy, birth, or breast feeding.**

Blood, Sexual secretions and breast milk have large number of HIV (high concentration) in HIV infected persons and bear higher risk of transmission

The overall HIV transmission from an infected mother to her child is estimated as 20 – 45 % .

- **Sharing needles and syringes with an HIV infected person has a risk of transmission among intravenous drug users.**

The risk of receiving blood transfusions and blood products that are contaminated with HIV is extremely small because of rigorous testing of all donated blood for transfusion transmitted diseases by the National Blood Center, Sri Lanka.

What are the Clinical Manifestations of HIV Infection?

Symptoms of AIDS appear in the most advanced stage of HIV infection. At this stage, the immune system is severely damaged and patients have a low CD4 cell count and a high viral load. An individual with HIV can present with a range of conditions till they develop AIDS. These conditions are categorized into 4 stages by the WHO.

WHO Clinical Staging of HIV/AIDS For Adults and Adolescents

Following the infection with HIV, the rate of clinical disease progression varies enormously from individual to individual. During the progression of HIV infection, the individuals show a number of clinical conditions depending on the stage of their immune damage. These clinical conditions are being categorized by the WHO, considering the stage of the disease.

Primary HIV infection

Develops within 4 weeks following the infection

- Asymptomatic or
- Acute retroviral syndrome(described in page No. 03)

*Unprotected
anal sex
carries
the higher
risk of HIV
transmission
compared to
the vaginal
unprotected
sex*

Stage 1

- Asymptomatic
- Persistent generalized lymphadenopathy (PGL)

Stage 2

- Moderate unexplained weight loss (<10% of presumed or measured body weight)
- Recurrent respiratory tract infections
- Herpes zoster
- Angular cheilitis
- Recurrent oral ulcerations
- Papular pruritic eruptions
- Seborrhoeic dermatitis
- Fungal nail infections of fingers

Stage 3

- Severe weight loss (>10% of presumed or measured body weight)
- Unexplained chronic diarrhoea
- Unexplained persistent fever
- Oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis (PTB)
- Severe presumed bacterial infections
- Unexplained anaemia (<8 g/dl), and or neutropenia (<500/mm³) and or thrombocytopenia (<50 000/ mm³)

Infected person has a severely damaged immune system, a low CD4 count and a high level of viral load in advanced stage of AIDS

Stage 4

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe or radiological bacterial pneumonia
- Chronic herpes simplex infection
- Oesophageal candidiasis
- Extrapulmonary TB
- Kaposi sarcoma
- Central nervous system (CNS) toxoplasmosis
- HIV encephalopathy
- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy (PML)
- Candida of trachea, bronchi or lungs
- Cryptosporidiosis
- Isosporiasis
- Visceral herpes simplex infection
- Cytomegalovirus
- Any disseminated mycosis
- Recurrent non-typhoidal salmonella septicaemia
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Visceral leishmaniasis

Some patients with HIV develop a cancer called Kaposi sarcoma

What are the Opportunistic Infections?

People with healthy immune systems can get exposed to certain viruses, bacteria or parasites. However, these pathogens do not cause a disease in them. But, infected persons can encounter serious health problems from what are known as “*opportunistic*” infections (OIs). These infections are called “opportunistic” because they take advantage of the weakened immune system, to cause serious illnesses. Eg: Candidiasis (Oral and Esophageal), Toxoplasmosis, Cryptococcosis

What are Antiretroviral Drugs?

HIV infected persons present with “opportunistic” infections due to the suppression of immunity

Drugs used to suppress HIV replication is called Anti Retroviral Therapy (ART). ART is effective enough to suppress HIV to an undetectable level. Often ART come in the form of combined pills, and the individual with HIV has to take the medicine every day. HIV can be suppressed by combined ART consisting of three or more ARV drugs. ART prevents multiplication of HIV and reduces HIV concentration in the body. Having lesser HIV in the body, it protects the immune system and prevents HIV infection from advancing to AIDS. The ART cannot completely destroy the HIV, but it can help people infected with HIV to live longer and healthier lives. The ART also reduces the risk of HIV transmission. When the patient adheres to the ART, viral load becomes undetectable and the risk of HIV transmission is minimal.

What is ART Adherence?

Adherence is defined as the “extent to which a client’s behaviour coincides with the prescribed regimen as agreed through a shared decision-making process between the client and the health care provider” .

Maintaining good adherence specially by taking ART at the given time may be challenging but crucial for most of the people living with HIV. Due to the poor adherence of

the patients, HIV becomes easily resistant. Managing an individual with mutated resistant HIV becomes a challenge, specially as ART types are limited in Sri Lanka.

For some people, taking their medicines every day remind them, the social and the emotional issues connected to HIV and AIDS, so they tend to avoid it. However, there are counselling sessions for patients to improve and maintain good adherence throughout their lives.

Can a Person be Infected with HIV By Donating or Transfusing Blood?

Some people are concerned about the risk of acquiring HIV when donating or transfusing blood. The entire health system in Sri Lanka is taking extreme precautions on this issue.

What are the Myths Related to HIV Infections?

There are several myths related to the transmission of HIV.

But, HIV does not spread by the following:

- Shaking hands
- Mosquitoes and flies
- Common use of cups, glasses and plates
- Using common toilets
- Cough or breathing
- Kissing or hugging
- Mutual masturbation

Adherence for ART is adhering to the treatment protocol and it is very essential for virus suppression

How can We Prevent HIV Transmission?

Prevention of Transmission Through Safe sex

- Abstaining from sexual intercourse till marriage or during temporary separation from the partner.
- Limit sexual exposure to one mutually faithful partner.
- Always use condoms regularly, correctly and consistently with anybody other than the faithful partner

Prevention of transmission through blood

- Do not share used needles or sharp equipments without sterilization.
- Minimize blood transfusions.
- Avoid blood donation if you have had unprotected sex

Prevention of transmission from infected mother to her child

- Prevention of HIV among sexually active men and women.
- Testing of individuals who have had unsafe sex, before planning a pregnancy.
- Prevention of unwanted pregnancies among HIV positive women.
- Pregnant women who are HIV positive should seek medical advice immediately
- Follow medical advice along with the use of ART to minimize HIV transmission to the baby.

HIV does not transmit via social contact activities

Can HIV Infected Children Play with Non-Infected Children?

Yes. HIV is not transmitted via physical touch. PLHIV students can participate in all activities in the school. They are separately counselled by the National STD/AIDS Control Programme (NSACP).

Can an HIV Infected Woman Give Breast Milk for Her Baby?

Breast feeding carries a significant risk with regard to HIV transmission. Therefore, when the formula milk is affordable or available, breast feeding is discouraged to minimize the associated risk. However, the decision should be taken after discussing with the mother, and the benefit should outweigh the risk.

Why Is it Important to Wear a Condom?

Consistent and correct condom use is the best way to prevent sexually transmitted infections including HIV infection when engaging in sexual activity. There is a wide range of condoms available, with varying levels of thickness, texture, material, size, colour and taste. Condoms work by forming a barrier between the penis, anus, vagina or mouth. This prevents high risk body fluids (blood, semen or vaginal fluids) coming into contact with the uninfected surfaces.

Not only condoms prevent STIs, but also they can prevent unintended pregnancies.

Wearing a condom is the best way of practicing safer sex, especially because some STIs do not show symptoms in the early stages.

Condoms are listed under the medical device category in the essential drug list of the Ministry of Health. Studies among sero discordant couples have shown that consistent condom

PLHIV students can participate in all activities in the school as they do not transmit HIV via social contact

use reduces the risk of HIV transmission by between 80% to 94%. Condoms can help to protect fertility by preventing transmission of STIs, such as chlamydia and gonorrhoea, that cause infertility. Women whose partners use condoms are at a 30 percent lesser risk of infertility due to STIs. The contraceptive benefit of condoms is around 98% when used correctly and consistently. Evidence shows that condoms and lubricants do not reduce sexual pleasure.

Consistent and correct condom use is the best way to prevent sexually transmitted infections including HIV infection

What are the Steps to Follow in Condom Education?

1. Introduction to advantages of condoms

- Prevention of sexually transmitted infections including HIV
- Prevention of unintended pregnancies

2. Educate the client on condom consistency

- To store condoms in a cool dry place
- To check the expiry date
- To check the integrity of the packet (air sealed)

3. Educate the client about opening the packet

- Not to use teeth or a pair of scissors to open the packet
- Open the packet by tearing from the saw toothed edge

4. Educate the client on wearing the condom

- Put the condom on, before having any genital contact.
- Condom should be worn only after penile erection.
- Take the condom out and find the correct side for use (Rolling edge should be facing out)

- Before wearing the condom, retract the foreskin fully
- Squeeze the teat of the condom with two fingers to expel air
- Unroll the condom on the erect penis up to the base
- Once the sexual act is over, the condom should be removed before the penis becomes flaccid.
- Withdraw the penis holding from its base while the condom is on.
- Use a tissue or paper to remove the condom. This prevents direct contact with genital secretions.
- Wrap the removed condom in a tissue or a paper and dispose appropriately.
- Avoid throwing the used condom into the toilet or open areas.
- Wash hands once the act is over.
- Do not wear two condoms at the same time. This may facilitate condom damage and may impair the sensation of the user.
- Use only water based lubricants, if required.
- Separate condoms should be used for vaginal, oral and anal sex.
- Flavoured condoms are available in the market for oral sex, if required by the clients.

*Never wear
two condoms
at a time*

What are the Objectives of Condom Programming in National STD/AIDS Control Programme?

The NSACP is responsible for the distribution of free condoms through all the STD clinics.

The objectives of the condom programming of NSACP are as follows:

- Prevent STIs and HIV infection through sexual transmission
- As a family planning measure for the clients attending the STD clinics
- Prevent exchanging of different virus strains among PLHIV when they have sex with positive partners, to avoid ART drug resistance.

NSACP encourages consistent condom use, in conjunction with the additional contraceptive methods among PLHIV women who need family planning services. The objective of giving an additional family planning method is to avoid accidental unplanned pregnancies among women who have not achieved undetectable viral suppression. This will prevent the mother to child transmission of HIV. All these steps are taken following a series of counselling sessions.

What is the Overview of Management of HIV Infections?

- Post test counselling and psychological support for newly confirmed cases of HIV.
- Assessment
 - * Clinical assessment (evidence of opportunistic infections, co-infections, co-morbidities etc.)
 - * Immunological assessment (CD4 count)

*Condoms
Prevent the
exchanging of
different virus
strains among
HIV positive
people when
they have sex
with positive
partners*

* Virological assessment (viral load)

- Baseline investigations (RFT, LFT, Blood glucose, Lipid profile, Haematological investigations, STI screening, OI screening)
- After initial assessment, the eligibility for ART is evaluated and the regimen which suits the patient is decided.
- Provision of ART with adherence counselling
- Partner tracing and screening
- Psychological support
- Contraception
- Condom promotion
- Nutrition counselling
- Linking with positive groups/NGOs for support.
- Follow up

What is Pre- Exposure Prophylaxis (PrEP)?

Pre-exposure prophylaxis (or PrEP) is when people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected. In other words, oral PrEP of HIV is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. When PrEP is combined with condoms and other prevention methods it works even better. A combination of two HIV medicines (tenofovir and emtricitabine), is approved for daily use as PrEP to help preventing an HIV-negative person from getting HIV from a sexual or injection-drug-using partner who's positive. Studies have shown that PrEP is highly effective for preventing HIV if it is being used as prescribed. However, PrEP may not work when the person skips doses and will be less effective when it is not taken consistently. Considering the low prevalent stage, PrEP is not available in Sri Lanka. However, in the near future, it will be available for sero discordant couples in Sri

PrEP leads to blocking the acquisition of HIV among uninfected people

Lanka.

What is Post-Exposure Prophylaxis (PEP)?

Post-exposure prophylaxis (PEP) is a short term antiretroviral treatment course given to reduce the likelihood of HIV infection after a potential accidental exposure. PEP is prescribed to reduce the risk if somebody has been exposed to HIV. Accidental exposure to HIV can occur in the healthcare setting due to:

1. Accidental needle prick injury
2. Cut injuries during surgeries
3. Splashing of infected material to mucous membranes such as eyes, mouth etc.
4. Exposure to infected material through non-intact skin

PEP should be offered, and initiated as early as possible, for all individuals with an exposure that has the potential for HIV transmission, ideally within 72 hours. PEP can reduce the risk of HIV infection by over 80%. Adherence to a full 28-day course of ARVs is critical for the effectiveness of the intervention. Effectiveness of PEP depends on high levels of adherence and completion of the prescribed course. Taking adequate measures to prevent exposure to blood and body fluids is the most important strategy for preventing exposure to HIV in the healthcare settings.

Antiretroviral drugs for PEP are now available in all STD clinics island wide. In addition, measures have been taken to make PEP drugs available outside working hours by keeping a stock of drugs in a place that is functioning round the clock.

How to Diagnose HIV Infections?

The only way to know for sure whether you have HIV is to get tested. Even if the person is using condoms and having sex with multiple partners, it's important to get tested for STDs every 3-6 months.

Post-exposure prophylaxis reduces the likelihood of HIV infection after a potential accidental exposure including an accidental needle prick

Knowing the HIV status gives powerful information to help the person to take steps to remain negative in the future, or if the person is positive for HIV he/she can access ART without delay.

What are the Tests Available for HIV/AIDS ?

The primary tests for diagnosing HIV and AIDs include:

- **Screening test**

ELISA Test (Standard HIV test) — ELISA, which stands for enzyme-linked immunosorbent assay, is used to detect HIV infection. If an ELISA test is positive, the Western blot test is usually carried out to confirm the diagnosis. Fourth generation ELISA can detect HIV infection after 2nd week of exposure. Even though one's test result may be negative during this window period, he/she will have high levels of viruses and will be at risk of transmitting the infection. Therefore, individuals should be advised to repeat their screening test 3 months following a high risk exposure, before confirming him or her as HIV negative.

Rapid test – It is an alternative method of performing an HIV screening test. It is a strip method and the benefit of this method is that the results can be made available in 20 minutes and needs only finger prick blood for the test. The Rapid HIV test detects HIV antibodies in the blood. The Rapid HIV test gives you a result in a few minutes, eliminating the stress of waiting a week for results. The Rapid test is just as accurate as a Standard HIV test.

Confirmatory test - Western Blot — When the screening is positive, the person should undergo a confirmatory test to confirm the HIV status. This is the confirmatory HIV test and it is available only at the reference laboratory in the central clinic in Sri Lanka.

Viral Load Test — This test measures the amount of HIV in your blood. Generally, it's used to monitor treatment response or to detect virological failure. This test costs more than antibody tests and is generally not used as a screening test.

When the screening is positive, the person should undergo the confirmatory test for confirmation of HIV status

CD 4 Count — This measures the status of the immune function of the affected individual.

What is the Window Period?

The *window period* is the time between potential exposure to HIV infection and the point when the test will give an accurate result. During the *window period* a person can be infected with HIV and be infectious, but will have a negative HIV test. The time between HIV acquisition and the production of enough HIV antibodies by the body to be detected by an HIV test is called the window period.

What are the Advantages of HIV Testing?

An HIV infected individual can be identified prior to symptomatic stage by HIV blood testing. This will help to;

- Start treatment at an appropriate time, thus prolonging life expectancy.
- Improve the quality of life.
- Minimize transmission to the others by taking treatment.
- Minimize mother to child transmission of HIV by planning the pregnancy and following medical advices.
- If the HIV test is positive, the person can be started on ART to stay healthy for many years and greatly reduce the chance of transmitting HIV to the sex partner.
- If the HIV test is negative, the person has more prevention tools available today to prevent HIV than ever before.
- All pregnant women should be tested for HIV so that they can initiate treatment early for prevention of mother to child transmission of HIV. When the infected mother's viral load is undetectable, transmission to the baby is very low.

The window period is the time between potential exposure to HIV infection and the point when the test will give an accurate result

What is “Treatment as Prevention”?

Treatment as prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission. ART reduces the HIV viral load in the blood, semen, vaginal fluid and rectal fluid to very low levels, reducing an individual’s risk of onward HIV transmission. Persons who know they have HIV can get medical care and take antiretroviral medications that can reduce HIV spread by as much as 96%. Thus, knowing the HIV status leads to effective treatment, keeping the HIV infected people healthy and living longer, and knowing that one is positive for HIV helps that person to make better decisions about sex and health care. Knowing that one does not have HIV infection can also help that person make better decisions about sex and health care.

What is Prevention of Mother to Child Transmission?

HIV can be transmitted from an HIV-positive woman to her child during pregnancy, childbirth and breastfeeding. Mother-to-child transmission (MTCT) accounts for more than 90% of new HIV infections among children. However, early detection and provision of ART timely to HIV-positive pregnant women can effectively stop their infants from acquiring the virus. Without treatment, the likelihood of HIV passing from mother-to-child is 15% to 45%. However, antiretroviral treatment and other effective PMTCT interventions can reduce this risk to below 1%. Considering the above prevention strategy, Sri Lanka too has started screening all pregnant mothers during early pregnancy for HIV. The aim of this project is to start ART for them by 14 weeks of POA and to bring their viral load to undetectable levels by the time of delivery. The mode of delivery mainly depends on the viral suppression of the mother. Mothers who show undetectable viral load at the time of delivery can safely undergo normal vaginal delivery

ART reduces the HIV viral load in blood, semen, vaginal fluid and rectal fluid to very low levels, reducing an individual’s risk of onward HIV transmission

without having any additional risk of transmitting HIV to the infant. When the viral suppression is not satisfactory, the preferred mode of delivery would be LSCS. All babies born to HIV positive mothers will be given ARV prophylaxis for 6 weeks or when diagnosed in late pregnancy for 12 weeks.

When formula milk is available or affordable for the mother, breast milk is discouraged to minimize the risk of transmission. In Sri Lanka, formula milk is provided freely for all HIV positive mothers following delivery. Diagnosis of the exposed infant is done by DNA PCR method (done in India). Confirmed infants will be started on triple ART regimens without delay.

For all exposed infants, BCG vaccine will be delayed until HIV infection has been excluded. Generally, other live vaccines should be avoided in infants with low immunity. .

All babies born to HIV positive mothers will be given ARV prophylaxis for 6 weeks

Why Good Nutrition is Important to PLHIV?

A healthy diet is essential to maintain good health across the life span. Healthy diet provides adequate energy to maintain a healthy weight, and does not contain excess fat, sugar, salt or alcohol. People living with HIV should aim to eat a balanced diet, without too much fat, sugar or salt. Healthy diet is important to optimize nutritional status, immunity and overall well-being. It is also important to prevent specific nutrient deficiencies and to prevent loss of weight and lean body mass. Good nutrition maximizes the effectiveness of medical and pharmacological treatments and it leads to minimize health care costs. Decreased appetite and intake are major causes of HIV-associated weight loss and wasting. Growth failure in HIV infected children is common and reflects HIV disease progression and reduced survival.

Altered immune system leads to disease progression.

What are the Food Safety Tips for PLHIV?

Because HIV affects the immune system, PLHIV may be at a greater risk for food-borne illnesses. So, in addition to eating well, food safety should be considered. A few basic safety rules can be adopted to get protected from food-related illnesses:

- Avoid eating raw eggs, meats, or seafood. Wash fruits and vegetables thoroughly.
- Use a separate cutting board for raw meats.
- Wash hands, utensils, and cutting boards with soap and water after each use.
- Water safety is extremely important, as water can carry a variety of parasites, bacteria, and viruses. To protect yourself against these infections, here are some helpful hints:
 - * Do not drink water from lakes, ponds, rivers or streams.
 - * Can use a store-bought water filter at home for drinking water.
 - * Can significantly reduce your risk of water-borne illnesses by using only boiled water for drinking and cooking.
 - * When travelling abroad in areas where sanitation is poor or water safety is questionable, drink only

Healthy diet is important to optimize the nutrition status, immunity and overall well-being of an HIV infected person.

bottled water and avoid ice or unpasteurized juices and drinks.

Can PLHIV Engage in Exercises?

Being active is good for PLHIV in a lot of ways – it can help to build the muscles, keep bones strong, burn fat and keep the heart healthy. Some PLHIV experience a loss of muscle mass and strength, so exercise can help prevent this. A moderate exercise programme will improve the body composition and minimize health risks.

What are the Effects of Smoking on PLHIV?

Tobacco use is the leading cause of preventable illnesses and death in many countries. Smoking increases the risk of developing lung cancer and other cancers, heart disease, chronic obstructive pulmonary disease (COPD), asthma and other diseases, and of dying early.

For these reasons, smoking is a significant health issue for all individuals, but it is even more of a concern for people living with HIV, who tend to smoke more than the general population. If an HIV positive individual smokes, he/she will have an additional risk of developing HIV-related infections, including:

- Oral candidiasis
- Hairy leukoplakia
- Bacterial pneumonia
- Pneumocystis pneumonia

Furthermore, HIV infected smokers are at a higher risk of developing other serious illnesses than nonsmokers with HIV. These illnesses can make the individual too sick to work (disabled) or even lead to early death. They include:

- COPD (chronic obstructive pulmonary disease, a serious lung disease that causes severe breathing problems and

A moderate exercise programme will improve the body composition and minimize health risks among PLHIV.

includes emphysema and chronic bronchitis)

- Heart disease and stroke
- Lung cancer, head and neck cancer, cervical cancer and anal cancer

People with HIV who smoke are also less likely to keep to their HIV treatment plan.

Can PLHIV Do a Job?

With proper care and treatment, many people living with HIV/AIDS lead normal, healthy lives, including having a job. Most people with HIV/AIDS can continue working at their current jobs or look for a new job in their chosen field. Overall well-being and financial status of PLHIV can be more stable when PLHIV are employed.

What is Stigma and Discrimination?

Stigma is undesirable or discrediting attribute that a person or group possesses that results in the reduction of that person's or group's status in the eyes of the society.

Discrimination is both negative attitudes or particular behaviour or actions, that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.

Living with HIV presents certain challenges, no matter what the age is. But older people with HIV may face different issues than their younger counterparts, including greater social isolation and loneliness. Stigma is also a particular concern among older people with HIV. Stigma negatively affects people's quality of life, self-image, and behaviors, and may prevent them disclosing their HIV status or seeking HIV care.

HIV infected smokers are at a higher risk of developing HIV related illnesses than nonsmokers with HIV.

What is Self-Stigma?

Self-stigma is felt by people with HIV when they internalise the negative attitudes often associated with the virus. When HIV-related stigma (an attitude) turns into discrimination (an act) it becomes a human rights violation.

How Does Stigma and Discrimination Lead to an HIV Epidemic?

Stigma and discrimination



Poor quality of care for people living with HIV



Limited uptake of treatment and prevention services



Increased number of people living with HIV

It is essential to help people living with HIV for positive living and reduce the epidemic of HIV.

What are the Good Practices of Health Care Providers to Eliminate Stigma and Discrimination?

- Greet warmly.
- Show care and compassion to people living with HIV.
- Touch them without any hesitation.
- Respect privacy, dignity and right to opinion of people living with HIV
- Listen to them well.
- Provide emotional support to people living with HIV.

Stigma negatively affects people's quality of life, self-image, and behaviors and leads to a silent epidemic of HIV

- Ensure confidentiality of people living with HIV.
- Use positive non-verbal and verbal communication.
- Follow universal precautions to treat people living with HIV.
- Do not display the HIV status in the patient's records.
- Do not isolate people living with HIV in a corner or in a special ward.
- Do not deny to provide them full, unconditional and high quality care and treatment.
- Do not change facial expressions when treating people living with HIV.

Who are the Key Population Groups?

Key populations are groups of people at highest risk of HIV acquisition and transmission. They are disproportionately infected with HIV compared to the general population in many settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to access HIV prevention and treatment. Key populations include: Men who have sex with Men (MSM), people who inject drugs, people in prisons and closed settings, Sex workers (SW) and transgender people.

Recent studies suggest that people who inject drugs are 24 times more likely to acquire HIV than adults in the general population, sex workers are 10 times more likely to acquire HIV and gay men and other men who have sex with men are 24 times more likely to acquire HIV. In addition, transgender people are 49 times more likely to be living with HIV and prisoners are five times more likely to be living with HIV than adults in the general population. Globally, new infections among key populations and their sexual partners accounted for 36% of all new HIV infections in 2015.

In addition to that, Sri Lanka recognizes Beach boys (BB) as a group of key populations in Sri Lanka.

Health care

providers

should

maintain the

confidentiality

of HIV infected

persons

Who are the Vulnerable Groups?

Vulnerability refers to unequal opportunities for people that leads to a person more susceptible to HIV infection. There may be different groups in a local area. These populations are not affected by HIV uniformly in all countries. Each country should define the specific populations that are vulnerable and key to their epidemic and response, based on the epidemiological and social context. Sri Lanka identified several vulnerable population groups, namely: Armed forces, tourist sector and both internal and external migrant populations. In your area, it may be urban slum youth or youth on the street etc.

*Self stigma
is affected
by a person's
negative
attitudes often
associated
with the HIV
virus*

What are the Laws Affecting Key Populations in Sri Lanka?

There are a number of supportive policies, laws, plans, guidelines, strategies and programmes in Sri Lanka which oversee the structure of the Sexual and Reproductive Health issues in the country, in order to ensure the supportive and conducive environment for prevention of STIs/HIV. In addition, Sri Lanka is a signatory to several international conventions that uphold Sexual and Reproductive Health rights. All these documents support and provide a supportive environment for HIV prevention. There is no specific legal offence in sex work in private. However, many facets of sex work including homosexuality are prohibited under the three ordinances, namely; Vagrants Ordinance, Brothels Ordinance and 365A of the constitution. There are misinterpretations of the law, which makes KPs reluctant to keep condoms with them, to use in need. This will lead to unprotected sex among them. But, during the recent past, these unpleasant situations were overcome with continuous training programmes among the Police sector. It is high time to revisit and amend the respective legal framework in the country, to facilitate improving sexual health.

Countries may use laws, policies and other regulatory mechanisms to guarantee the promotion, protection and provision of sexual health information and services. As signatories to the different international and regional human rights treaties, countries should strive to fulfil their human rights obligations. They might do this by providing health care to everyone or by ensuring the right of people living with STIs or HIV to access information and services without discrimination.

How World has Planned to End the AIDS Epidemic by 2030?

The world is committed to end the AIDS epidemic by 2030, as part of the Sustainable Development Goals (SDG) with the support of all global partners. The Sustainable Development Goals are the goals which the United Nations Member States adopted unanimously in 2015. The lessons learnt in responding to HIV will play an instrumental role in the success in achieving many of the Sustainable Development Goals, notably Sustainable Development Goal 3, good health and well-being, and the goals on gender equality and women's empowerment, reduced inequalities, global partnerships and just, peaceful and inclusive societies. Ending the AIDS epidemic by 2030 will include:

- Zero new HIV infections
- Zero discrimination
- Zero AIDS-related deaths

Ending the AIDS epidemic by 2030 will require countries to take a Fast-Track approach during the next five years. It has been planned according to UNAIDS 90–90–90 fast track targets, which should be achieved by 2020. This comprises of :

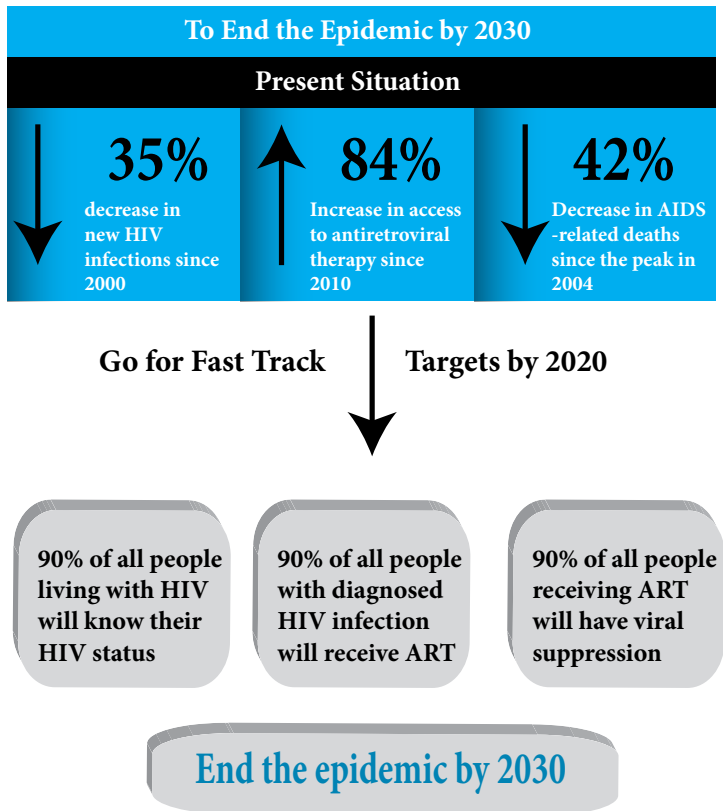
- 90% of people (children, adolescents and adults) living with HIV knowing their HIV status;

Punitive laws for key populations lead to less access for health care services

- 90% of people who know their HIV positive status are receiving treatment.
- 90% of people on HIV treatment have a suppressed viral load so that their immune system remains strong and the likelihood of their infection being passed on is greatly reduced.

Global decision to reduce new infections to 500 000 by 2020 requires continued progress towards the 90–90–90 target and intensive focus on a people-centred, combination approach.

Figure 2- Achieving 2020 Targets



Key populations are at highest risk of HIV acquisition and transmission

Figure 3 - Achieving 2030 Targets



UNAIDS has recommended to achieve the fast track targets by 2020 by implementing the following strategies:

- Accelerate the implementation of HIV prevention and treatment services and address underlying barriers to access.
- Implement programmes with the greatest impact to reach 90% of the key populations (including men who have sex with men, people who inject drugs, sex workers and transgender people).
- Reach men and young women and adolescent girls in the geographical locations where most HIV transmission is occurring.
- Ensure all programmes are implemented based on equality and nondiscrimination.
- Adapt the delivery of HIV services for maximum efficacy and efficiency.
- Substantially increase investment in community-based services and community mobilization.
- Reallocate and use maximum available resources for the greatest effectiveness and generate new domestic and international investment.
- Improve legal environments, including those needed for harm reduction and other evidence-informed services.

*Ending AIDS
by 2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

- Ensure full respect for human rights and eliminate stigma and discrimination, coercion and violence. This includes the establishment of accountability mechanisms, the participation of affected populations and the establishment of processes to redress human rights violations.

What is the Present HIV Situation in Sri Lanka? (As per end of the 2nd Quarter 2016)

Although Sri Lanka is experiencing a low level of HIV epidemic, the new infection rate is going up

Currently Sri Lanka is experiencing a low level of HIV epidemic which is indicated by a HIV prevalence of <5% in any defined key population and <1% in the general population. People living with HIV in 2015 was estimated as 4100. HIV prevalence rate in the 15-49 age group was less than 0.1% at the end of 2014. Detection of the first patient with HIV in Sri Lanka dates back to 1987, and since then the NSACP reports a cumulative number of 2436 HIV positives by the end of the 2nd quarter of 2016, while the cumulative AIDS cases reported is 631. There is a total of 111 foreigners reported to be HIV positive up to date. The cumulative number of prenatally acquired HIV is 78 as at the end of the 2nd quarter of 2016. In 2015, a total of 1,021,663 HIV tests were carried out (majority of tests were carried out by blood banks) and based on the results of those tests, HIV Sero-positivity was 0.03%. The majority of people tested positive were male, and the male to female ratio amounts to 1.7:1. The cumulative AIDS deaths reported to the NSACP is 390 by the end of the 2nd quarter of 2015.

Since 2011, the proportion of males with HIV are gradually increasing. The male to female ratio of cumulative reported cases as of end 2015 was 1.7:1. However, during 2015 the male to female ratio increased to 2.8:1. Sexual transmission accounted for 86% of all cases reported during 2015. However, in 10% of the cases, adequate data was not available to ascertain the probable mode of transmission. A

closer observation of data shows a small but a rising trend in the prevalence of HIV infection among male to male or bisexual relationships over the years, while the predominant mode of HIV transmission still continues to be heterosexual. During 2015, nearly 50% of all males reported with HIV gave a history of male to male sexual contacts. Most of these men are married, thus causing added implications on transmission to women and to their babies. There are no HIV cases reported due to blood transfusions since year 2000. Since 2011, all pregnant women diagnosed with HIV infection, who received services for elimination of mother to child transmission, delivered HIV uninfected babies, and 1% of reported cases had a history of injecting drug use in the same reporting period. The rate of HIV among young (15-24 age group) shows a slow but a steady upward trend since 2003. Colombo, Gampaha and Puttalam districts show the highest HIV rates, with over 100 HIV cases reported during year 2015. The data indicates that the number of reported HIV positives to the NSACP per quarter has doubled, compared to the situation 6 years ago. The largest proportion of people with HIV falls into the age category of 25 to 49 years (75%) and this age category continues to dominate over the reporting years. Ten percent (10%) of the cumulative number of HIV positives is above the age of 50 years at the time of diagnosis. The age category of below 15 years, which is an equivalent to prenatally acquired HIV, has a cumulative figure of 3%.

Early diagnosis will improve the quality of life of PLHIVs and prognosis due to early linkage to HIV care and ART treatment. Since 2013 there is a slight reduction of AIDS (later stage of HIV infection) stage patients among the reported HIV positive cases.

During 2015, over 90% of reported HIV cases were linked to care during the same year. Stringent measures taken over the years to motivate all diagnosed HIV positive cases to link with HIV services have been productive. Networking with private hospitals and laboratories and engaging with newly diagnosed PLHIV via telephone, have remarkably reduced the number of pre- ART loss to follow-up cases.

*Ending AIDS
by 2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

How is Sri Lanka Going to Achieve Fast Track Targets?

Sri Lanka recognizes that HIV/AIDS is not only a public health concern but also a social and development challenge

The Government of Sri Lanka recognizes that HIV/AIDS is not only a public health concern but also a social and development challenge, hence the importance of strengthening and scaling up preventive interventions aimed at behaviour development and change to maintain a low prevalence of HIV infection in keeping with the Sustainable Development Goals and also providing care and support for those infected and affected.

The Venereal Diseases Control Programme was initiated in 1938 and the Venereal Diseases Ordinance No. 27 was ratified. Anti-Venereal Diseases Campaign (Anti-VD Campaign) was established in 1952 with the objective of controlling and preventing sexually transmitted diseases (STDs). Anti-VD Campaign was renamed as the National STD/AIDS Control Programme in 1985 and more attention was given for the prevention of HIV and provision of treatment and care for people infected with HIV, in addition to the prevention and control of STDs.

At the end of 2015, there were 30 full-time and 22 branch STD clinics to provide curative health services and sexual health promotion including condom promotion in Sri Lanka. NSACP provides services to various categories of the community including key affected populations.

STI prevention and control services, HIV counselling and testing services and HIV care services are rendered through STD Clinics island-wide. Currently, the National STD/AIDS Control Programme of the Ministry of Health is the sole provider of ART for the people with HIV infection in Sri Lanka, and there are 14 ART centres.

The National HIV/AIDS Policy was developed by the Ministry of Health in 2011. The objectives of the policy were, to prevent HIV and other sexually transmitted infections in

Sri Lanka through effective strategies aimed at reducing sexual transmission, transmission through blood and blood products, and mother to child transmission and to improve the quality of life of people infected and/or affected by HIV/AIDS through minimizing stigma & discrimination, and providing quality care and support. The policy has identified twelve strategic areas for implementation in the country to achieve the expected objectives. These strategies are implemented at central, provincial and regional level, with close monitoring and evaluation of the central NSACP.

There are a number of supportive policies, laws, plans, guidelines, strategies and programmes in Sri Lanka which oversee the structure of the Reproductive and Sexual Health issues in the country, in order to ensure the supportive and conducive environment for condom programming for prevention of STIs/HIV and family planning. In addition, Sri Lanka is a signatory to several international conventions that uphold Sexual and Reproductive Health rights. All these provide a supportive environment for HIV prevention and control. But there are some punitive laws which affect key populations and currently, revisiting and amending the respective legal framework in the country is under discussion for the next new constitution.

The National AIDS Committee which includes representation from all the relevant stakeholders, guides and monitors the national response to HIV/AIDS. The National AIDS Committee (NAC) co-ordinates activities on HIV/AIDS at the national level and is chaired by the Secretary to the Ministry of Health. The NAC comprises of several other ministry representatives, including Finance, Education, Justice, Social Services, Labour, Women's Affairs, Tourism, Youth Affairs, Defence and Sports. It also has representation from the Chamber of Commerce, UN Theme Group, non-governmental organizations, community-based organizations and people infected with HIV.

The National AIDS Council guides and monitors the inter-ministerial support extended to the national response to fight HIV/AIDS, under the chairmanship of His Excellency

*National HIV/
AIDs Policy
directs to
overcome
stigma and
discrimination*

the President of Sri Lanka, and this council has met once in the recent past. The NAC is supported by four technical subcommittees, namely; 1. HIV care, treatment, counselling, and laboratory services, 2. Policy, legal and ethical issues; 3. Multi-sectoral (prevention) 4. Strategic information management. Each subcommittee has separate terms of references, and provides necessary recommendations to the supreme body, which is the NAC.

The National STD/AIDS Control Programme of the Ministry of Health, with the involvement of relevant governmental, non-governmental, international, civil society and professional organizations, business sector, media and PLHIV will implement the National Strategic Plan. The National Strategic Plan (2013-2017) will be implemented by all sectors of government and civil society, under the technical guidance of the National STD/AIDS Control Programme, with high level leadership from the NAC to accelerate the scale up of HIV prevention, care and treatment services and ensure collecting robust strategic information to monitor and guide the national response to the HIV epidemic. The National Strategic Plan (NSP) has identified five Strategic Directions and a list of Key Strategies to meet the needs of HIV prevention, treatment, care and programme management. These are to be monitored and evaluated using a set of core indicators. The Mid Term External review in 2015 has provided a set of observations on the outcomes that were achieved during the present National Strategic Plan and has made a series of important recommendations that could be taken on board at present in both preventive and curative services.

First HIV sentinel sero surveillance was carried out in July 1990 and this has been conducted annually. In addition to that, first Integrated Biological and Behavioural Survey (IBBS) was carried out in 2014, and it has been planned to conduct the 2nd IBBS. These evidence are used to plan the interventions. Data of Global AIDS Response Progress Reporting are used widely by the international community and organizations to assess the country situation, to justify fund allocation.

The National Strategic Plan identifies Strategies to meet the needs of HIV prevention, treatment, care and programme management

A national HIV/AIDS Strategic Information Management plan was developed and a set of core indicators for the national programme for monitoring the national response to HIV/AIDS in Sri Lanka. The data on the services delivered are collected regularly and analyzed strategically for the purpose of monitoring and evaluation of the whole programme. This is carried out using the recording and reporting formats of all STD clinics by the Strategic Information Management unit of the National STD/AIDS Control Programme, and have a link with PR 2. These collected evidence will be used for planned interventions and to overcome the challenges in weak areas and further strengthening of achieved areas by evidence based approach.

Sri Lanka has consistently applied a combination of HIV prevention approach, which provides packages of services—including behavioural, biomedical and structural components—tailored to priority population groups and other vulnerable and general population within their specific local contexts.

According to the National level estimation in 2013, there were an average of 14,312 FSW in Sri Lanka. Out of these sex workers, 51% were residing in the Western Province, while the district of Colombo accounted for 44% of the total. As pointed out in the HIV Sentinel sero-surveillance, the prevalence of HIV among sex workers was less than 0.2% over the last 10 year period. The IBBS 2014 detected an aggregated prevalence of 0.81% across the three district samples, with 1% prevalence in the capital Colombo. The percentage of use of condoms at last act of sex with a client was 93%, and an equally high percentage of 90% was revealed with non-paying partners. Average number of clients per day was 2.1.

Prevention of HIV infection and STIs among KPs has been recognized in the NSP under the “Global fund to fight AIDS, Tuberculosis and Malaria (GFATM) ” and covering all groups of key populations. Family Planning Association of Sri Lanka (FPASL) is the Principal Recipient two (PR2). FPASL

*NSACP uses
evidence
to plan
interventions*

is responsible for designing, implementing and monitoring the interventions with KPs, with technical partnership of PR 1. Prevention activities for KPs by the NSACP were mainly carried out through community outreach activities by district STD clinic staff. Awareness and Behavioural Change Communication on sexual health STI/HIV, condom education and distribution, screening for syphilis and HIV were conducted during outreach programmes.

According to the National estimates in 2013, there are an average 7,551 MSM in the country as shown in the HIV Sentinel Sero-Surveillance. HIV prevalence among this group of people was 0% in 2008, 0.48% in 2009 and 0.9% in 2011. The IBBS 2014 detected an aggregated prevalence of 0.88% across the three district samples, with a 1.2% prevalence in the capital Colombo.

*District STD
clinic staff
carry out
community
outreach
activities*

The percentage of men reporting the use of a condom at the last anal sex encounter with a male partner was 58%. A majority of MSM are having concurrent sex with women. For these bisexual men, their condom usage is lower with women (50%). The 2014 IBBS found that 4% of FSWs and 3% of MSM refused health services due to their unwillingness to be identified as FSWs or MSM.

There were an average of 17,459 drug users in Sri Lanka in 2013, and it is estimated that there are 423 IDUs in the country on a given peak day. Although needle exchange and substitution therapy are not available for IDUs in Sri Lanka, drug users receive a comprehensive sexual health package through the GFATM project. According to the IBBS 2014, the percentage of injecting drug users reporting the use of a condom at the last anal sex encounter with a male partner was 25%. The national size estimation of 2013 revealed that an average of 1,314 beach boys are present in and around coastal areas in the country on a given peak day. They are mostly found in selected coastal areas where tourists aggregate, mainly in 2 districts, Galle in the Southern Province and Amapara in the Eastern province, accounting

for 44% of the total. Over 80% of BB could be reached in 5 districts in 3 Provinces.

According to the IBBS 2014, condom use at the last casual sex act among BB was fairly high (70%), even though consistent condom use was very low at 35%. Condom use at the last sexual act with a tourist was also fairly high (67%). Within the response to AIDS, leaving no one behind is both a moral and human rights imperative and a public health necessity. HIV-related vulnerabilities are fuelled by inequalities and prejudices entrenched within the legal, social and economic structures of society. Harmful cultural and social gender norms, criminalization of same-sex relationships, identification of transgender persons, and drug use, block HIV prevention and increase risky behaviour. These factors moving away from HIV testing and HIV prevention activities and is associated with lower adherence to treatment.

Prisoners are one of the key population groups due to the high incidence of unprotected homosexual activities in the prisons. There were approximately 117,839 convicted and unconvicted prisoners entering into the island-wide prisons in year 2014. Daily average convicted and unconvicted prisoners were 19,108 in Sri Lankan Prisons in year 2014. HIV prevention activities in prisons island-wide include advocacy and skill building programmes for rehabilitation officers and sexual health promotion for medical staff and welfare officers. Trained rehabilitation officers educate prison inmates as peer educators (PE). The PE are carrying out both formal and informal education sessions for inmates and promote HIV testing. Prison inmates voluntarily participate for HIV testing after peer educator's discussions. 30 mobile clinics are conducted island-wide within the prison setup with the help of local STD clinics. HIV testing is carried out through 30 mobile clinics on a monthly basis since 2012. The seroprevalence rate of HIV positive cases among prison inmates in year 2014 was 0.03. Currently, development of the Prison HIV policy is in process.

*Provider
initiated HIV
testing is
carried out in
the Sri Lankan
prison setup*

Presently, the principal recipient 2 performs interventions with KPs under the patronage of the new funding model of GFATM. It is linked to the Sub-recipients and Sub-sub recipients to reach the KPs and the majority of the interventions are targeted for them. Interventions for key affected populations are reached through the peer leader intervention model, and this model has been assessed by an external group in 2016. Recommendations were considered to improve the interventions by PR 1 & PR 2. It has been identified that the HIV testing and the intervention coverage for key populations has increased. Intervention coverage has increased from 2016 and the HIV testing has increased by outreach testing as well as by introducing rapid tests.

As a result of TB/HIV collaborative activities, all PLHIV are screened for TB and all TB patients are screened for HIV.

All PLHIV are screened for TB and all TB patients are screened for HIV

A public health and human rights-based approach is used for HIV testing along with counselling, correct results, quality assurance and linkage to care. Focused and strategic approaches are used for HIV testing. During 2015, over 1 million blood samples were tested for HIV, and of them, 235 persons were found to be positive giving an overall test positivity rate of 0.02%. The highest test positivity rate is seen among STD clinic samples.

Providing outreach HIV testing services has been a long standing approach of the NSACP and new services have been added to the service package offered to recipients. HIV testing services are increasingly becoming a component of the package offered through outreach services. From 2016, it has been accelerated by rapid testing and by increasing the outreach programmes. In addition to that, to achieve these fast track targets, Sri Lanka has decided the theme of “Test Today” from the year 2014 onwards, to promote HIV testing among the general public, vulnerable and key populations. Since HIV is associated with stigma and discrimination, promotion of HIV testing to meet the 90–90–90 fast track treatment targets require innovative public health approaches. Testing for HIV is the only way to know their HIV status where many people do not have any symptoms and can live for longer.

The ART programme was initiated with financial support of the World Bank in 2004 and was continued with the support of the Global Fund until 2015. The Ministry of Health has initiated the process to procure ARV drugs from 2016 through government funds. Treating all HIV infected persons with ART will lead to viral suppression and will halt the transmission. NSACP took a decision to start ART for all diagnosed PLHIV irrespective of their CD4 count from 2016 to achieve zero new infections by 2030. Treating all HIV infected persons with ART from government funds can be considered as a major milestone.

The treatment services offered include counselling, support for disclosure and partner notification, screening for STI, TB, CMV, toxoplasma, Hepatitis B and C infections, screening for non-communicable diseases, Cotrimoxazole prophylaxis and Hepatitis B vaccination. In addition, positive females are offered services for family planning, regular Pap smear screening and PMTCT services in pregnancy. HIV testing guidelines, treatment protocol and defaulter tracing guideline are followed to improve the quality services. PEP is now available in all STD clinics island-wide and is provided for health care providers after an accidental prick injury. In the year 2014, out of the 228 diagnosed, 185 were linked with services and 144 were started on ART. Of them, 95 had a viral load testing 12 months after ART initiation. Of these, 90 PLHIV (95 %) had achieved viral suppression (less than 1000 copies/ml) 12 months after ART initiation. This gap should be further reduced by applying different strategies to increase adherence to ART. Though efforts are taken to improve ART services based on the latest changes in the WHO ART guideline, ART coverage still remains low in the country. One important reason is the limited number of people in key populations getting tested for HIV. Linking diagnosed PLHIV with services has improved over the years. Retention of patients in care services is satisfactory; however, there is room for further improvement.

Condom promotion is an important programme area in the National STD/AIDS control programme and is carried

The Ministry of Health has initiated the process to procure ARV drugs from 2016

out by different categories of health care providers. The first ever comprehensive situation assessment on condom programming in the country was carried out in 2015 and recommendations are being implemented from 2016 onwards. National STD/AIDS Control Programme developed a national condom strategy based on the key outcomes of the situation assessment of condom programming conducted during 2015. This was developed in line with the National AIDS Policy (2011). The main aim of the national condom strategy is to ensure the availability of quality condoms of choice, either free of charge or at an affordable price, through an effective and responsive service delivery system, in order to provide quality sexual health services to the entire country. The priority of the national condom strategy is to ensure the availability of quality condoms throughout the country and to enhance the use of condoms among those key populations, vulnerable groups and PLHIV.

Condom promotion is an important programme area in the National STD/AIDS Control Programme

National STD/AIDS Control Programme works with Multisectoral agencies and provides technical support for advocacy, capacity building, awareness and internalization of STI and HIV prevention activities to multi-sectoral institutions. NSACP closely works with Prison Department, Department of Police, Sri Lanka Air Force, Sri Lanka Army, Sri Lanka Navy, National Youth Services council, Ministry of Fisheries, Ministry of Education, Ministry of Labour, Sri Lanka Foreign Employment Bureau, and Road Development Authority in relation to the HIV/AIDS prevention. Each institution has different objectives under the National HIV strategic plan which tally with the National AIDS policy. The main objective is prevention and control of HIV/AIDS and STIs among people who are working in institutions and their respective target populations. All these training objectives are based on the development of capacity building in each respective institution through training of trainers. These trainings are based on training modules which include life skill based participatory training. The objective of Sri Lanka police is to develop a conducive environment for key populations to access preventive and curative health services. In addition to that, NSACP has close relationship with HIV positive

organizations and organizations who are working for key populations, and they represent all subcommittees of NAC.

At present there is a robust programme being implemented by the National STD/AIDS Control Programme along with the Family Health Bureau, aiming at eliminating mother to child transmission of HIV. It is integrated with the existing programme for elimination of Syphilis, and both programmes were scaled up in 2014. This programme aims to cover screening of all antenatal mothers attending the government institutions in the entire country.

The laboratory services of NSACP are provided by the National reference laboratory (NRL) and the peripheral laboratories for HIV and other sexually transmitted infections. NRL is the apex body of the laboratory network. It provides technical guidance for diagnostic laboratory services of the country on HIV and STI and it is the reference centre for those services. One of the primary roles of the laboratory is to screen, to diagnose and to monitor the patients with sexually transmitted infections. The range of tests provided covers mainly the bacterial and the viral STIs. Although private sector provides a range of STI and HIV screening tests, the confirmatory test for HIV can only be done at NRL.

Information, Education and Communication on STIs and HIV/AIDS is an important programme area of the NSACP. This work is carried out routinely at different levels. NSACP has taken steps to develop a communication strategy for reaching key populations, vulnerable populations and the general population. This will address the further strengthening of existing programmes and to achieve the target of zero new HIV infection by 2030.

Training and capacity building of healthcare workers and other staff is an important programme area of the NSACP. The training includes both preventive and clinical training. Undergraduate and postgraduate medical training is one of the most important activities conducted by the NSACP and other STD clinics located in teaching hospitals. The continuous training is provided for the health care providers

All antenatal mothers are screened for provider initiated HIV

to update the knowledge and skills in relation to STIS & HIV, and to minimize stigma and discrimination. In addition to that, district level Primary Health Care Workers are provided training on behavioural change communication during year 2016 with the published booklet on “Social behavioural change communication for HIV prevention” which was published in 2015. Although Sri Lanka has a comprehensive reproductive health education policy in the school education sector for a long time, it is not comparable with international standards in relevance to sexual health. One of the aims of the district level public health staff should be to provide knowledge for school children during routine school medical inspections.

Training and capacity

building of healthcare workers

reduce the

Stigma and discrimination towards

HIV infected persons

Financial commitment is essential to respond to the national AIDS response successfully. Sri Lankan Financial contribution for AIDS response is improving year by year, and from 2016 in both curative and preventive sectors. Although Sri Lanka provides free ART from year 2004, government funds are allocated for ART from 2016 onwards.

It should be noted that the number of new cases identified annually is increasing. This may be due to increasing of the incidence or increasing of HIV testing, or both. Most of the risk behaviours that facilitate the spread of HIV exist within the country. Hence, necessary policy development & legislation, strengthening of national coordination through multisectoral approach, community participation and capacity building should be further strengthened to achieve zero new HIV infection by 2030.

What are the Services Available at Sexually Transmitted Disease Clinics in the Government Sector in Sri Lanka?

- HIV/ STI screening
- Diagnosis and management of STI/HIV
- Condom promotion
- Counselling
- Health education
- Partner notification and epidemiological treatment
- Family planning services for people living with HIV

Government Hospitals Which Have STD Clinics

Any person can visit these clinics without a referral. Confidentiality will be kept very strictly.

Colombo Central Clinic	-	01 1-2667163
Ampara	-	063-2224239
Anuradhapura	-	025-2236461
Badulla	-	055-2222578
Balapitiya	-	091-2256822
Batticaloa	-	065-2222261
Chilaw	-	032-2220750
Embilipitiya	-	047-2230261
Galle	-	091-2245998
Gampaha	-	033-2234383
Hambantota	-	047-2222247
Jaffna	-	021-2217756
Kalubowila	-	0114-891055
Kalmunai	-	067-2223660
Kalutara	-	034-2236937

*Referral
is not
necessary
to attend
a STD
Clinic*

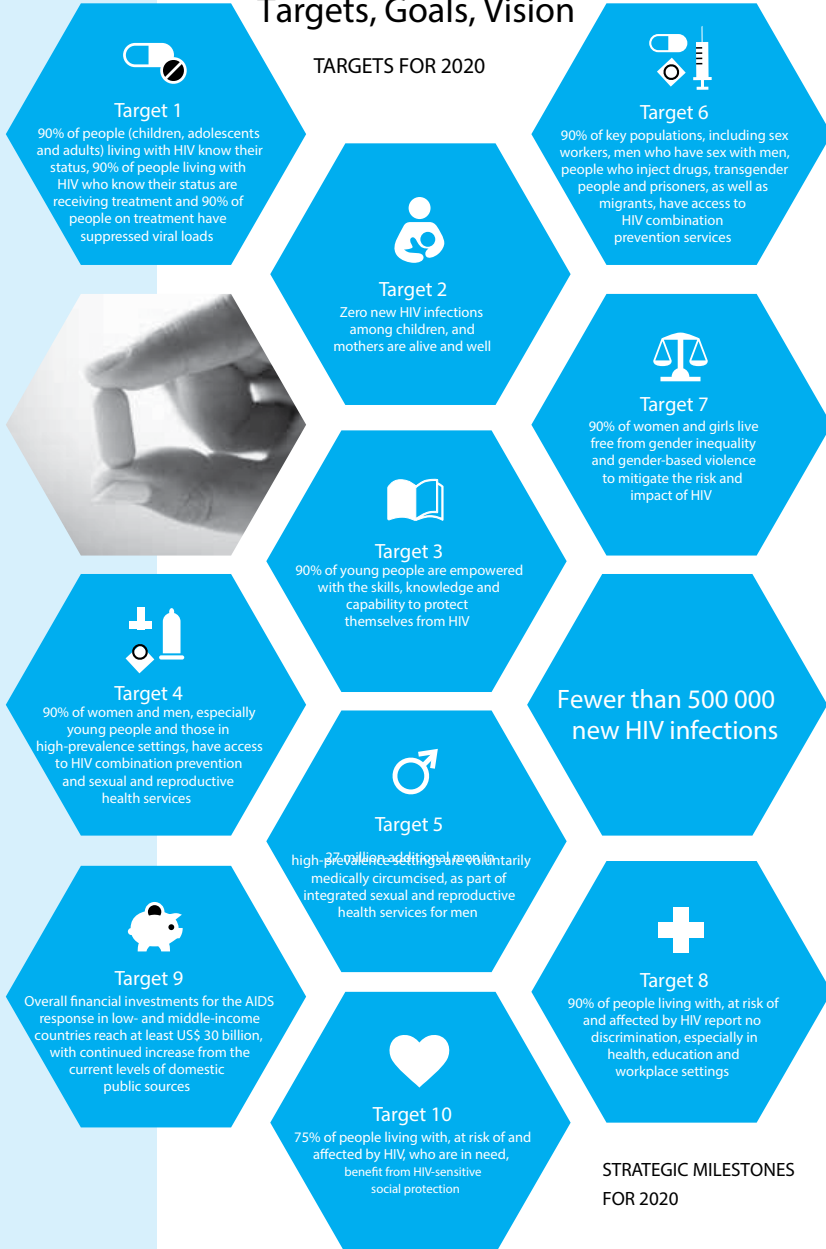
*Clients'
confidentiality
is maintained
at STD Clinics*

Kandy	-	081-2203622
Kegalle	-	035-2231222
Kilinochchi	-	021-2285327
Kurunegala	-	037-2224339
Mannar	-	023-2250573
Matale	-	066-2222261
Matara	-	041-2232302
Monaragala	-	055-2276826
Mahamodara	-	091-2245998
Mahiyangana	-	055-2257261
Negombo	-	031-2222261
NuwaraEliya	-	052-2222261
Polonnaruwa	-	027-2225787
Ragama	-	0112960224
Rathnapura	-	045-2226561
Trincomalee	-	026-2222563
Vavuniya	-	024-2224575
Wathupitiwala	-	033-2280261

Sustainable Development Goals for 2030



Figure 5 - UNAIDS 2016–2021 Strategy:
Targets, Goals, Vision



Strategies at a Glance: Eight Result Areas

GOOD HEALTH AND WELL-BEING (SDG 3)

Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

- Voluntary HIV testing services accessible for people at risk of HIV infection
- Early infant diagnostic services accessible to all children exposed to HIV, and all children under 5 years living with HIV on treatment
- All adults, adolescents and children offered antiretroviral therapy and linked to treatment services upon HIV diagnosis
- People on treatment supported and monitored regularly, including scaled-up viral load monitoring, and treatment literacy and nutritional support
- Accessibility, affordability and quality of HIV treatment improved, including through community delivery systems
- HIV services scaled-up and adapted to local contexts, including in cities, fragile communities and humanitarian emergencies
- Adequate investments made in research and development for better diagnostics, antiretroviral medicines, prevention commodities, monitoring tools, vaccines and a cure

Ending AIDS by

2030

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

REDUCED INEQUALITIES (SDG 10)

Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

- Youth-friendly HIV, sexual and reproductive health and harm reduction information and services accessed independently and equally by young women and men
- All people, especially young people, reduce HIV-related risk behaviour and access HIV combination prevention services, including primary prevention and sexual and reproductive health services
- Twenty billion condoms available annually in low and middle income countries for people of all ages
- Additional 27 million men in high-prevalence settings voluntarily medically circumcised as part of access to integrated sexual and reproductive health services for men
- Quality and comprehensive education on sexuality accessed by all adolescents and young people
- Information accessed, awareness raised and demand created through traditional and new forms of communication and outreach
- Young people meaningfully engaged in the response to ensure effectiveness and sustainability

New HIV infections among children eliminated and their mothers' health and well-being is sustained

- Immediate treatment accessible to all pregnant women living with HIV (Option B+)
- HIV, sexual and reproductive health, including family planning, tuberculosis and maternal and child health

*Ending AIDS by
2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

- services integrated and accessible for women, especially women living with HIV
- HIV prevention services for male partners promoted, including testing and treatment

Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

- Combination of preventive services adequately resourced and available, tailored to populations, locations and interventions with maximum impact
- Outreach and new media inform and create demand for use of traditional and new prevention technologies, including condoms and pre-exposure prophylaxis
- Three million people on pre-exposure prophylaxis annually, focused particularly on key populations and people at high risk in high prevalence settings
- People who inject drugs access clean needles and syringes, as well as opioid substitution therapy and other evidence informed drug dependence treatment
- Migrants, refugees and crisis-affected populations have access to HIV-related services
- People living with HIV and other key populations meaningfully engaged in decision-making and implementation of HIV prevention programmes

*Ending AIDS by
2030*

*Zero new
infections*

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related
deaths*

GENDER EQUALITY (SDG 5)

Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

- Women & girls and men & boys engaged and empowered to prevent gender-based, sexual and intimate partner violence, and promote healthy gender norms and behaviour
- Laws, policies and practices enable women and girls to protect themselves from HIV and access HIV-related services, including by upholding their rights and autonomy
- Sexual and reproductive health and rights needs fully met to prevent HIV transmission
- Young women in high-prevalence settings access economic empowerment initiatives
- Women meaningfully engaged in decision-making and implementation of the AIDS response

PARTNERSHIPS FOR THE GOALS (SDG 17)

AIDS response is fully funded and efficiently implemented based on reliable strategic information

- Investment of at least US\$ 31.1 billion available for the global AIDS response annually in 2020 in low- and middle-income countries, with one quarter invested in prevention globally
- Low-income countries mobilize at least on average 12% of country resource needs, lower-middle-income mobilize 45% and upper-middle-income countries mobilize 95% from domestic sources

*Ending AIDS by
2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

- International investment for the AIDS response reaches US\$ 12.7 billion
- Financial sustainability transition plans and country compacts implemented
- Countries use timely, appropriate and reliable strategic information to prioritize resource allocation, evaluate responses and inform accountability processes
- Allocative and productive efficiency gains fully exploited and commodity costs reduced in countries of all income levels, including by overcoming restrictive intellectual property and trade barriers
- Country capacity built, including through technology transfer arrangements
- Investment and support to civil society, including networks of people living with, at risk of and affected by HIV, scaled up to enhance their essential role in the response
 - Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed
- Punitive laws, policies and practices removed, including overly broad criminalization of HIV transmission, travel restrictions, mandatory testing and those that block key populations' access to services
- People living with, at risk of and affected by HIV know their rights and are able to access legal services and challenge violations of human rights
- HIV-related stigma and discrimination eliminated among service providers in health-care, workplace and educational settings
- Laws, policies and programmes to prevent and address violence against key populations issued and implemented

*Ending AIDS by
2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

People-centred HIV and health services are integrated
in the context of stronger systems for health

*Ending AIDS by
2030*

*Zero new
infections*

*Zero
discrimination*

*Zero AIDS
related
deaths*

- HIV-sensitive universal health coverage schemes implemented
- People living with, at risk of and affected by HIV empowered through HIV-sensitive national social protection programmes, including cash transfers
- People living with, at risk of and affected by HIV access integrated services, including for HIV, tuberculosis, sexual and reproductive health, maternal, newborn and child health, hepatitis, drug dependence, food and nutrition support and noncommunicable diseases, especially at the community level
- Comprehensive systems for health strengthened through integration of community service delivery with formal health systems
- Human resources for health trained, capacitated and retained to deliver integrated health and HIV services
- Stock-outs prevented through strengthened procurement and supply chain systems

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MULTI-SECTORAL UNIT
NATIONAL STD/AIDS CONTROL PROGRAMME

**Working together, ending the AIDS epidemic is possible
and it will take leaving no one behind**

Michel Sidibe, Executive Director of UNAIDS 2015

**Together We Can End the AIDS
Epidemic by 2030.**

