Presidential Address - 2012

National response to the HIV epidemic in Sri Lanka

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The Chief Guest, Dr Nihal Jayatilaka,
Secretary, Ministry of Health, Sri Lanka

Guest of Honour. Dr Russell Waddell,
Consultant in Sexual Health, Royal Adelaide Hospital,
South Australia

All the overseas speakers

Local speakers

Additional Secretary, Ministry of Health
Dr Palitha Mahipala

Deputy Director General, Public Health Services
Dr Sarath Amunugama

Director, National STD / AIDS Control Programme,
Dr Nimal Edirisinghe

Members of the council of the College of
Venereologists

My colleagues and staff in the National STD/AIDS
Control Programme

My colleagues in Teaching Hospital, Ragama and all
of you who are here today to grace this occasion,

I take this opportunity to give you an insight into the
national response to the HIV epidemic in Sri Lanka.

I would like to start my address by taking you through
the history of the HIV epidemic in Sri Lanka.

As many of you are aware, Sri Lanka is still classified
as a low prevalent country for HIV. We came across
our first HIV positive patient in 1987 with a diagnosis
of *Pneumocystis jirovecii* pneumonia. He has had
homosexual exposures in a foreign country. The first
Sri Lankan who acquired the infection locally was
diagnosed in 1989. The facilities for management of
HIV positives were very limited at that period, and

the awareness and attitudes of health care staff and
the general public on HIV was very much different
to the situation which prevails today.

The incidence of HIV in Sri Lanka gradually increased
since 1987 where more males were affected than
females. By the end of year 2003 most number of
cases were reported from the district of Colombo.
By the end of 2010, heterosexual transmission has
contributed most to the epidemic (82.5%). The
transmission of HIV through homo or bisexual
exposures was 11.3% with 4.4% being transmitted
perinatally.

Almost 23 years after the diagnosis of the first patient,
as at June 2012, a total of 1544 cases have been
reported to the National STD/AIDS Control
Programme. The reasons for gradual increase may
be due to the increased awareness among health care
workers leading to more testing, and partly due to
the availability of ART which encourages people to
come forward for testing.

The estimated number of HIV cases for year 2009
and 2011 are 3000 and 4200 respectively. The
estimates are made by mathematical calculations
taking certain variables into consideration. Though
the number estimated is 3000, so far we have
identified only 1544 patients. The undiagnosed
positives are a major threat especially if they are
among the most at risk populations. The diagnosis of
the undiagnosed can be achieved only by testing. It
is the responsibility of all of us to encourage people
more and more for voluntary counselling and testing,
specially the most at risk populations.

The National STD/AIDS Control Programme
conducts annual sero surveillance to find out the

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changes in the epidemic since 1993 and conducts sentinel surveys annually to find the prevalence of HIV in different populations. These surveys show a dramatic increase of HIV prevalence among the MSMs from 2009 (0.48%) to 2011 (0.9%) and quite correctly we have started the targeted interventions.

The prevalence among sex workers has not shown any significant change. The reasons may be the early interventions among that group by governmental as well as through some non-governmental organisations.

The trend of early syphilis during the recent years (2008-2011) shows a very clear rise in males above 25 years, again giving clear evidence of unprotected sex among MSMs.

Taking all these data and trends into consideration, what have we done to prevent HIV transmission in Sri Lanka?

These are some of the milestones in the national response of Sri Lanka towards the HIV epidemic.

1985 - Sri Lanka took steps to face an impending threat and the Anti VD Campaign which was established in 1952 was upgraded as the National STD/AIDS Control Programme.

1987 - The visible threat of HIV/AIDS was felt in Sri Lanka with the detection of HIV infection in a Sri Lankan citizen (10.02.1987)

1988 - Medium term plan I (MTP I) formulated

1989 - The National AIDS Committee (NAC) was established, chaired by the Secretary of the Ministry of Health with a wide representation from many fields

1994 - Medium term plan II (MTP II) formulated

1998 - National integrated work plan developed

The national response is guided by the **‘three ones’ principle**.

- One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One agreed country-level Monitoring and Evaluation System.

The National AIDS Council formed in 2006, is the highest governing body chaired by His Excellency the President and relevant ministers as members. The National AIDS Committee (NAC) which is chaired by the Secretary Health oversees the implementation of the national response. The NGOs and donors have representatives in the NAC. NAC has sub committees in areas of prevention, care & support, research, surveillance, legal & ethical issues.

A national strategic plan was developed for the period of 2007- 2011. The overall goal of the national response was to reduce the impact of the HIV/AIDS epidemic on social development of Sri Lanka.

The goals of the National STD/AIDS Control Programme

- Maintain current low prevalence of HIV among most-at-risk-populations (MARPs) and the general population
- Improve the quality of life of people infected with, or affected by HIV

The strategic objectives

1. Increase coverage and effectiveness of preventive interventions
2. Increase coverage and effectiveness of care, support and treatment interventions

Under the prevention component of the national strategic plan, increased scale and quality of comprehensive interventions for MARPs was the priority. Female sex workers and clients, MSM and clients of male sex workers, drug users/ intravenous drug users, and prisoners were considered as MARPs. There are many targeted interventions covering these priority groups.

We have not forgotten the lesser risk groups and the general population and there are many preventive activities for these populations as well.

STI prevention and control services were established in Sri Lanka in 1952. To date this service has expanded to provide treatment, care and support for people living with HIV (PLHIV). The STD headquarters is located in Colombo where prevention activities are planned and guided. It is supported by a National Reference Laboratory. The national STD centre networks with 29 full time peripheral and 19 branch clinics. There are 5 full time ART centres and the main STD clinics are visited by a consultant twice a week.

Although the HIV sero-positivity rate among antenatal mothers range between 0.01-0.02%, there are 54 children who have acquired HIV infection through vertical transmission. In order to reduce the number of paediatric HIV infections and provide comprehensive care for HIV positive mothers, strategies for sexual and reproductive health integration into the maternal and health care services is being implemented. Prevention of mother-to-child transmission has been integrated to the antenatal care package of the Family Health Bureau of Ministry of Health. Universal antenatal screening for HIV is being considered, given the high degree of quality care that is being given to women during pregnancy in Sri Lanka. It is important to mention here that Sri Lanka has remarkably low maternal mortality, infant mortality and under 5 mortality rates.

Sri Lanka is one of the few countries in the world which has kept transfusion related HIV infection at a very low level. An important policy decision was made in 1988 to educate all blood donors on STI/HIV/AIDS, provide counselling for blood donors and screening all donated blood for HIV infection. As a result since year 2000 no transfusion transmitted infections have been reported.

We have taken all the steps to prevent transmission in health care settings as much as possible and to provide the health staff who are subjected to

occupational exposures with post exposure prophylaxis (PEP).

Treatment and care services for PLHIV are delivered through 28 STD clinics. ART is available free of charge since 2004 in 5 centres (4 centres are on site drug dispensing units and one identified Base Hospital, former Infectious Disease Hospital in Angoda). Under the GFATM project, the other major STD clinics are visited by consultants twice a month including Jaffna. National treatment protocols are used for treating patients. All eligible patients are given ART.

Availability of CD4 monitoring and viral load testing, training of health care workers on HIV, ART, diagnosis and management, confidentiality, prevention of stigma and discrimination are some of the services we provide for people living with HIV. The positive networks are actively involved in all decision making and are represented in the NAC as well.

The other major strategy is generating and using strategic information. A national HIV/AIDS Strategic Information Management (SIM) 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 SIM monitors the NSP and its targets.

We have identified the importance of multi-sectoral involvement in the national response to HIV and we have increased engagement and capacity of NGOs in prevention, care and policy development and got the other ministries and sectors such as Department of Education and National Institute of Education, Foreign Employment Bureau and Department of Fisheries and Aquatic Resources involved in prevention activities. By now many non- health ministries have internalized HIV prevention and care.

Policy development and legislation and strengthening national coordination and management capacity are other strategies in the direction of reaching the national goal.

The National STD/AIDS Control Programme has many committees and sub committees for planning and implementation of identified strategies.

There are many successes and challenges that we faced during this journey.

Sri Lanka managing to get support from the Global Fund, which is the biggest fund received so far is a major success. The most important activity which is being carried out under the Global Fund is the targeted interventions for MARPs. ART is also supplied by the Global Fund. High involvement of non-governmental organisations also is a major achievement that we have gained. (But the capacity of those organizations should be increased)

In reaching key populations we had to face many challenges. Among these, difficulty in working with MARPs due to the existing law in the country was a major challenge. More conducive, non stigmatizing and non discriminating legal and policy environment should be created for effective interventions.

Educating and sensitizing police officers on the targets of NSACP has been taken up as a priority and island wide coverage of police officers is done by the multi-sectoral unit.

Due to the current low prevalence of the disease it is difficult to convince the policy makers on the importance of addressing HIV.

Policies on FSWs, MSMs should be seriously considered with a greater political commitment.

We have the task of finding a way to continue ART without the support of external funding. As Sri Lanka became a low middle income country, we are facing problems in funding and getting ART at subsidised rates.

With all these challenges we were able to adopt some best practices like treatment as prevention where the cut off CD4 count for starting ART was increased from 200 to 350 cells/mm³ globally, treatment for sero-discordant couples irrespective of the CD4 count and

treatment for high risk populations irrespective of the CD4 count.

An external review was done in 2011 June, for the development of the next strategic plan which is in the draft stage now. A major observation by the review was the discriminatory practices of health care workers once the diagnosis of HIV is made. They were also concerned on the continuation of ART, free of charge.

The other important observation made by the review was on injecting drug users. As we do not have sufficient data on injecting drug users and their behaviour, preventing HIV infection among injectors should be a priority in the future with mapping, size estimation, studying transmission patterns and trends among injecting drug users.

I hereby request from this learned audience to understand the multi-sectoral approach and partnership which is needed in curbing the epidemic, since all the measures are taken with an evidence based approach with a blend of modern programme science with local mindfulness.