Integration of STI and HIV services in Sri Lanka

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Sri Lanka remains one of the few countries in the region which maintains low epidemic levels even 25 years after the detection of the first HIV infected Sri Lankan in 1987. HIV prevalence appears to be below 1% even among the most at risk population such as sex workers and men having sex with men. The estimated number of people living with HIV at the end of 2009 was 3000 and the estimated prevalence among adults (15-49 years) is less than 0.1%. By end of 2011, 1463 cases were reported to NSACP with HIV infection. Male to female ratio has remained 1.5:1. (1)

Early response

The establishment of the Venereal Diseases Control Project (Ceylon 0005) in 1952 was one of the earliest field projects undertaken by the WHO in the South East Asia region. In 1954 this was named Anti Venereal Diseases campaign. (2)

Anti Venereal Diseases Campaign of Sri Lanka responded to the HIV epidemic as early as 1986 by establishing the National Task Force (NTF) for prevention and control of AIDS as well as developing the short term strategic plan of action (STP). The first ever epidemiological surveillance was included in the STP in 1986. Screening tests for HIV were also introduced to Sri Lanka in the same year. These actions were taken even before the detection of the first case of HIV in Sri Lanka in a foreigner in September 1986. (3)

The first Sri Lankan with HIV was identified in the very early period of the epidemic in April 1987. The NTF was improved as the National AIDS Committee (NAC) in February 1988. This was followed by formulation of medium term plan 1 (MTP- 1) in October 1988 with the objectives of upgrading of STD services for prevention and control of AIDS.

The AIDS project office was established in 1990 at Palmyrah Avenue, Colombo 4 under the Director of the National STD Control Programme. Based on the suggestions of the external review in 1993, the AIDS project office was formally integrated into the existing National STD Control Programme as the National STD AIDS Control Programme (NSACP) of Sri Lanka. Integrating both STI and HIV prevention and care services under one authority was a major positive step taken in the early period. Since then NSACP has been leading the national response against STD and HIV with other relevant stake holders. (3)

Strategic planning based on external review

The first external review, conducted in 1993 suggested expansion of the National AIDS Committee to include other sectors and to form provincial level committees to act on AIDS prevention. Sub committees were developed for IEC, clinical, epidemiology, research and laboratory components. Based on the findings of the external review, the Medium Term Plan 2 was formulated in 1994. UNAIDS theme group was formed one year later in 1995.

The National Integrated Work plan was formulated in 1998. Second external review was conducted in 2000 and strategic plan for the period 2001-2005 was developed based on the suggestions. In 2006 an extensive external review was conducted to assess the response of the programme and the findings and recommendations were considered in developing the strategic plan for 2007 -2011. (4)

Surveillance

Effective surveillance is an essential part of successful response to STI/HIV epidemic. STI surveillance in Sri Lanka began in 1950s with establishment of the

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Anti VD Campaign. In 2010, STI cases have been reported from 30 sentinel sites across the country. Standard case definitions are developed and uniformity of data collection is ensured by regular training. (5)

HIV AIDS case reporting was started in 1987 in all facilities conducting HIV testing.

First round of HIV sentinel sero surveillance was carried out in July 1990 and this has been conducted annually. The sentinel surveillance was further strengthened in 1993 and 1997. The key populations identified included high risk (STD clinic attendees and FSW), moderate risk (TB patients) and low risk (blood donors). Drug users and MSM populations were included in the surveillance since 2009. (6)

Community based behavioural surveillance in high risk populations was conducted in 2006 covering MARP such as FSW, MSM, beach boys and drug users and intermediate risk groups such as factory workers and three wheeler drivers. (7)

Regular surveillance over the years has given a better understanding of the epidemic situation in the country. HIV prevalence levels have remained at low without significant changes over the years. In 2009, sero-prevalence among FSW was zero (n=1032) and 0.15% among STD clinic attendees.

In low level epidemics STIs are sensitive markers of high risk sexual activity. Monitoring STI rates can help identify HIV vulnerability and also help to evaluate the success of prevention programmes. Rates of sexually transmitted infections among FSW range from 0.72% for infectious syphilis to 3.4% for gonorrhoea. (2)

Development of STI services

STI services are critical entry point for HIV prevention in low –level epidemics. Early diagnosis and treatment of STI will decrease related morbidity and reduce the likelihood of HIV transmission.

The national programme reaches the provinces through 28 STD clinics throughout the island. As part

of the NSACP these clinics are involved in advocacy, surveillance and preventive work in the community, in addition to provision of patient management services.

Under the HIV component of the World Bank Health Services project 1997 -2001 twenty one STD clinics were upgraded including laboratories, furniture and equipment. Vehicles were provided to facilitate preventive work in the community. These changes facilitated STD and HIV prevention work in respective provinces.

Comprehensive care is offered free of charge to all who seek services at the STD clinics in a non judgmental environment where seeking services is encouraged by having open clinics with wider accessibility. Diagnostic facilities are offered to all those who seek services including counselling and testing for HIV, screening for STI with routine pap screening for females. Patients are managed according to the guidelines on STD and HIV including appropriate treatment, contact tracing, regular follow up and defaulter tracing. Services for PLHA are offered in the same STD clinics ranging from counseling to provision of ART services.

The skilled, trained staff (including curative as well as preventive staff) is the strength of the national programme. Compulsory pre-service training for major staff at the NSACP premises, before assuming office in the provincial STD clinic, have contributed to better service provision of services which need to be regularized and maintained.

Laboratory services

The NSACP is privileged to have the reference laboratory for STI and HIV headed by a consultant microbiologist since late 1950s. The reference laboratory provides technical support to all regional STD clinic laboratories. Twenty five district STD clinics do have laboratory facilities for microscopy and serology testing for VDRL and HIV. Six clinics have facilities for gonococcal culture and ABST. HSV culture facilities are provided by the reference laboratory to the clinics in Colombo and suburbs. The

laboratory facilities are made available to grass root level through provision of testing facilities to other institutions in the district including antenatal VDRL testing.

Facilities are available for CD4 and viral load testing as well as base line screening tests for PLHA at the reference laboratory. However, facilities need to be developed for resistance testing and for early identification of paediatric cases.

Quality of testing is assured by regular external quality assurance by the reference centre which is in place for microscopy and VDRL and HIV testing. (6)

Over the years bacterial STI have shown a gradual decline while increasing trend has been observed in viral STI such as genital herpes and genital warts. In the year 2009 17,231 new infection episodes were reported to the NSACP, with 20.5% having genital herpes infection. (2)

Counselling and testing facilities

Increasing the numbers of people who know their HIV status is the key to expanding access to HIV prevention, treatment and care. The national policy clearly indicate the fundamental principles of testing making sure the maintenance of three Cs – informed consent, counseling and confidentiality.

Counselling and testing facilities have been scaled up since early 1990s and currently are available in all major hospitals of Sri Lanka through 30 STD clinics.

The national HIV testing algorithm is consistent with international norms and uses strategy iii in testing. The National Reference Laboratory administers external quality assurance for the public sector testing services.(2) However, there is room for improvement in uptake of testing as still a reasonable number of PLHA are identified in late stages. (8)

Scaling up HIV treatment and care

Although targeted prevention interventions designed to modify risk behaviours in sero negative individuals are important, it is clear that other preventive

approaches targeting sero-positives should also be a priority. Interventions to prevent HIV transmission and prevent ill health are termed as positive prevention.

All diagnosed PLHA are usually referred to STD clinics. STD clinics offer services ranging from screening for infections such as TB, hepatitis B, STI, CMV, toxoplasma, ongoing counseling, regular assessment of clinical and immunological stage of infection (CD4), viral load testing and co-trimoxazole prophylaxis. Females are offered regular pap smear screening and services for family planning and prevention of mother to child transmission of HIV. At the STD clinic, mild to moderate infections are managed and all eligible patients are offered ART according to the guidelines. Patients with acute illnesses and severe infections are managed in general wards. All pregnant women identified with HIV infection are managed according to the locally adapted guidelines on PMTCT, offering ART for mother and baby, obstetric care including LSCS, infant feeding counseling and facilities for formula feeding when necessary. (9)

Development of national guidelines on HIV care in 1998 and national ART guidelines in 2005 and regular training of STD clinic staff on relevant aspects of care including stigma and discrimination and emphasis on public health approach may have further helped in positive prevention. (2) Among identified PLHA, 720 have been registered at the government STD clinics and of this all eligible are offered ART.

Low prevalence levels were observed over the years and this was maintained up to the last sero-surveillance conducted in 2009 among MARP indicating 0.2% seroprevalence among MSM and 0.15% among STD clinic attendees and seroprevalence zero for other groups. There was no significant change in the seroprevalence levels in MARP over the years. (5)

Free health services

Provision of free health care facilities encourages early health care seeking behaviors. All services are offered free of charge for STI and HIV management

including ART, testing facilities and drugs for management of opportunistic infections. The well structured primary health care system which is in operation for over six decades facilitates the accessibility to health services. General health improvement is indicated in several health indices including MMR and IMR. Socio cultural factors play an important role in improving reproductive health of individuals. In Sri Lanka the high literacy rate due to free education has helped to improve the status of women in the society.

Conclusion

Sri Lanka has shown an early response to the epidemic with appropriate planning based on regular external reviews which may have helped to maintain very low prevalence for three decades. Regular surveillance since 1986 with periodical improvements helped in identifying trends and monitoring the situation. Having a strong national STD control programme and integrating HIV control into the existing programme with well established network of clinics throughout the island and development of the speciality of venereology emphasizing the public health approaches may have helped to maintain reasonable standards in services.(10)

Further, access to free quality health services including primary health care and antenatal care and STI services, low prevalence of STI even among MARP, safe blood transfusion services and TB control services may have helped to maintain the low level epidemic. (11)

However, it should be noted that the number of new cases identified annually is increasing. Most of the risk behaviours that facilitate the spread of HIV exist within the country. According to UNAIDS, countries that still have low levels of HIV infection, should avert the epidemics potential spread, rather than take comfort from current infection rates. The moment we become complacent the possibility is there that the epidemic which has already got a foot hold in the country, will get firmly entrenched in it. The need of the hour is to strengthen the existing programmes to reduce the HIV and STI transmission further.(12)

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