

# Annual Report

**2016**

**National STD/AIDS Control Programme, Ministry of Health, Sri Lanka**

## **National STD/AIDS Control Programme**

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## Table of contents

Table of contents	ii
List of figures	iii
List of tables	vi
Foreword	viii
Acknowledgements	ix
Abbreviations	x
Introduction	1
Situation of HIV epidemic in Sri Lanka	3
Sentinel Sero-surveillance - 2016	16
HIV testing services in 2016	19
HIV treatment and care services	22
Post exposure prophylaxis for HIV-2016	32
Situation of STIs during 2016	37
Monitoring STD services – 2016	51
EMTCT of syphilis and HIV	68
Condom promotion	74
Laboratory services	76
Multi-sectoral collaboration	81
Review of Northern & Eastern Provinces	88
Global Fund supported activities in 2016	91
Peer-led targeted interventions in 2016	95
Publications of NSACP during 2016	96
Training and capacity building	101
IEC and Advocacy programmes	104
World AIDS Day 2016	106
Demolition of old NSACP building	112
Retirement of NSACP staff in 2016	114
Obituary notice	116
News from the peripheral STD clinics	117
Financial summary - 2016	123
Contact information of STD clinics- 2016	125

## List of figures

Figure 1: Senior management team1 of the National STD/AIDS control programme	1
Figure 2: Organogram of the National STD/AIDS control programme	2
Figure 3: Sources of HIV case reporting	3
Figure 4: Trends of reported HIV cases by sex, 2007-2016	4
Figure 5: Cumulatively reported HIV cases by Age and Sex by end of 2016	4
Figure 6: Trend of age categories of reported HIV cases, 2007-2016	5
Figure 7: Probable modes of transmission of HIV cases reported in 2016 (N=249)	5
Figure 8: Probable modes of HIV transmission of reported HIV cases 2012-2016	6
Figure 9: Percentage of male to male transmission among reported male HIV cases	6
Figure 10: Number of HIV cases reported from each district during 2016	7
Figure 11: Rate of HIV cases reported in 2016 per 100,000 population	8
Figure 12: Cumulative number of HIV cases reported, 1987- 2016	9
Figure 13 : Cumulative rate of HIV cases reported 1987-2016	10
Figure 14: Number and percent of reported HIV cases by stage, 2012-2016	11
Figure 15 : Percentage and number of PLHIV linked to HIV care, 2009-2016	11
Figure 16 : Trend of HIV sero-positivity rate (%) in the donated blood, 2012-2016	12
Figure 17 : Percentage of ANC HIV seropositivity rates in DMH and CSHW 2012-2016	13
Figure 18: Cumulative cross-sectional cascade graph of HIV services for PLHIV - 2016	14
Figure 19: Cascade graph for HIV services of the cohort of PLHIV diagnosed in 2015	14
Figure 20: Estimated HIV population by sex and HIV % prevalence in 15-49 yrs.	15
Figure 21: Estimated new HIV infections by risk group during 2016	15
Figure 22: Sample collection sites for MSM and PWID in 2016	16
Figure 23: Sample collection sites for FSW and Clients of SW in 2016	17
Figure 24: HIV testing site organised on the World AIDS day, 2016	19
Figure 25: Colombo HIV clinic provides services to over 50% of all PLHIV in care	22
Figure 26: Some of the antiretroviral drugs available in Sri Lanka	23
Figure 27: Location of ART centres and number of PLHIV in HIV care as of end 2016	24
Figure 28: Number of PLHIV who initiated ART, 2004-2016	26
Figure 29: Outcome of PLHIV who initiated ART in 2015 after 12 months (N=192)	26
Figure 30: Summary of cohort analyses done from 2007-2015	27
Figure 31: Median CD4 counts at ART initiation from 2012-2016	29
Figure 32: Summary of PEP services in 2016	33
Figure 33: ART regimens used for PEP in 2016 (N = 56)	33

Figure 34: Some of the antiretroviral medicine available at NSACP _____	36
Figure 35: Diagnoses reported from STD clinics by sex during 2016 _____	38
Figure 36: Age and sex of patients with genital herpes from all STD Clinics _____	39
Figure 37: Non-gonococcal urethritis cases in all STD clinics, 2012-2016 _____	39
Figure 38: Syphilis cases (early and late) reported from STD clinics during 2016 _____	40
Figure 39: Classification of syphilis cases reported during 2016 _____	41
Figure 40: Age and sex of early syphilis cases in all STD clinics 2012-2016 _____	41
Figure 41: Age and sex of cases of late syphilis from all STD clinics, 2012- 2016 _____	42
Figure 42: Age and sex of gonorrhoea cases from all STD clinics, 2012-2016 _____	42
Figure 43: Age and sex of genital wart cases from all STD clinics, 2012 - 2016 _____	43
Figure 44: Trichomoniasis cases from all STD clinics, 2012- 2016 _____	43
Figure 45: Full-time of STD clinics in Sri Lanka, 2016 _____	51
Figure 46: New patients registered at STD clinics during 2016 (Total 21,973) _____	52
Figure 47: Sex distribution of new patients registered at STD clinics in 2016 _____	53
Figure 48: New sex workers registered in all STD clinics 2012-2016 _____	53
Figure 49: No. of new female sex workers registered in STD clinics 2012-2016 _____	54
Figure 50: Number and type of samples screened for HIV, 2012 - 2016 _____	55
Figure 51: Clinic based HIV testing and counselling for most at risk populations _____	56
Figure 52: Outreached HIV testing and counselling for most at risk populations _____	56
Figure 53: Number and type of samples screened for syphilis (in thousands) _____	57
Figure 54: Number of PAP smear tests done during 2016 _____	58
Figure 55: Results of Pap smear tests done at Colombo STD clinic, 2007-2016 _____	58
Figure 56: A healthy baby is the dream of every mother _____	68
Figure 57: IEC material developed on EMTCT during 2016 _____	70
Figure 58: Cascade graphs for elimination of mother-to-child transmission of HIV _____	73
Figure 59: Number of condoms distributed by STD clinics during 2016 _____	74
Figure 60: Number of condoms distributed by all STD clinics 2012-2016 _____	74
Figure 61: Condom promotion by Family planning association on the World AIDS Day _____	75
Figure 62: HIV testing at NRL, 2011-2016 _____	77
Figure 63: Medical Laboratory Technologists at NRL _____	80
Figure 64: Gonococcal antibiotic resistance pattern 2007-2016 _____	80
Figure 65: HIV testing center _____	
Figure 66: Media conference _____	90
Figure 67: A training session of Public Health Laboratory Technician students _____	101
Figure 68: A major staff training event at NSACP _____	102

Figure 69: Condom promotion IEC material developed by NSACP _____	105
Figure 70: Starting point of the world AIDS Day walk in 2016 _____	106
Figure 71: Participation of youth at the world AIDS Day walk in 2016 _____	108
Figure 72: Colourful events from the world AIDS Day walk in 2016 _____	108
Figure 73: Launching of Books at the world AIDS Day in 2016 _____	109
Figure 74: Section of audience at the world AIDS Day event in 2016 _____	109
Figure 75: World AIDS Day walk 2016 _____	111
Figure 76: Old building of NSACP demolished in 2016 _____	112
Figure 77: Packing and transporting furniture and other material to the new site _____	113
Figure 78: New building and its location map at No. 464, TB Jaya Mw., Colombo 10 _____	113
Figure 79: Mr W.M. Chandrarathe's farewell ceremony On 17.10.2016 _____	114
Figure 80: Mrs M.A. Sumithra's farewell ceremony on 29.8.2016 _____	114
Figure 81: Mrs. Anoma Wimalaratne's farewell ceremony on 16/6/2016 _____	115
Figure 82: Ms. G.M. Chandrawathie's farewell ceremony on 18/12/2016 _____	115
Figure 83: Dr Gowri Manohari Nanthakumar _____	116
Figure 84: Daily Mirror news article on the incident _____	116
Figure 85: Hands up for HIV prevention in Anuradhapura _____	117
Figure 86: Events from Badulla STD clinic _____	118
Figure 87: World AIDS day events organized by STD clinic Hambantota. _____	119
Figure 88: World AIDS Day events organised by STD clinic, Kalubowila _____	119
Figure 89: Training and HIV testing programmes conducted by STD clinic, Kalubowila _____	120
Figure 90: World AIDS day campaign organized by STD clinic, Kandy _____	120
Figure 91: World AIDS Day campaign and IEC material of STD clinic, Negombo _____	121
Figure 92: Creating public awareness by the staff of STD clinic, Ragama _____	121
Figure 93: Awareness and HIV testing events organised by STD clinic, Ratnapura _____	122
Figure 94: Budget allocation for NSACP during 2016 _____	124
Figure 95: Expenditure of the allocated amount by NSACP during 2016 _____	124

## List of tables

Table 1: Summary results of Sentinel survey 2016-HIV _____	17
Table 2: Summary results of Sentinel survey 2016-HBV _____	17
Table 3: Summary results of Sentinel survey 2016-HCV _____	17
Table 4: Summary results of Sentinel survey 2016 - Ever infected with syphilis _____	18
Table 5: Summary results of Sentinel survey 2016 - Active syphilis (VDRL $\geq$ 1:8) _____	18
Table 6: HIV testing details in 2016 _____	19
Table 7: HIV screening through outreach activities by all STD clinics -2016 _____	20
Table 8: HIV testing among Key populations (Escorts by peer-educators) _____	20
Table 9: Number of PLHIV* in pre-ART and ART stage as of 2016 _____	25
Table 10: Outcome of PLHIV who initiated ART in 2015 after 12 months _____	26
Table 11: Details of opportunistic infections in the year of 2016 _____	27
Table 12: ART regimens used in 2016 _____	28
Table 13: Children in HIV care services as of end 2016 _____	29
Table 14: Children in HIV care according to ART stage as of end 2016 _____	29
Table 15: Location information of ART for PEP in Sri Lanka during 2016 _____	34
Table 16: Diagnoses reported from STD clinics during 2016 _____	37
Table 17: Number of Early (Infectious) Syphilis cases reported, 2013-2016 _____	44
Table 18: Number of Late Syphilis cases reported from STD clinics during 2013-2016 _____	45
Table 19: Number of Gonorrhoea cases reported from STD clinics during 2013-2016 _____	46
Table 20: Number of Non-Gonococcal infections reported, 2013-2016 _____	47
Table 21: Number of Genital Herpes cases reported, 2013-2016 _____	48
Table 22: Number of Genital warts cases reported from STD clinics during 2013-2016 _____	49
Table 23: Number of Trichomonas cases reported from STD clinics during 2013-2016 _____	50
Table 24: HIV testing and counselling services for most at risk populations _____	55
Table 25: Number and details of clinic attendances for STD clinics during 2016 _____	59
Table 26: Treatment of Contacts in 2016 _____	60
Table 27: Samples screened for syphilis - 2016 _____	61
Table 28: Sex workers Among Clinic Attendees in 2016 _____	62
Table 29: Civil Status of New STD Clinic attendees during 2016 _____	63
Table 30: Occupational Status of New STD clinic attendees in 2016 _____	64
Table 31: Reason for attendance Among New STD clinic attendees in 2016 _____	65
Table 32: Details of the Awareness Programmes conducted by STD clinics in 2016 _____	66
Table 33: HIV Testing and Counselling Details from STD clinics during 2016 _____	67

Table 34: Minimum global indicators for validation of EMTCT _____	69
Table 35: Sri Lankan status with regards to EMTCT validation during 2016 _____	69
Table 36: Data related to mother to child transmission of syphilis during 2016 _____	70
Table 37: Indicators on EMTCT of HIV _____	71
Table 38: Children living with HIV receiving HIV care services as of end 2016 _____	72
Table 39: Number of condoms distributed to most-at-risk populations 2013 - 2016 _____	75
Table 40: Number of microscopic tests carried out in 2016 _____	79
Table 41: Number of microscopic tests carried out in 2016 _____	79
Table 42: Performance in STD clinic services in 2016 _____	88
Table 43: STD clinic performance in clinic activities in 2016 _____	88
Table 44: Financial Progress during the year 2016, by category _____	91
Table 45: Financial Progress during the year 2016, by Module _____	92
Table 46: Coverage indicators on peer-led interventions by in 2016 _____	92
Table 47: Performance reported through STD clinics for coverage indicators for 2016 _____	93
Table 48: Performance by planned interventions/major activities in 2016 _____	94
Table 49: Achievements of the peer-led targeted intervention programme by end 2016 _____	95
Table 50: The field level staff and geographic coverage of peer-led programmes _____	95
Table 51: Training and capacity building carried out by the Central clinic, Colombo _____	103
Table 52: Awareness activities carried out by NSACP in 2016 _____	104
Table 53: IEC activities work completed by district STD clinics in 2016 _____	104
Table 54: Summary of WAD activities conducted by peripheral STD clinics _____	110
Table 55: Summary of financial details for 2016 _____	123



## Foreword

The National STD/AIDS Control programme (NSACP) of the Ministry of Health, Sri Lanka is the focal point for the prevention and control of sexually transmitted infections (STI) including HIV. As a specialized public health programme under the Ministry of Health, NSACP is responsible for coordinating, planning, implementation, monitoring and evaluation of the national response to the control and prevention of STI including HIV.

At the end of 2016, NSACP has been providing both preventive and curative services through 31 full-time STD clinics and 23 branch clinics distributed island wide. The expansion of antiretroviral treatment (ART) services to 21 centers is an important achievement made during the current year. In addition, the government of Sri Lanka took over funding the programme for antiretrovirals using domestic resources from 2016.

This volume of NSACP annual report summarizes the activities conducted by the NSACP during 2016 and documents the strategic information on STI and HIV collected from all the peripheral STD clinics and ART centers situated island-wide. It is noted with satisfaction that over the years the annual report of NSACP has become a reliable reference document on HIV and STI situation in the country to both the public and the research community.

Publication of this Annual Report would not have been possible without the continuous support from the staff in STD clinics and ART centers throughout the year. NSACP continues to work towards the improvement of data quality of the reporting units and would like to acknowledge the effort taken to submit data on a timely and regular basis.

I would like to take this opportunity to thank all contributors to this document. The dedicated work of the SIM unit and contributions from staff of all reporting units are highly appreciated. It is my fervent hope that the information available in this document will be of value to further strengthen the national response to HIV and STI in Sri Lanka.

Dr Sisira Liyanage  
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National STD/AIDS Control Programme  
April 30, 2017

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## Abbreviations

• ABST	antibiotic susceptibility test
• AIDS	Acquired Immunodeficiency Syndrome
• ABC	abacavir
• ANC	antenatal clinic
• ART	antiretroviral treatment
• ARV	antiretroviral drugs
• AZT	zidovudine
• BB	Beach boy
• BCC	Behaviour Change Communication
• BH	Base Hospital
• CD4	Cluster of differentiation
• CMV	Cytomegalovirus
• CSHW	Castle Street Hospital for Women
• DGHS	Director General of Health Services
• DDG(PHS)	Deputy Director General of Public Health Services
• DFM	Diploma in Family Medicine
• DGH	District General Hospital
• DMH	De Soysa Maternity Hospital for Women
• DRV	darunavir
• DTM	Diploma in Transfusion Medicine
• DU	Drug user
• ECS	early congenital syphilis
• EFV	efavirenz
• EID	early infant diagnosis
• ELISA	enzyme linked immunosorbent assay
• EMTCT	elimination of mother to child transmission
• EIA	enzyme immune assay
• ETU	emergency treatment unit
• EQA	external quality assessment
• FSW	Female sex worker
• FTC	emtricitabine
• GFATM	Global Fund to fight AIDS, TB & Malaria
• GOSL	Government of Sri Lanka
• GH	General Hospital
• HBsAg	Hepatitis B Surface Antigen
• HCW	Health care worker
• HDL	high density lipoprotein
• HIV	human immunodeficiency virus
• HPV	human papillomavirus

- HSV herpes simplex virus
- HTC HIV testing and counselling
- HTS HIV testing services
- HCG human chorionic gonadotropin
- ICU intensive care unit
- ICTA information and communication technology agency
- IDU Injecting drug user
- IDV indinavir
- IEC information, education & communication
- KP Key population
- LFU lost to follow up
- LPV lopinavir
- LPV/r lopinavir and ritonavir
- LDL low density lipoprotein
- MAC mycobacterium avium complex
- M&E monitoring and evaluation
- MCH maternal & child health
- MARP most at risk populations
- MD Doctor of medicine
- MDG Millennium Development Goals
- MLT Medical laboratory technologist
- MO Medical officer
- MOIC Medical officer in charge
- MS Medical student
- MTCT mother to child transmission
- MSM Men who have sex with men
- NAC National AIDS Committee
- NGO nongovernmental organization
- NGU non-gonococcal urethritis
- NBTS National Blood Transfusion Service
- NFM New funding model
- NNRTI non-nucleoside reverse transcriptase inhibitor
- NPTCCD National Programme for Tuberculosis Control and Chest Diseases
- NRL National Reference Laboratory
- NRTI nucleoside reverse transcriptase inhibitor
- NSACP National STD/AIDS control programme
- NS Nursing student
- NVP nevirapine
- OI opportunistic infections
- PA particle agglutination
- PCR polymerase chain reaction

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• PE	peer educators
• PLHIV	People living with human immunodeficiency virus
• PHI	Public health inspector
• PHNS	Public health nursing sister
• PGC	presumptive gonococcal infection
• PI	protease inhibitor
• PMTCT	prevention of mother to child transmission
• PEP	post exposure prophylaxis
• PEPFAR	President's Emergency Plan for AIDS Relief
• PCU	primary care unit
• PICT	provider initiated counselling and testing
• PWID	people who inject drugs
• RAL	raltegravir
• SGOT	serum glutamic oxaloacetic transaminase
• SGPT	serum glutamic pyruvic transaminase
• STI	sexually transmitted infections
• STD	sexually transmitted diseases
• TB	tuberculosis
• TDF	tenofovir
• TPPA	Treponema pallidum particle agglutination assay
• TOT	Training of trainers
• TTI	Transfusion transmissible infections
• UNAIDS	Joint united nations programme on HIV/AIDS
• UNICEF	United nations international children emergency fund
• UNFPA	United Nations Population Fund
• VDRL	venereal disease research laboratory test
• WHO	World health organization
• 3TC	lamivudine
• VCT	Voluntary Counselling and Testing

Final draft

*“National STD/AIDS control programme (NSACP) is responsible for coordinating, planning, implementation, monitoring and evaluation of the national response to the control and prevention of STI including HIV. In Sri Lanka”*

## Introduction

### Introduction

The National STD/AIDS control programme (NSACP) is responsible for coordinating, planning and implementation of the HIV National Strategic Plan in line with the AIDS Policy in the country. The headquarters of the NSACP is situated at 29, De Saram Place Colombo 10, Sri Lanka. As of end 2016, there are 31 full-time STD clinics and 23 branch STD clinics in Sri Lanka. Of these STD clinics, 21 have the capacity to provide antiretroviral treatment (ART) services. NSACP networks with all these clinics. Other than Base hospital Angoda (IDH), NSACP is the sole provider of antiretroviral treatment services in Sri Lanka.

**Figure 1: Senior management team<sup>1</sup> of the National STD/AIDS control programme**



### Vision

Quality sexual health services for a healthier nation.

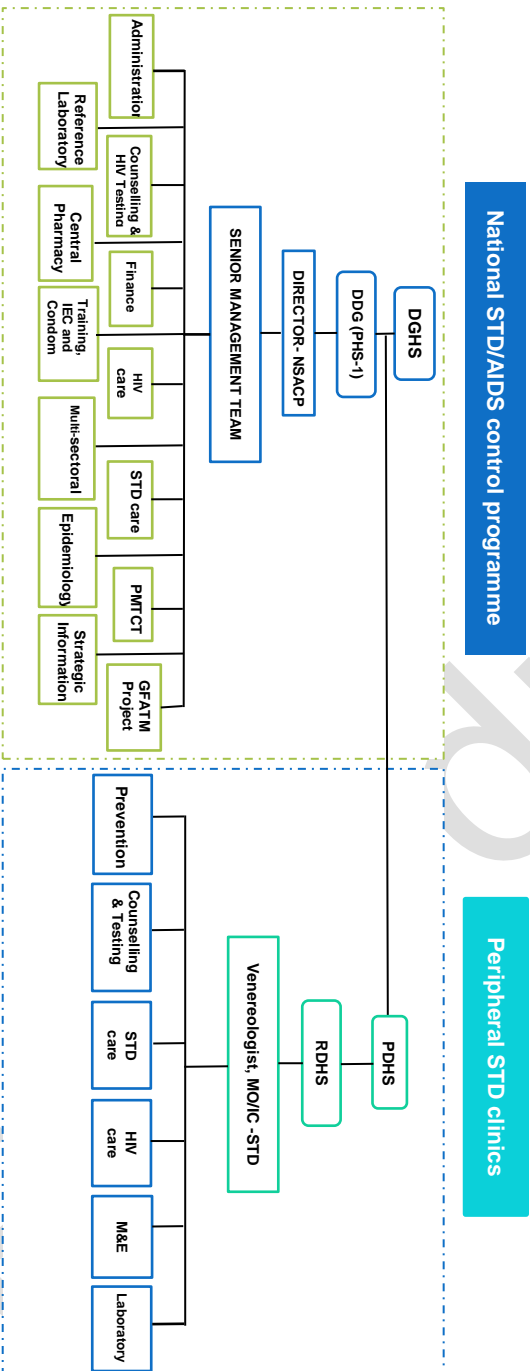
### Mission

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

1.

**Seated L to R:** Dr S. Beneragama, Dr G. Weerasinghe, Dr S. Liyange, Dr L.I. Rajapakse, Dr K. A. M. Ariyaratne,  
**Standing L to R:** Ms P. Valli, Mrs. W.A. Malani, Dr J. Vidanapathirana, Dr J.P. Elwitigala, Dr H.P. Perera, Dr S. Herath

Figure 2: Organogram of the National STD/AIDS control programme



Abbreviations used: DGHS- Director general of health service, DDG (PHS-1)- Deputy director general (public health services-1), PMTCT- Prevention of mother to child transmission, GFATM- Global Fund for AIDS, tuberculosis and malaria, PDHS- Provincial director of health services, RDHS- Regional director of health services, M&E- monitoring and evaluation



## Situation of HIV epidemic in Sri Lanka

*“HIV and AIDS are not notifiable in Sri Lanka. Reported HIV cases may represent only a fraction of HIV infected people as many infected persons may not be aware of their HIV status and the reporting is adversely affected by stigma and discrimination towards this condition”*

During 2016, a total of 249 HIV cases were newly reported in Sri Lanka. This is the highest number reported in a year since the identification of the first HIV infected Sri Lankan in 1987 and this amounts to about 21 persons newly reported with HIV for a month. However, the reported numbers represent only a fraction of HIV infected people in the country as many infected persons may perhaps not be aware of their HIV status and in addition, stigma and discrimination towards HIV hinders seeking HIV testing services.

NSACP captured data on HIV infected persons through both active and passive surveillance case reporting systems. Components of these systems include,

- HIV case reporting data
- Antenatal testing data
- Blood donor data
- HIV estimation data
- HIV sentinel surveillance

### HIV case reporting data

Although HIV is not a notifiable disease in Sri Lanka, data on all HIV infected persons are collected by National STD/AIDS control programme. This is possible as the Western-Blot, the confirmatory test for HIV, is available only at the National reference laboratory of the NSACP. However, it is not uncommon to find incomplete basic epidemiological information about the infected persons. NSACP updated the data collection formats on HIV case reporting to get more relevant strategic information on persons reported with HIV infection.

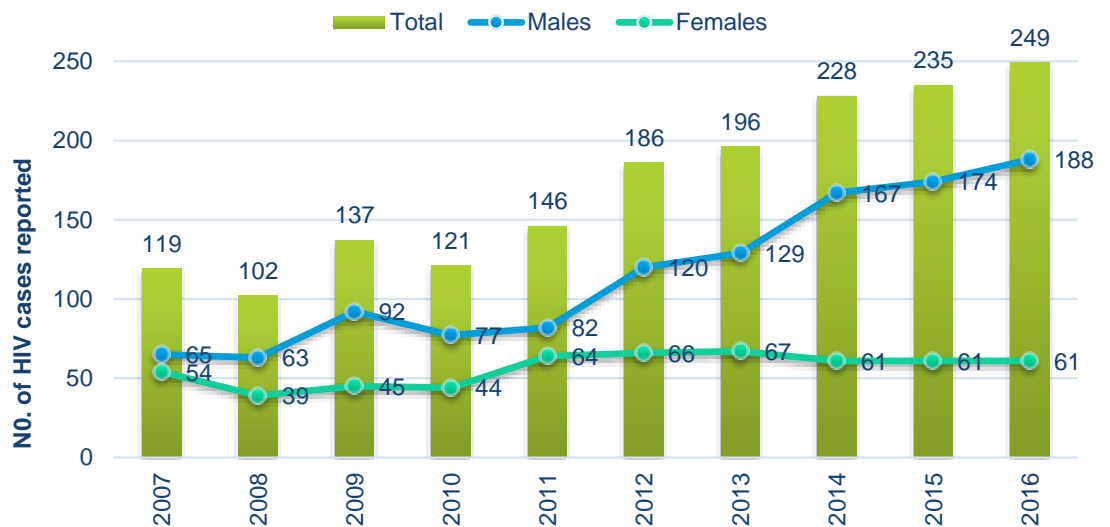
**Figure 3: Sources of HIV case reporting**



## Trends of reported HIV cases by sex

Figure 3 shows the trend of reported HIV cases by sex during last 10 years. Although the percent increase in number of HIV cases reported is nearly 110% over last 10 years, this increase is mainly due to increase among males. The percentage increase among males is 190% whereas number of females has increased only by 13% during this period. In addition to increase in new HIV infections, increase in testing facilities and better reporting have contributed to this trend.

**Figure 4: Trends of reported HIV cases by sex, 2007-2016**



Since 2011, proportion of males with HIV are gradually increasing. The male to female ratio of cumulative reported cases as of end 2016 was 1.8:1. However, during 2016 the male to female ratio increased to 3.1:1.

**Figure 5: Cumulatively reported HIV cases by Age and Sex by end of 2016**

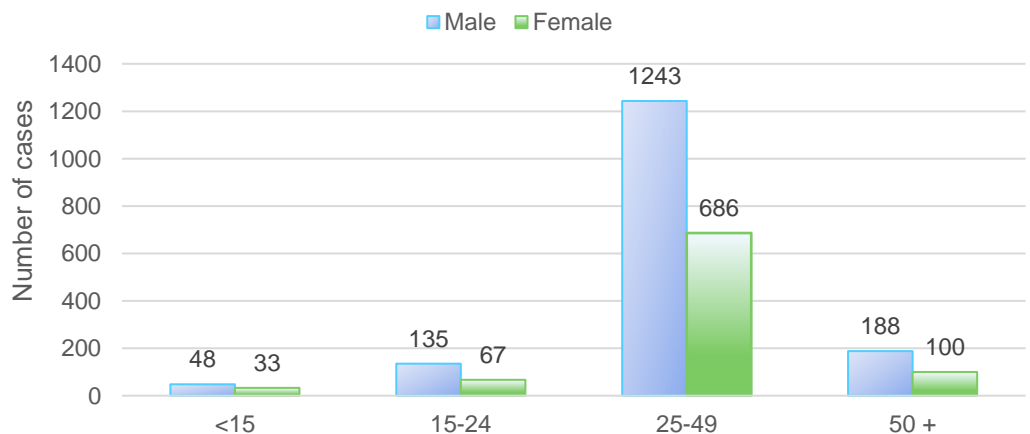
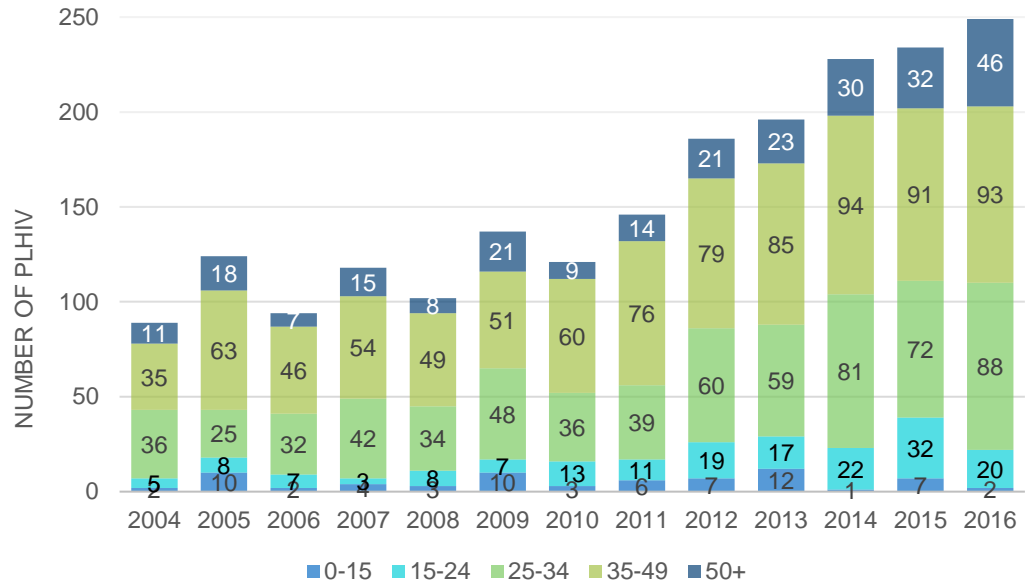


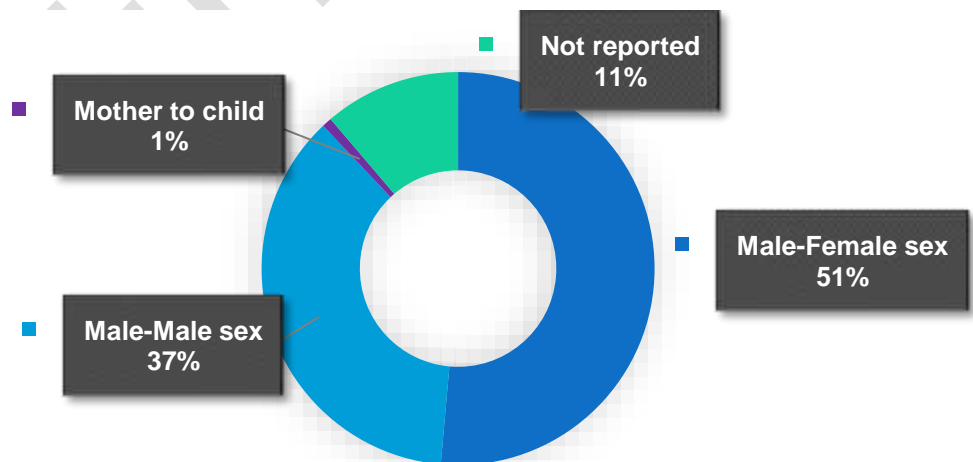
Figure 4 shows age and sex distribution of cumulative reported HIV cases since 1987 (N=2500, age and sex not reported in 57 cases)

**Figure 6: Trend of age categories of reported HIV cases, 2007-2016**



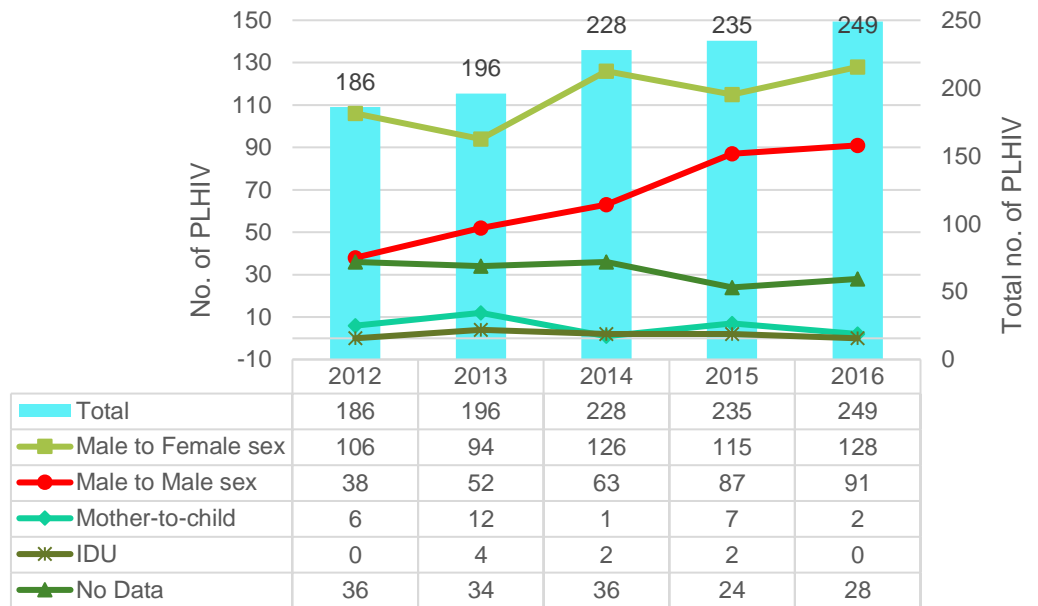
Above graph shows age categories of reported HIV cases during the last ten years. Consistently the majority have been between 25-34 and 35-49 age categories. Cases in the age category 0-14 are due to mother to child transmission. There were only 2 such cases reported during 2016. The number in 15-24 age category showed a decline during 2016 (20 cases).

**Figure 7: Probable modes of transmission of HIV cases reported in 2016 (N=249)**



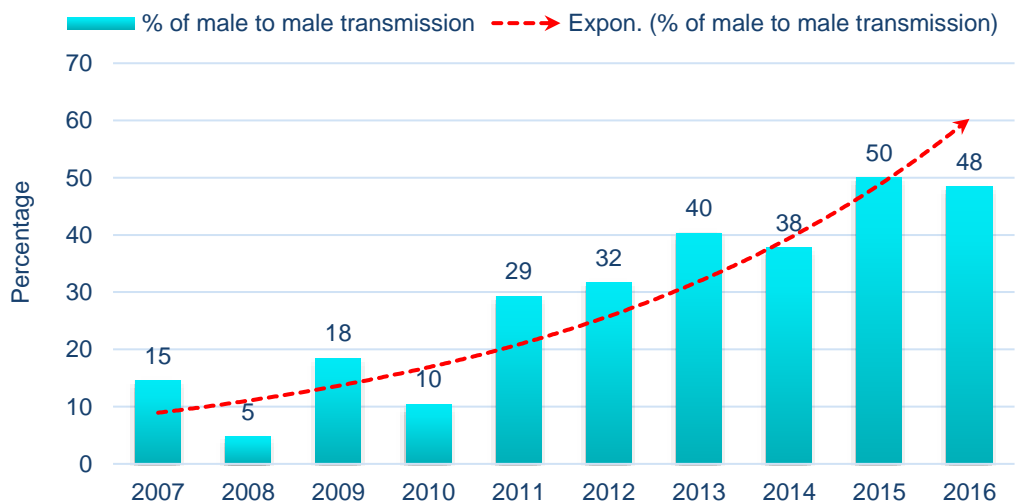
Sexual transmission accounted for 88% of all cases reported during 2016. However, in 11% of cases adequate data was not available to ascertain the probable mode of transmission.

**Figure 8: Probable modes of HIV transmission of reported HIV cases 2012-2016**



According to figure 7 and 8, the proportion of male to male HIV transmission is gradually increasing. 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 spousal transmission and mother to child transmission of HIV.

**Figure 9: Percentage of male to male transmission among reported male HIV cases**



### Geographical distribution of reported HIV cases

Figure 10: Number of HIV cases reported from each district during 2016

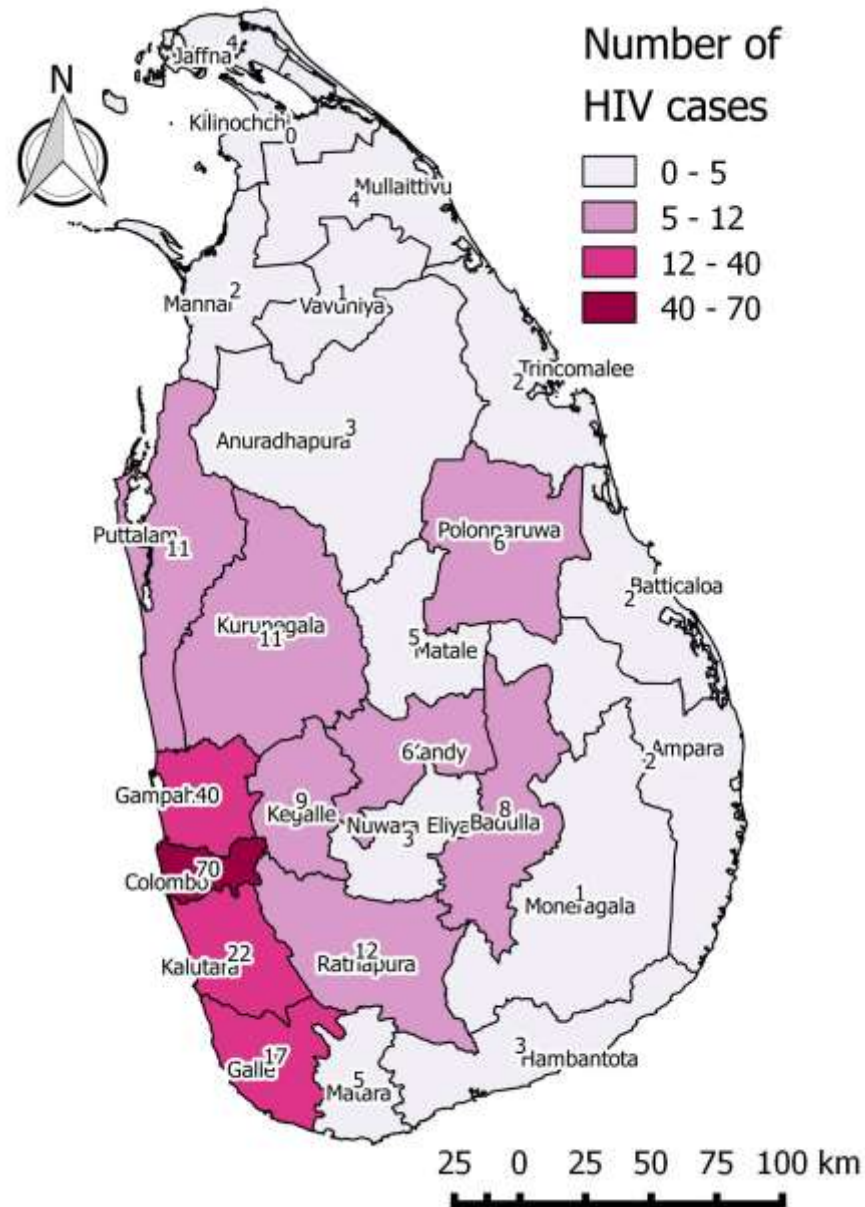
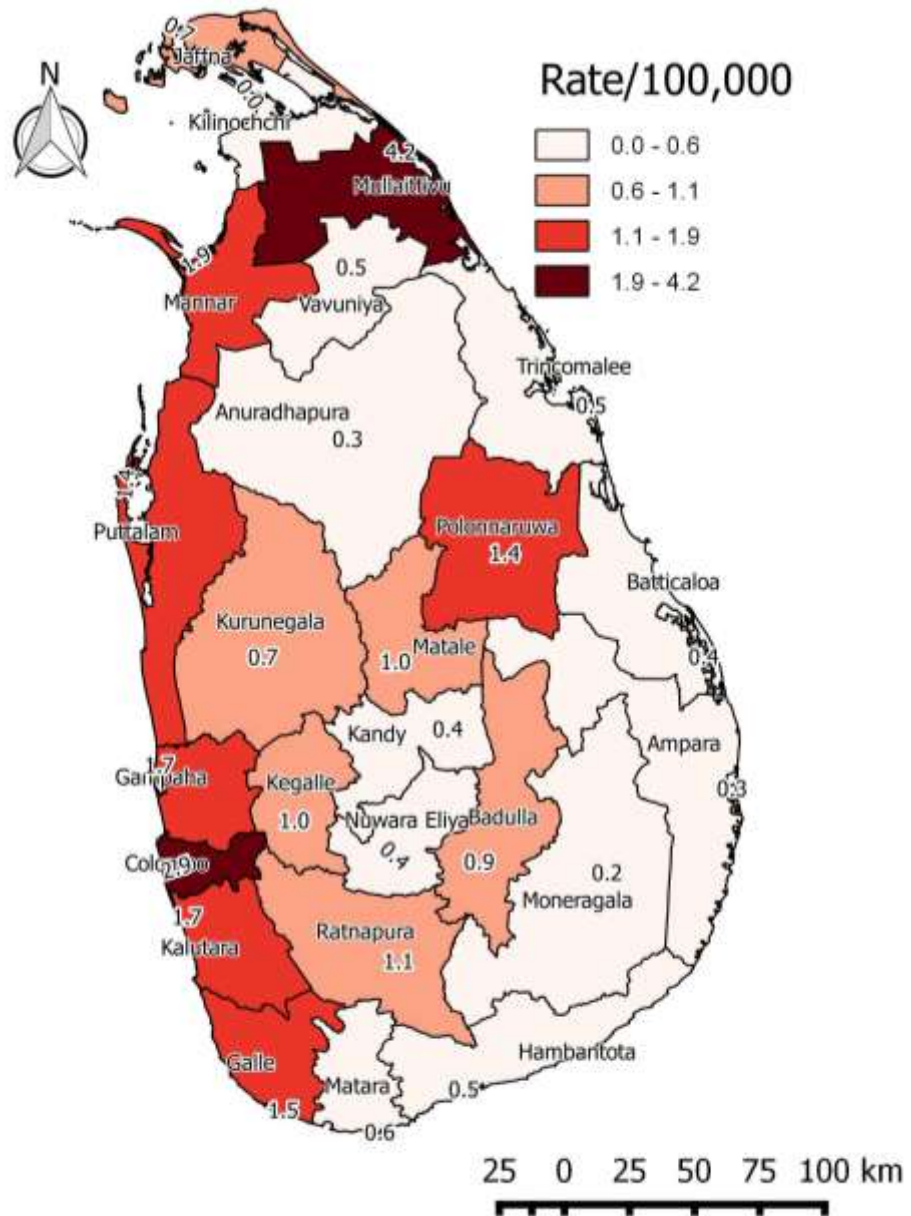


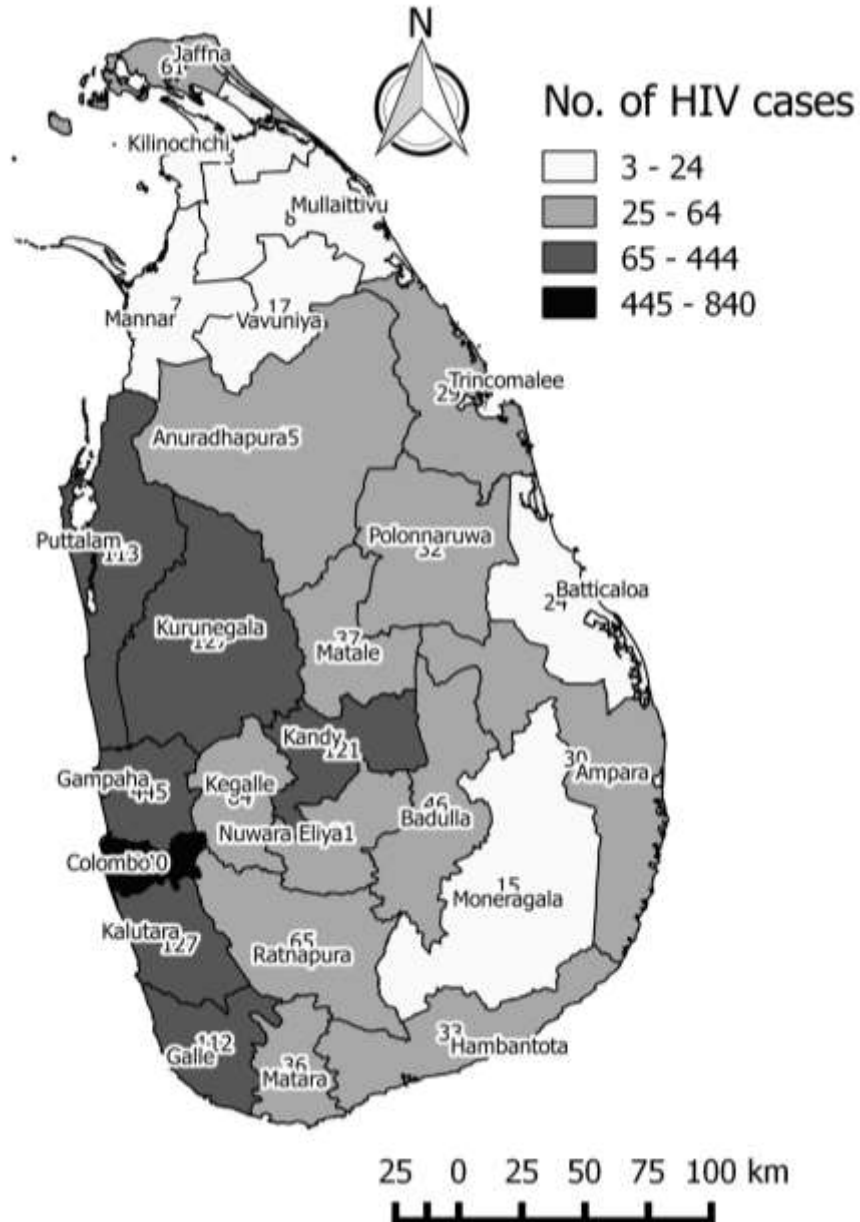
Figure 9 shows the number of HIV cases newly reported from each district during 2016. All three districts in Western province and Galle district reported higher numbers than the districts in other provinces. Less than five cases reported from districts in Northern, Eastern and North Central provinces while no cases newly reported from Kilinochchi district during 2016.

Figure 11: Rate of HIV cases reported in 2016 per 100,000 population



One of the main reasons for variation of reported HIV case load is population density in each district. Calculation of a rate will help to identify areas with higher risk. As shown in figure above, Mullaitivu and Colombo had the highest rate of reported HIV cases during 2016. Six other districts showed a HIV case rate of over 1 per 100,000 population. These districts are Gampaha, Kalutara, Galle, Puttalam, Mannar and Polonnaruwa.

Figure 12: Cumulative number of HIV cases reported, 1987- 2016



Above figure shows the cumulative number of HIV cases reported from each district from 1987 to end of 2016. Colombo, Gampaha, Kurunegala, Kandy, Kalutara, Galle and Puttalam districts have more than 100 cumulative HIV cases reported up to end 2016.

Figure 13 : Cumulative rate of HIV cases reported 1987-2016

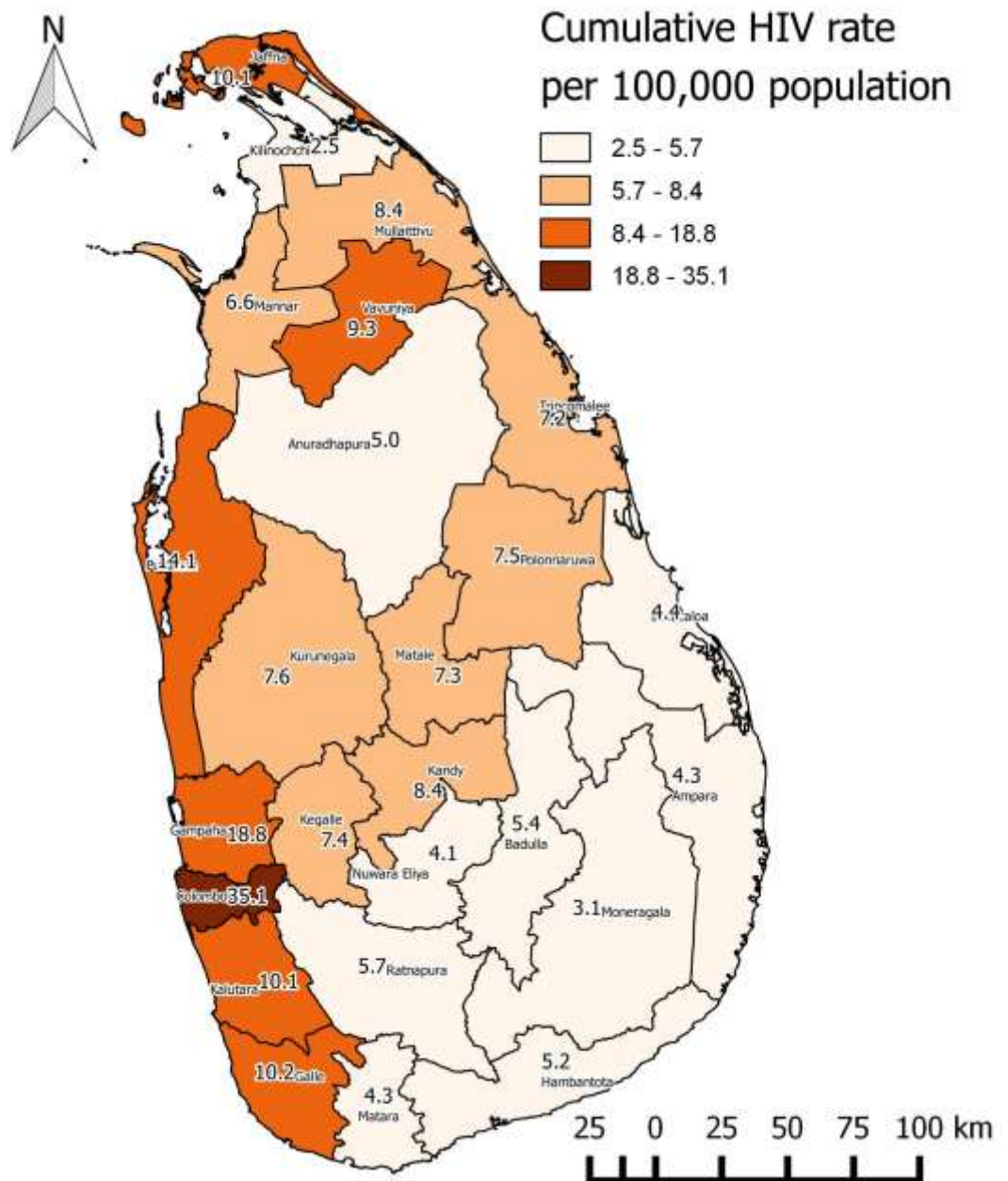


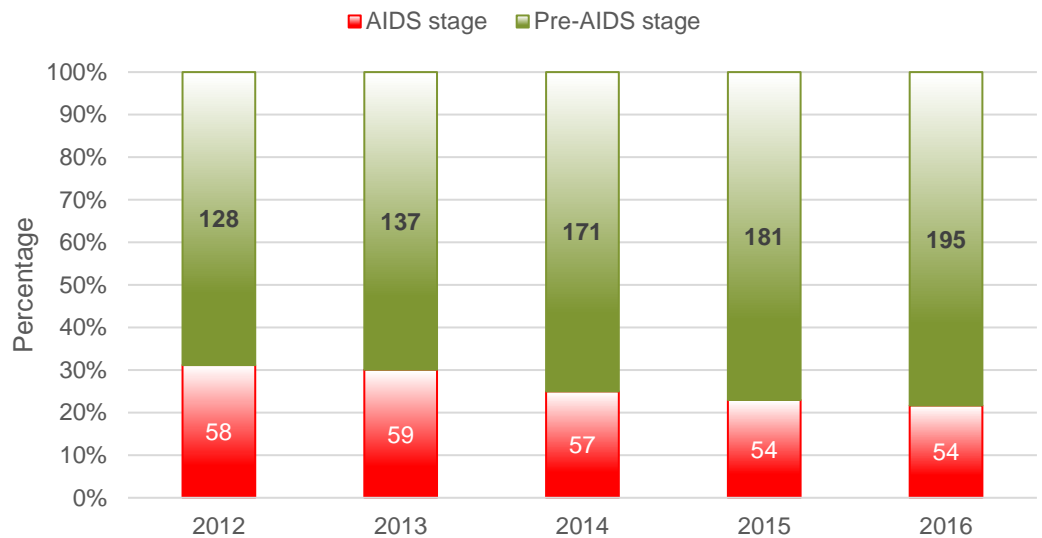
Figure 12 indicates the cumulative rate of HIV cases reported per 100,000 populations in each district. Similar to the rate of newly reported HIV case in 2016, Colombo recorded the highest HIV cumulative rate of 35.1 per 100,000 population. Gampaha, Galle, Kalutara, Puttalam and Vavuniya districts had higher prevalence rates than other districts.



**Stage of HIV diagnosis**

Figure 13 shows the trend of HIV stage at the time of reporting. Early diagnosis will improve the quality of life of PLHIVs and prognosis due to early linkage to HIV care and ART. Since 2013 there is a slight but consistent reduction of AIDS (later stage of HIV infection) stage patients among the reported HIV positive cases.

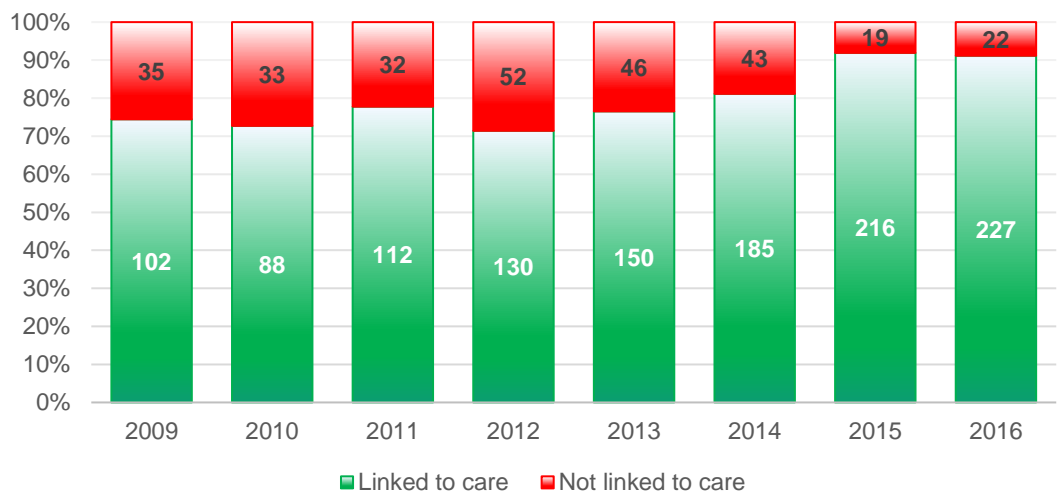
**Figure 14: Number and percent of reported HIV cases by stage, 2012-2016**



**Linking with HIV care services**

Figure below shows the number and proportion of reported HIV cases who were linked to HIV care services during last eight years. Since 2012 the proportions of linking to care shows consistent increase.

**Figure 15 : Percentage and number of PLHIV linked to HIV care, 2009-2016**



During 2015 and 2016 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 successful.

### HIV in donated blood

During 2016 over 400,000 blood units have been screened for HIV to ensure blood transfusion safety. This includes samples screened by National Blood Transfusion Service as well as some of the private sector blood banks. The National Blood Transfusion Service is promoting voluntary, unpaid, blood donors and conducting comprehensive pre-donor screening to ensure safer blood donations.

**Figure 16 : Trend of HIV sero-positivity rate (%) in the donated blood, 2012-2016**

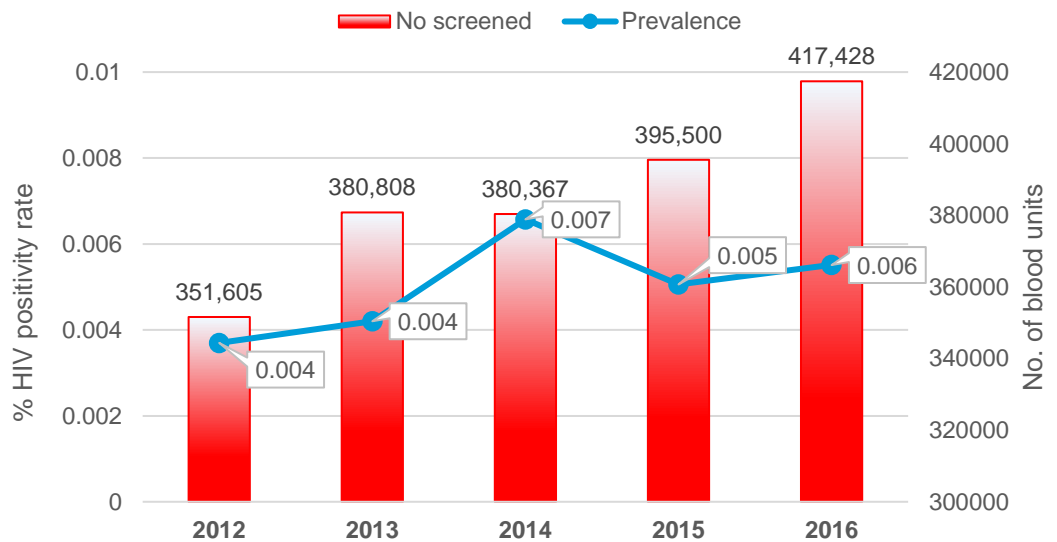
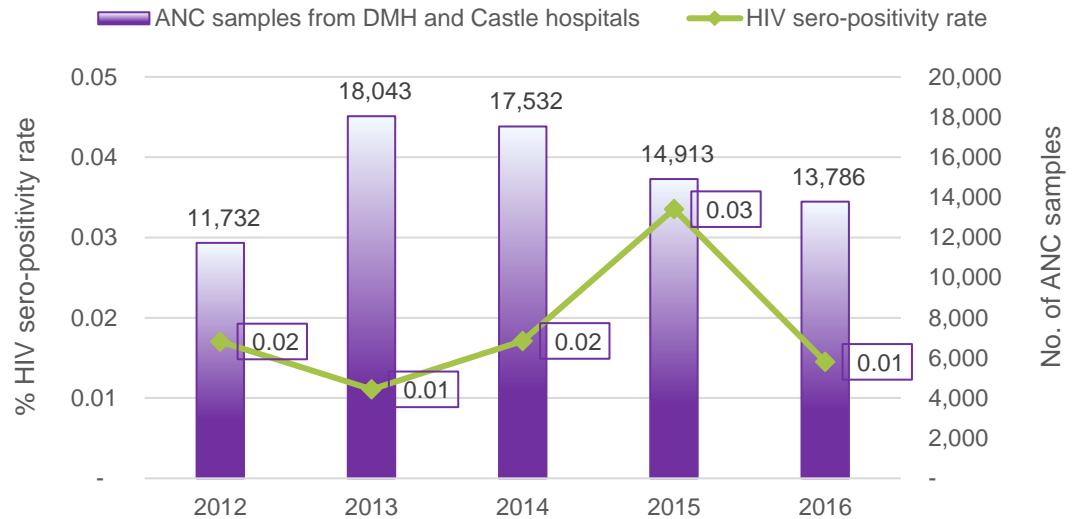


Figure 15 shows the HIV seropositivity rate in donated blood units from 2012 to 2016. HIV seropositivity rate in donated in 2016 is 0.006%. It is estimated that HIV prevalence is < 0.1% in the general population of Sri Lanka. Although blood donors are representing the general population, due to the pre-donor screening process, HIV prevalence is considerably low in donated blood. During 2016 a total of 23 confirmed HIV cases were newly diagnosed among blood donors. This indicates the necessity to further strengthen the screening procedures to safeguard donated blood.

### HIV in antenatal screening

Two premier maternity hospitals situated in Colombo namely the De Soysa Maternity Hospital (DMH) and the Castle Street Hospital for Women (CSHW) have been screening antenatal mothers for HIV since early 2000. These two hospitals represent urban antenatal women and their HIV prevalence is considered higher than the rural antenatal prevalence.

Figure 17 : Percentage of ANC HIV seropositivity rates in DMH and CSHW 2012-2016



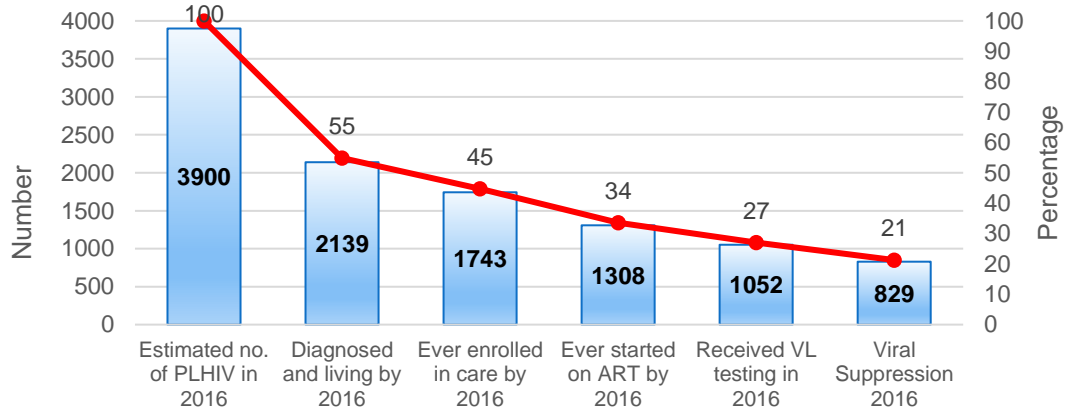
The graph given above shows a gradual increase of HIV prevalence among antenatal women from 2013-2015. However, same trend was not observed in 2016.

## Cascade analysis

### A) Cumulative cross-sectional cascade analysis of HIV services for people as at the end of 2016

At the end of 2016 the estimated number of PLHIV was 3900. Of them 2139 were diagnosed and living at the end of 2016 (this number was calculated by subtracting all reported deaths from all reported HIV cases). Out of them, 1743 were linked to care and 1308 were started on ART by the end of 2016. Of these, viral load testing was done for 1052 during 2016. Of these PLHIV, 829 had achieved viral suppression by the end of 2016 (less than 1000 copies/mL). As illustrated in the graph below the biggest drop is seen from the estimated number to number diagnosed and living.

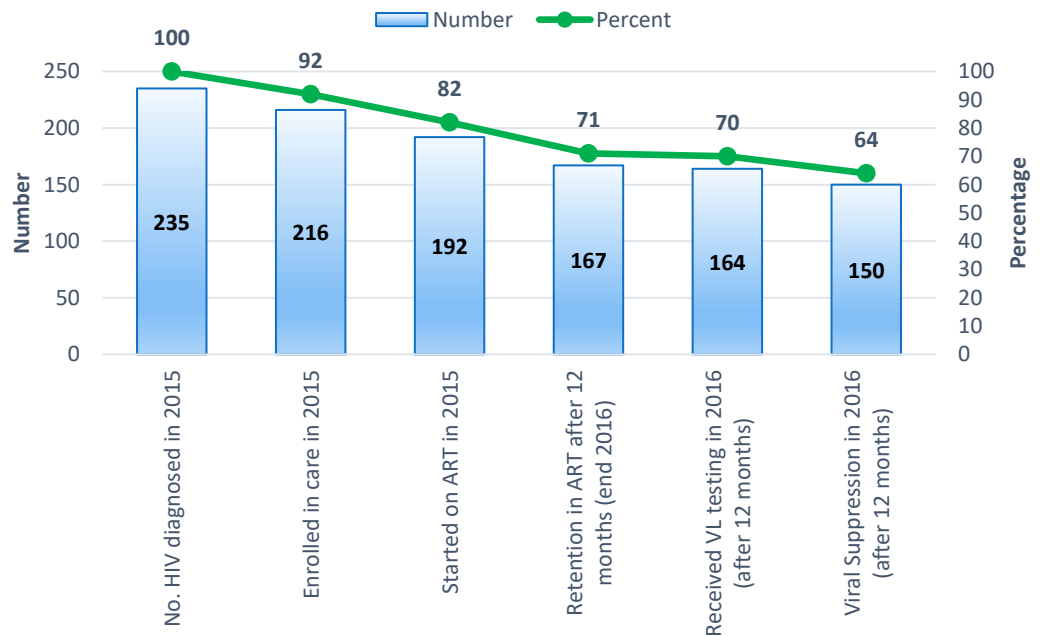
Figure 18: Cumulative cross-sectional cascade graph of HIV services for PLHIV - 2016



**B) Cohort cascade analysis for HIV services**

Blow graph shows the cascade analysis of PLHIV diagnosed in 2015, after a 12-month follow up at the end of 2016. Of the newly diagnosed PLHIV in 2015, 64% were virally suppressed after 12 months in 2016.

Figure 19: Cascade graph for HIV services of the cohort of PLHIV diagnosed in 2015



**Sri Lankan HIV estimations for 2016**

At the time of printing of this report, only final draft estimate HIV data were available for 2016. As such, there is a possibility that these preliminary data could undergo minor changes once the final data are released by UNAIDS, Geneva during the latter part of 2017.

HIV Estimation for 2016 was carried out using Spectrum software version 5.55. Following table summarizes the Key HIV estimated figures for 2016.

- People living with HIV in 2016 - 3900
- Estimated new HIV infections in 2016 - 550
- Estimated AIDS deaths in 2016 - 110
- Estimated HIV prevalence in 2016 - < 0.1

**Figure 20: Estimated HIV population by sex and HIV % prevalence in 15-49 yrs.**

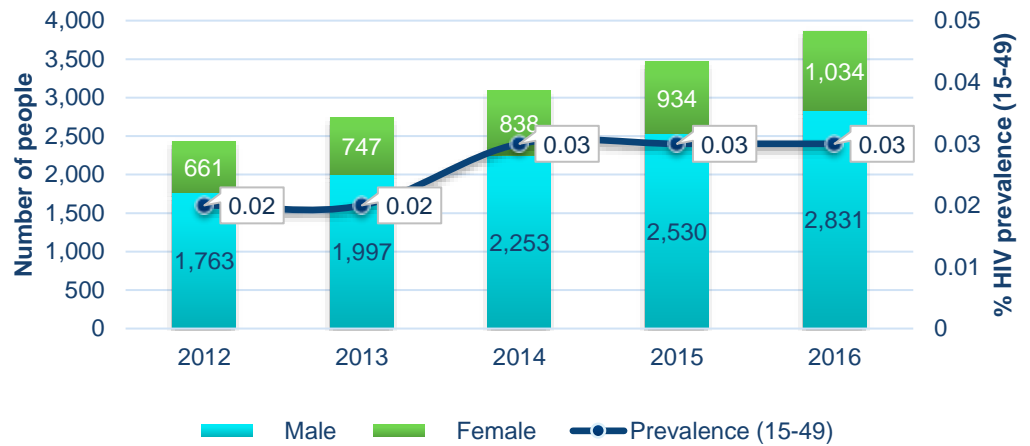


Figure 17 shows the total (male and female) HIV population for the period of 2012-2016 and the HIV prevalence in the 15-49 year age group.

**Figure 21: Estimated new HIV infections by risk group during 2016**

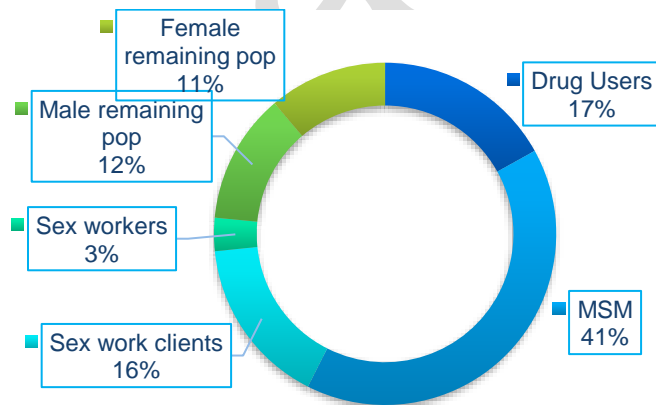


Figure 18 shows the estimated number of new HIV infections by risk groups. MSM have contributed to the largest portions of PLHIV (41%) followed by drug users and sex work clients (17% and 16% respectively). Together male and female remaining populations have contributed 23% of all estimated new HIV infections during 2016.

*Sentinel Sero-Surveillance is conducting cross-sectional HIV sero-prevalence surveys at regular intervals among selected population groups. These populations are referred to as "sentinel groups".*

## Sentinel Sero-surveillance - 2016

Sentinel sero-surveillance survey was conducted in 2016 after a gap of 5 years. This survey has been conducted on an annual basis from 1990 to 2007. Initially HSS was conducted among female sex workers, STD clinic attendees, TB patients, antenatal mothers and later expanded to include Men who have sex with men, Drug users and Client of sex workers. A decision was taken in 2007 to conduct sero-surveillance surveys once in two years as limited information was generated from this activity. The last survey was conducted in 2011. Sentinel sero-surveillance surveys have been giving low HIV prevalence rates (<1%) among all the Key population groups over the years.

Sentinel sero-surveillance in 2016 was carried out covering all 9 provinces for FSW and Clients of SW. MSM and PWID only in limited locations (see the figure given below) Sentinel groups for this round included Female sex workers (FSW), Men who have sex with men (MSM), People who inject drugs (PWID) and Client of sex workers. It should be noted that PWID and Clients of sex workers were enrolled for the first time in 2016 survey. PWID were enrolled from both STD clinics and outreach activities. Clients of sex workers were exclusively enrolled from the STD clinic attendees.

In addition to HIV, other relevant infections like Hepatitis B, Hepatitis C and syphilis prevalence were also studied in 2016. World Health Organization supported this surveillance activity by providing test kits.

Following figures show sample collection centers for the survey in 2016.

**Figure 22: Sample collection sites for MSM and PWID in 2016**

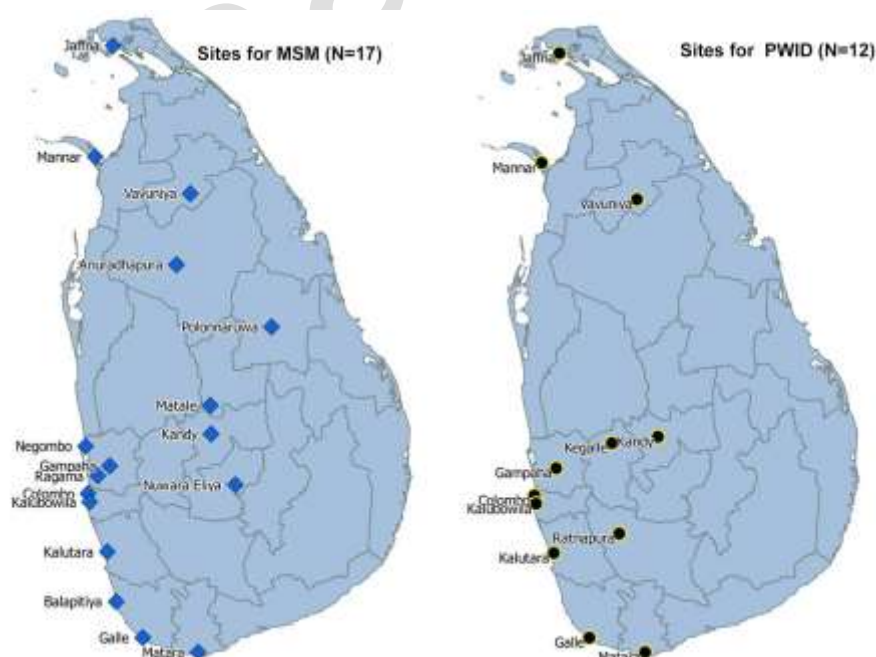
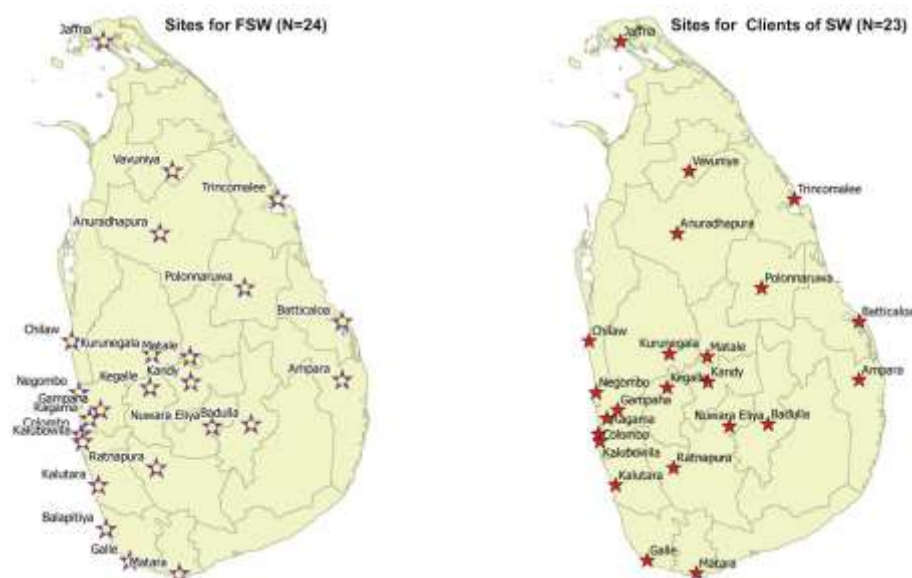


Figure 23: Sample collection sites for FSW and Clients of SW in 2016



## Results of Sentinel surveillance -2016

Table 1: Summary results of Sentinel survey 2016-HIV

	No. tested for HIV	No. positive	HIV Prevalence
Female sex workers	1,332	0	0.0%
Men who have sex with men	739	11	1.5%
People who inject drugs	172	0	0.0%
Clients of SW	906	1	0.1%

The highest HIV prevalence rate was seen among MSM (1.5%). Surprisingly FSW and PWID gave zero prevalence rates. Clients of sex workers gave a prevalence of 0.1% (Table 1).

Table 2: Summary results of Sentinel survey 2016-HBV

	No. tested for HBV S Ag	No. positive	HBV Prevalence
Female sex workers	517	-	0.0%
Men who have sex with men	222	-	0.0%
People who inject drugs	21	-	0.0%
Clients of SW	364	2	0.5%

Number of samples tested and number positive for Hepatitis B are given in the table above. However, only two Clients of sex workers gave positive result, giving zero hepatitis B prevalence among other Key populations tested. Of the PWID, only 21 samples have been tested for HBV.

Table 3: Summary results of Sentinel survey 2016-HCV

	No. tested for HCV Ab	No. positive	HCV Prevalence
Female sex workers	237	1	0.4%
Men who have sex with men	146	-	0.0%
People who inject drugs	44	1	2.3%
Clients of SW	168	-	0.0%

Results of Hepatitis C screening is summarized in above table. Only one sex worker and one PWID became positive for HCV antibodies. None of the MSM and Clients of SW samples had given positive results. Similar to HBV S Ag, HCV Ab testing also done only in a smaller samples of PWID.

**Table 4: Summary results of Sentinel survey 2016 - Ever infected with syphilis**

	No. tested for syphilis	No. positive	All syphilis prevalence
Female sex workers	1,332	25	1.9%
Men who have sex with men	739	50	6.7%
People who inject drugs	172	1	0.6%
Clients of SW	906	37	4.1%

Table 4 shows the prevalence of all form of syphilis (both active and inactive). MSM showed the highest prevalence rate (6.7%) followed by Clients of sex workers (4.0%)

**Table 5: Summary results of Sentinel survey 2016 - Active syphilis (VDRL  $\geq$  1:8)**

	No. tested for syphilis	No. positive	Active syphilis prevalence
Female sex workers	1,332	0	0.0%
Men who have sex with men	739	7	0.9%
People who inject drugs	172	0	0.0%
Clients of SW	906	13	1.4%

Table 5 shows the prevalence of active syphilis. Those who have a VDRL titre of  $\geq$  1:8 taken as a proxy for active syphilis infection. Highest active syphilis prevalence is found among Clients of SW (1.4%) followed by MSM (0.9%).

## Conclusions

Sentinel sero-surveillance conducted in 2016 included two new sentinel groups. i.e. People who inject drugs (PWID) and Clients of sex workers. Hepatitis B and Hepatitis C prevalence assessment included for the first time in 2016.

Sample collection seems to be still challenging especially for PWID and MSM sentinel groups. All serological tests have been conducted using WHO approved tests kits by trained laboratory personnel in the national reference laboratory and some of the peripheral STD clinic laboratories.

According to Sentinel sero-surveillance conducted in 2016, Men who have sex with men (MSM) is the most high risk Key population with a HIV prevalence of 1.5% and over all syphilis prevalence of 6.4%.

It should be noted that, of the total PWID samples collected for the survey (172), only few samples have been tested for HBV and HCV prevalence i.e. 21 samples for HBV and 44 samples for HCV. This is due to delays in supply of test kits and lack of laboratory facilities available for storing samples until the test kits are delivered.



*“The first of the 90-90-90 targets to end the HIV epidemic is for 90% of people living with HIV to learn their HIV status. HIV testing is therefore essential to achieving “the first 90”. Around 40% of people with HIV are unaware of their infection. The only way to determine a person’s HIV status is for them to have an HIV test”.*

## HIV testing services in 2016

HIV testing services are critical in national response to HIV epidemic in the country. Over the years the number of HIV tests carried out in the country has increased. However, total number of HIV tests done may be underreported in the private sector as there is no formal mechanism established to report all the HIV tests. However, all confirmed positive HIV results are reported to NSACP as confirmatory test (Western Blot) testing is available only at the national reference laboratory of NSACP. Diversification of testing and service delivery methods were attempted during 2016.

**Figure 24: HIV testing site organised on the World AIDS day, 2016**



**Table 6: HIV testing details in 2016**

Types of blood samples screened for HIV	Number tested	% of samples	Number positive	% of positives	Positivity rate
Blood donor screening (NBTS & Private blood banks)	417,428	37%	23	9%	0.01%
Antenatal mothers	322,977	29%	11	4%	0.003%
Private hospitals, laboratories and Sri Jayewardenepura GH	225,047	20%	40	16%	0.02%
STD clinic samples*	90,271	8%	160	64%	0.18%
Tri-forces	29,236	3%	4	2%	0.01%
Survey sample	23,615	2%	1	0%	0.004%
Prison HIV testing programme	12,776	1%	6	2%	0.05%
TB screening	7,896	1%	4	2%	0.05%
Total	1,129,246	100%	249	100%	0.02%

*\*(STD clinic samples include; clinic attendees, symptomatic patients, outreach samples and testing of contacts)*

A total of 1,129,246 HIV tests had been done in 2016. There is an increase of over one-hundred thousand (100,000) HIV tests compared to that of 2015. As expected, antenatal

samples and testing through STD clinics have shown an increase. Blood donor screening also had added a significantly higher number of HIV tests compared to 2015 and a slight increase of testing among TB patients also observed in the given year. Total number of HIV positive persons detected during the year was 249.

### HIV testing services through outreaching by STD clinics

Below given is the table which shows the out-reach HIV testing services provided by STD clinics in the country.

**Table 7: HIV screening through outreach activities by all STD clinics -2016**

Type of outreach activities	Number tested
Prison blood survey	12,776
Female sex workers	1,408
Men who sex with men	379
Drug user survey	975
Colombo municipal council	288
World AIDS day 2016-Colombo	1,401
Others	33,270
<b>Total</b>	<b>50,497</b>

Providing HIV testing services through outreaching is an accepted good practice in many parts of the world. In Sri Lanka, there is an increase of outreach activities to provide STI/HIV/AIDS related services and HIV testing services are also increasingly being provided through outreaching. While the total number of HIV tests provided through outreaching in 2015 was 35,385 that in 2016 was 50,497. In 2017, a significant improvement is expected in the given area of services.

### Key population escorting to STD clinics

Peer-led targeted intervention programme provide a sexual health services package to Key population groups. Promoting care seeking behavior among service recipients is one component of the package. Within that component, the peer-leaders (peer-educators) are supposed to escort certain number persons of relevant Key population groups. These escorts usually are offered HIV tests when they attend STD clinics.

**Table 8: HIV testing among Key populations (Escorts by peer-educators)**

Type of Key population	Number of HIV tests
Female Sex workers	1413
Men who have sex with men	1085
Beach Boys	492
<b>Total</b>	<b>2990</b>

NSACP and its partners are planning to start community level HIV testing in 2017 for female sex workers, men having sex with men and drug users. In this service model, communities will provide services to fellow members of the communities. The services will be run by communities. An increased service uptake is expected by above population groups in coming years.

### **National HIV Testing Guidelines**

National HIV Testing guidelines were launched on 1st December 2016. Achieving 90-90-90 targets by 2020 is the strategy accepted by all countries to achieve the goal of ending AIDS in the world. The first 90 is that 90% of people living with HIV will know their status by 2020. Achieving this would be possible only by increasing HIV testing. However, HIV testing is meaningful only when it is conducted by targeting relevant populations.

Final draft

## HIV treatment and care services

*“During 2016, a policy decision was taken to start ART for all people living with HIV, irrespective of their CD4 count.”*

The world has embarked on a mission to end the AIDS pandemic. Globally there is consensus that activities for HIV prevention and care services need to be accelerated to reach the targets of ending AIDs by 2030. Early enrollment in ART services contributes significantly to the ability for expanded ART access to make impact on averting AIDS related morbidity and mortality and reducing HIV transmission.

**Figure 25: Colombo HIV clinic provides services to over 50% of all PLHIV in care**



In the 2016 political declaration on HIV and AIDS, the global community adopted new targets and made firm political commitments for 2020 and 2030. These targets aim to “fast track” the response, to accelerate scale up in the next five years.

These new bench marks include:

- Achieving the 90-90-90 target, i.e.
  - 90% of all people living with HIV will know their HIV status,
  - 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
  - 90% of all people receiving antiretroviral therapy will have viral suppression
- Elimination of new HIV infections among children
- Elimination of stigma and discrimination

The achievements of these fast track targets will reduce the number of new infections.

### Ending AIDS by 2025

Sri Lanka aims to reach the target of “ending AIDS by 2015. In order to achieve this, the number of new HIV infections and AIDS related deaths need to decline by 90% compared to that in 2010. A circular was developed on the theme on “Ending AIDS by 2025” with special emphasis on appropriate management in health care settings. The circular highlighted the country HIV policy and the recent judgement of the Fundamental rights court case with regard to discrimination of PLHIV.

### Antiretroviral treatment

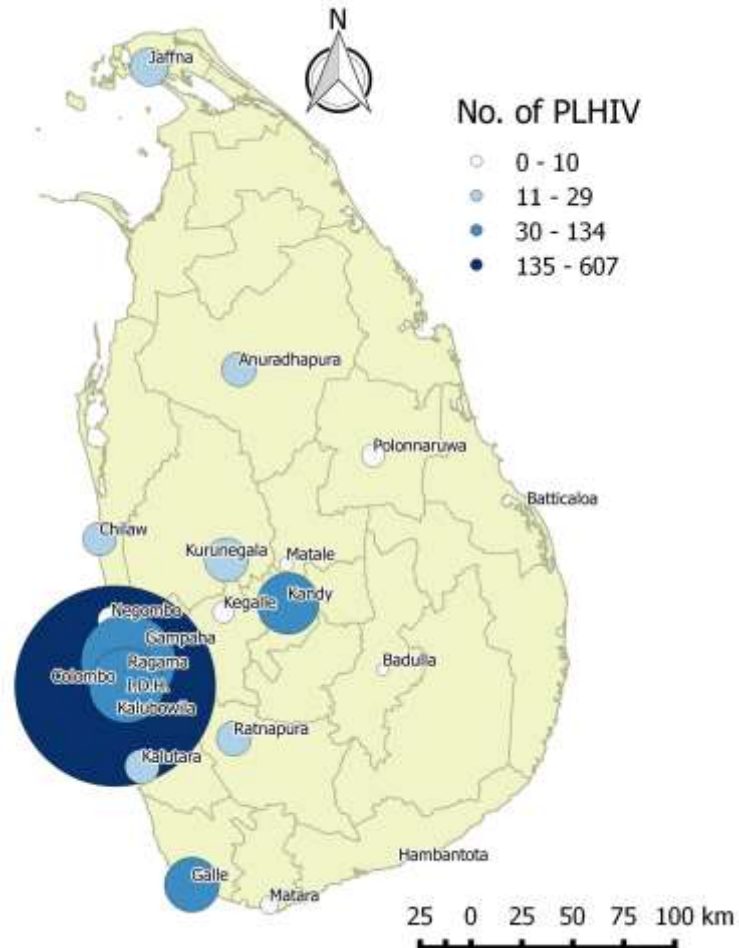
Figure 26: **Some of the antiretroviral drugs available in Sri Lanka**



In Sri Lanka, the antiretroviral treatment (ART) was added to the HIV care programme in late 2004. Until 2015, ART was procured using funds from World bank and Global Fund for AIDS, Malaria and TB. **The Ministry of Health procured ARV drugs from 2016 using government funds. This can be considered as a major step in improving HIV care services in Sri Lanka.** A meeting was organized with participation of venereologists in February 2016 to understand ARV needs for the year 2017. ARV procurement review committee with members from Medical supplies Division, State pharmaceutical Cooperation and NSACP met frequently to assess the situation and to make sure availability of antiretroviral drugs in Sri Lanka. Same committee was identified as ARV quantification working group. Several important decisions were taken on assumptions to be considered for ARV drug estimate.

Global Fund provided funds for some of the second-line ARV drugs such as atazanavir, darunavir, ritonavir and raltegravir during 2016.

Figure 27: Location of ART centres and number of PLHIV in HIV care as of end 2016



Above figure shows the location of ART centres and number of PLHIV under HIV care. Of these, all centres except IDH (Base hospital, Angoda) are located within STD clinics. Most of the care facilities are concentrated in the Western province where over 56% of all diagnosed cases of PLHIV have been reported since 1987.

Table 9: Number of PLHIV\* in pre-ART and ART stage as of 2016

	Name of clinic	Pre ART	ART	Total	%
1	Colombo	26	581	607	54%
2	Ragama	4	131	135	12%
3	IDH	2	83	85	8%
4	Kandy	4	53	57	5%
5	Galle	1	44	45	4%
6	Kurunegala	3	26	29	3%
7	Kalubowila	3	25	28	2%
8	Jaffna	1	21	22	2%
9	Anuradhapura	2	16	18	2%
10	Kalutara	1	17	18	2%
11	Ratnapura	1	17	18	2%
12	Chilaw	3	14	17	2%
13	Gampaha	1	10	11	1%
14	Negombo	1	10	11	1%
15	Polonnaruwa	0	8	8	1%
16	Kegalle	3	4	7	1%
17	Matara	0	4	4	0%
18	Matale	0	3	3	0%
19	Badulla	1	1	2	0%
20	Hambantota	0	0	0	0%
21	Batticaloa	0	0	0	0%
	<b>Grand Total</b>	<b>57</b>	<b>1068</b>	<b>1125</b>	<b>100%</b>

(\* Lost to follow up cases excluded)

In the year 2016, the number of PLHIV newly diagnosed was 249. Of this 227 (90%) were linked to HIV care services. According to the progress report of WHO SEA Region in 2016, the ratio of newly enrolled in care to newly diagnosed HIV cases is closer to 1 in Sri Lanka, suggesting strong linkages.

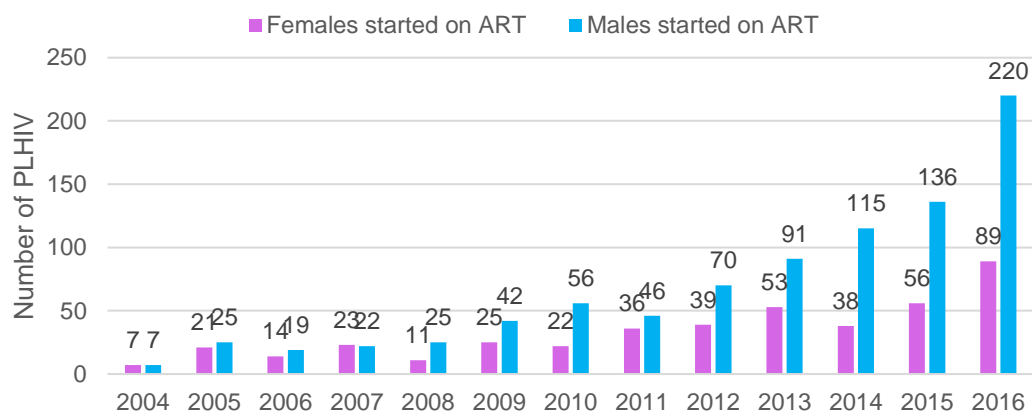
## Comprehensive HIV care services

Comprehensive services are provided to PLHIV including ART services to reduce illness, improve quality of life and also to prevent further transmission. The services offered include counseling, 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, females are offered services for family planning, regular Pap smear screening and PMTCT services in pregnancy.

National STD/AIDS control programme of the Ministry of Health is the sole provider of ART in Sri Lanka. Except National Infectious Diseases Hospital Angoda (NIDH), all other ART centers are STD clinics coming under the National STD/AIDS Control Programme.

During the year 2016, there were 54 AIDS cases diagnosed. Out of 47 reported deaths, 24 were diagnosed with AIDS in 2016. Eight deaths were among those diagnosed in 2015 in the late stage with AIDS. Others have defaulted services and had poor adherence to ART.

Figure 28: Number of PLHIV who initiated ART, 2004-2016



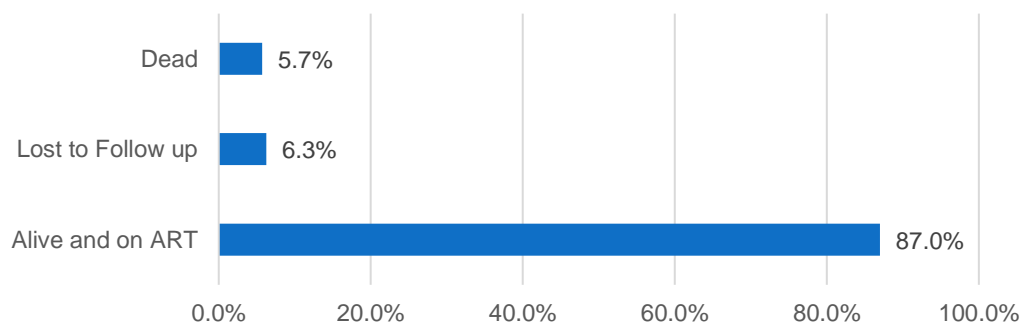
Above graph shows the number of PLHIV started on ART annually since 2004. The highest number of ART initiation done during 2016. Of these majority were males.

Table 10: Outcome of PLHIV who initiated ART in 2015 after 12 months

Outcome	All	Male		Female	
		<15	15+	<15	15+
a. Original net cohort started on ART in 2015 (N)	192	2	134	5	51
<b>Status of these PLHIV after 12 months of starting ART</b>					
b. On original 1st line regimen	167	2	116	4	45
c. On 2nd line regimen (Switched)	0	0	0	0	0
d. Stopped (S)	2	0	0	0	2
e. Died (D)	11	0	9	1	1
f. Lost to follow-up (F)	12	0	9	0	3
g. Number alive and on ART (A) = {N-S+D+F}	167	2	116	4	45
h. Percent alive and on ART (A/N*100)	87.0%	100.0%	86.6%	80.0%	88.2%

Above table shows the summary of outcomes for the cohort of PLHIV who initiated ART during 2015. Of the 192 PLHIV who initiated ART during 2015, 87% were alive and on ART after 12 months.

Figure 29: Outcome of PLHIV who initiated ART in 2015 after 12 months (N=192)



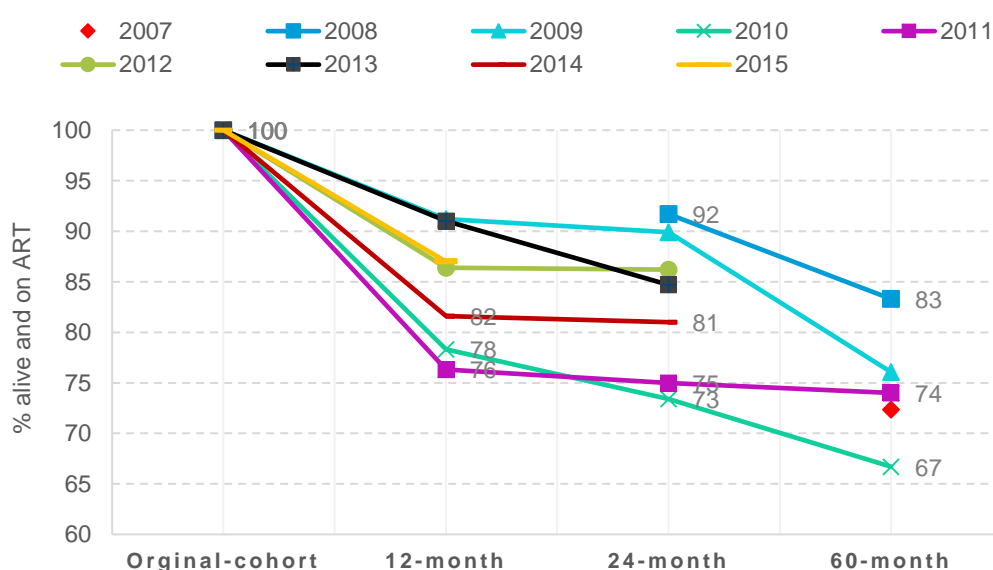


### Lost to follow-up during HIV care

Among PLHIV who initiated ART in 2015, only 6.3% were lost to follow-up after 12 months of ART. Defaulter tracing protocol was developed and services were improved. Attempt has been made to trace all defaulted PLHIV through telephone, letter or home visits.

### Summary of all cohort analyses done since 2007

Figure 30: Summary of cohort analyses done from 2007-2015



Strategic information management unit of NSACP conduct cohort analysis for PLHIV since 2007. These include 12 months, 24 months and 60 months analyses. Above graph summarizes all findings of these analyses.

### Opportunistic infections during 2016

Table 11: Details of opportunistic infections in the year of 2016

Opportunistic infection	Number	Percent
Candidiasis (Oral, Oesophageal)	49	37%
Tuberculosis	25	19%
PJP	25	19%
Herpes zoster	13	10%
Chronic Diarrhea	7	5%
CMV Retinitis	5	4%
Cryptococcal Meningitis	4	3%
Pneumonia	3	2%
Toxoplasmosis	1	1%
MAC	1	1%
<b>Total</b>	<b>133</b>	<b>100%</b>

Opportunistic infections were reported from 133 PLHIV who were receiving HIV care during 2016. Candidiasis, tuberculosis and PJP were more frequent than other opportunistic infections.

### TB/HIV collaborative activities

NSACP works closely with the National Programme for Tuberculosis Control & Chest Diseases (NPTCCD) of Sri Lanka. All newly diagnosed PLHIV and PLHIV with symptoms are referred to NPTCCD for screening to exclude TB. During 2016, 25 PLHIV were diagnosed as having TB. All of them were started on anti-TB treatment. INAH prophylaxis was started on 87 PLHIV during 2016 for latent TB infections.

### ART regimens (ARV drug combinations)

Combination ART regimen; tenofovir, emtricitabine and efavirenz were used as the preferred first-line ART regimen in the year 2016 according to the new guidelines. New ARV drugs include atazanavir, darunavir and raltegravir which can be considered as second or third-line options.

**Table 12: ART regimens used in 2016**

	ARV Regimen	Number of PLHIV		Total	Percent
		1st-line ARV	2nd-line ARV		
1	TDF+FTC+EFV	597	3	600	56%
2	AZT+3TC+EFV	242	1	243	23%
3	AZT+3TC+NVP	57	0	57	5%
4	TDF+FTC+LPV/r	31	24	55	5%
5	TDF+FTC+ATV/r	31	6	37	3%
6	AZT+3TC+LPV/r	17	4	21	2%
7	ABC+3TC+EFV	18	0	18	2%
8	TDF+FTC+RAL	8	1	9	1%
9	ABC+3TC+LPV/r	2	5	7	1%
10	TDF+FTC+DRV/r	2	3	5	0%
11	AZT+3TC+RAL	3	1	4	0%
12	TDF+FTC+NVP	4	0	4	0%
13	AZT+3TC+DRV/r	2	1	3	0%
14	ABC+3TC+DRV/r	0	1	1	0%
15	ABC+3TC+NVP	1	0	1	0%
16	ABC+TDF+FTC+DRV/r	0	1	1	0%
17	AZT+3CT+RAL+ATV/R	0	1	1	0%
18	RAL+3TC+DRV/r	0	1	1	0%
	Grand Total	1015	53	1068	100%

## Children in HIV care during 2016

Following tables give details of children in HIV care as of end 2016.

**Table 13: Children in HIV care services as of end 2016**

Sex	Age category				Total
	<1	1-4	5-9	10-14	
Female	-	-	10	5	15
Male	1	1	17	10	29
<b>Total</b>	<b>1</b>	<b>1</b>	<b>27</b>	<b>15</b>	<b>44</b>

Most of children were males (66%) and were in 5-9 (61%) age group.

**Table 14: Children in HIV care according to ART stage as of end 2016**

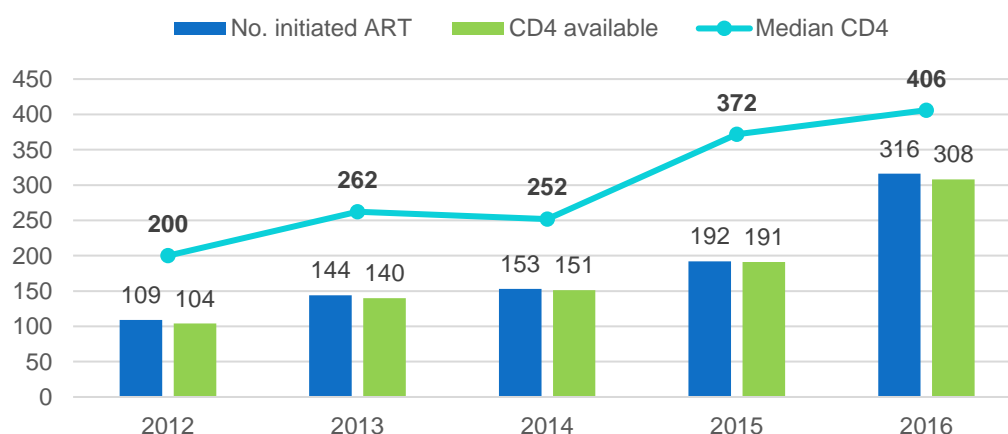
	Age category				Total
	<1	1-4	5-9	10-14	
ART	1	1	26	13	41
Pre ART	-	-	1	2	3
<b>Total</b>	<b>1</b>	<b>1</b>	<b>27</b>	<b>15</b>	<b>44</b>

There were only 3 children in pre-ART stage. AZT+3TC+EFV and ABC+3TC+EFV were used in children as preferred ART regimen.

## Median CD4 count at ART initiation

Following graph illustrates the trend of median CD4 count at ART initiation in Sri Lanka. During 2016, the median CD4 count at ART initiation has been increased to 406. The trend of median CD4 reflects the indication for ART initiation as well as improvement of HIV testing and linkage to care services. Sri Lankan ART guidelines closely followed the WHO recommendations. Accordingly, Sri Lankan guidelines increased the CD4 count eligibility criteria for ART initiation as follows.

**Figure 31: Median CD4 counts at ART initiation from 2012-2016**



Year	CD4 count eligibility criteria for ART
2004 to 2009	< 200
2010 - 2014	< 350 + special groups irrespective of CD4 count
2015	< 500 + special groups irrespective of CD4 count
Since 2016	Treat all irrespective of CD4 count

### **Counselling and other services**

Counselling services were offered to PLHIV by the medical officers at the time of diagnosis as post-test counselling and continued regularly on prevention, ART adherence, family planning, disclosure, pregnancy and on various social issues. PLHIV who need psychiatrist services were referred to the visiting psychiatrist. Need of a public health nursing sister and a social worker for the main HIV clinic are being considered currently.

### **Involvement of PLHIV on HIV care services**

NSACP resource persons provided services for two training programmes conducted for PLHIV organized by FPA using GF funds. During the one-day training many aspects relevant to available services including importance of adherence to ART, disclosure to partners, prevention of infections, EMTCT services etc. were discussed.

### **Subcommittee of NAC on HIV care and counselling**

HIV care subcommittee of National AIDS Committee met once in 3 months. These meetings facilitated the links among stakeholders including PLHIV. A technical steering committee was identified to support PLHIV care and services issues. All the professional colleges were invited for a meeting and nominations were requested for members of the technical steering committee.

Two day workshop was conducted to understand the need for social marketing for services and mass media messages were developed. Annual review of HIV care services was done on 7th and 8th December 2016 to assess the current situation.

### **National ART guidelines**

There were many new developments in use of ART globally. Based on changes in WHO, BHIVA and CDC guidelines it was decided to update the guidelines on use of ART and HIV care services including OI management as two documents. Guidelines on use of ART was finalized and printed in 2016 and guidelines on HIV care services and OI management which is being developed will be printed in 2017. "Strategy for scaling up of HIV care services" was developed to understand the appropriate scaling up process.

### **Training of healthcare workers on HIV care**

As a country with low prevalence, the society still carries some level of stigma and discrimination towards PLHIV. This affects testing uptake and seeking of services for HIV. There are many improvements in the health care setting in relation to stigma and discrimination. However, still there is room for improvement. In the year 2016, several training programmes were carried out in order to improve attitudes and skills of health care workers in the main hospitals in the country.

### **IEC material for PLHIV**

During 2016, IEC materials on positive living, disclosure and importance of ART, adherence, resistance development etc. were developed using government funds.

### **Improvement to the main HIV clinic, Colombo**

Main HIV clinic was further improved with necessary facilities such as computers, photocopy machines etc. Consultant psychiatrist from the Mental Hospital, Angoda visits once in two weeks to conduct a psychiatry clinic at the HIV clinic premises. During the year 2016 several measures were taken to improve the public health aspect of patient management. Defaulter tracing was improved and steps are being taken to improve contact tracing and developing links with male patients and female patients through Nursing Officers and Public Health Inspectors.

### **Scaling up ART services**

Scaling up of ART services continued in the year 2016 and venereologists were appointed to many STD clinics increasing ART centres in the country. Currently all the provinces and most of the districts are served by venereologists. Consultants visited Polonnaruwa, Ampara, Chilaw and Gampaha STD clinics monthly to provide ART services. STD clinic, Ragama provides services to highest number of PLHIV outside Colombo and needs more facilities including space and human resources. To improve the quality of services many STD clinics need to expand space and infrastructure facilities and human resources.

### **Challenges**

In the year 2016, there was marked improvement in geographical accessibility to HIV care services through appointing venereologists to many provincial clinics. However, the quality of services need to be improved further through improving infrastructure facilities as well as human resource needs in ART centres. Linking diagnosed PLHIV with services has improved over the years. Retention of patients in care services is satisfactory; however, has room for improvement. Deaths due to AIDS is mainly due to late diagnosis or defaulting services. Social stigma and issues in disclosure affects accessibility to services in some cases. Contact tracing is an area which needs further improvement.

Though efforts are taken to improve ART services based on the latest changes in the WHO ART guideline, the ART coverage still remains low in the country. One important reason is the limited number of people in Key population getting tested for HIV. Social marketing of services would improve seeking early testing and will link more PLHIV to services.

## Post exposure prophylaxis for HIV-2016

PEP (post-exposure prophylaxis) for HIV 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

Preventing exposure to blood and body fluids is the most important strategy for preventing occupationally acquired HIV infection. If an occupational exposure has occurred, appropriate post exposure management is an important element of workplace safety. Post exposure prophylaxis refers to medications given to prevent HIV infection after exposure to potential infectious materials like blood, CSF, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, semen, vaginal secretions.

Before prescribing post exposure prophylaxis, the severity should be assessed by an expert medical officer. Then detailed counselling should be done and if PEP is indicated and the health care worker is willing, PEP must be started as soon as possible from the exposure, preferably within 72 hours. It should be continue for 28 days if there are no side effects to antiretroviral drugs.

### PEP services during 2016

Post exposure prophylaxis was given by 27 STD clinics and it was available at 37 hospitals in the country during 2016.

A total of 3136 healthcare workers came following potential exposure to HIV and of them 56 (1.78%) were started on PEP throughout the country. Only 18 people completed the total 28 days of treatment. Majority came to the Colombo and Anuradhapura STD clinic and the numbers were 537 and 496 respectively. In addition to occupational exposures, 2 people were started on post exposure prophylaxis following sexual exposure at Colombo and Ratnapura STD clinics. Both completed their 28 days.

When considering the antiretroviral treatment, most clinics used TDF+FTC+EFV regimen for PEP (46%). In addition following combinations had been given.

- TDF+FTC+EFV                      26 health care workers
- TDF+FTC+LPV/r                    23 health care workers
- AZT+3TC+LPV/r                    03 health care workers
- AZT+3TC                              02 healthcare workers
- TDF+FTC+ATZ/r                    01 health care worker
- AZT+3TC+EFV                      01 health care worker



### Summary of statistics on PEP during 2016 at Colombo

A total number of 537 health care workers were offered PEP services which comprised of 17.1% out of all registered for PEP services Island wide. Twenty three HCWs were started on PEP and only 8 people continued full course of PEP. Others discontinued PEP due to a negative HIV test on source blood or due to side effects of treatment.

Figure 32: Summary of PEP services in 2016

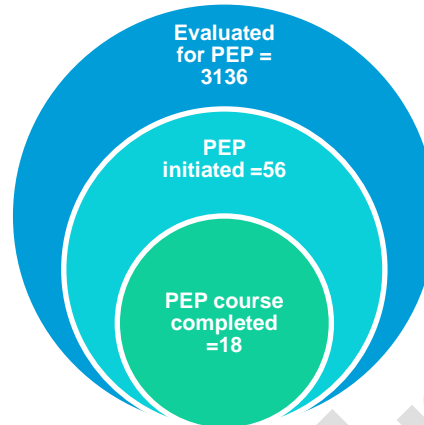


Figure 33: ART regimens used for PEP in 2016 (N = 56)

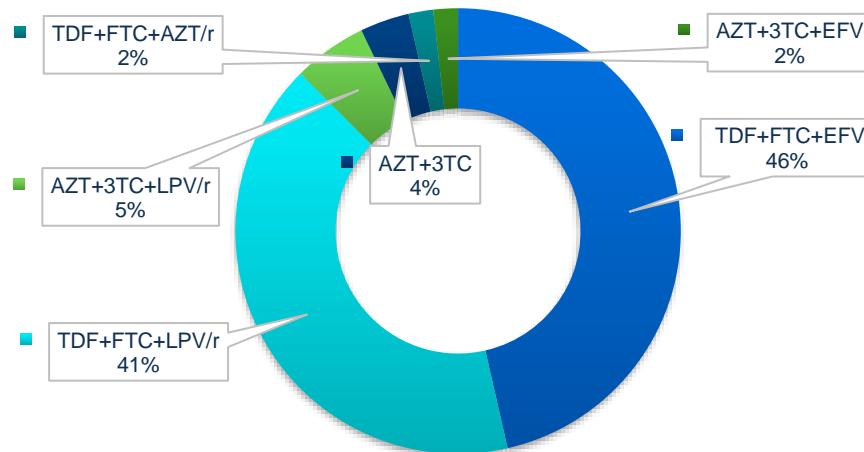


Table 15: Location information of ART for PEP in Sri Lanka during 2016

District	Institution	Unit of location	Contact Number
Anuradhapura	TH - Anuradhapura	Medical ICU	025 2236461
Badulla	PGH – Badulla	ETU	055 2222261 Ext.322
	STD clinic – Badulla	STD clinic	055 2222578
	BH – Diyathalawa	ICU	057 2229061 Ext.357
Batticaloa	STD clinic - Batticaloa	STD clinic	065 2222261
Colombo	National hospital of Sri Lanka	ETU/OPD	011 2691111 Ext.2429
	Lady Ridgeway hospital	Indoor dispensary	011 2693711-2 Ext.219, 242
	De Soysa maternity hospital	Theatre	011 2696224-5 Ext.326
	Castle Street hospital for women	Intensive care unit(ICU)	011 2696231-2 Ext.230
	Eye hospital	Room 4A injection room	011 2693911-5 Ext.231
	TH- Sri Jayawardenapura	ETU	011 2802695-6 Ext.3018 3019
	TH- Kalubowila	ETU	011 2763261 Ext.277
	STD Clinic- Kalubowila	STD clinic	011 4891055
	National institute for mental health	Pharmacy	011 2578234-5 Ext.222
	BH- Angoda (IDH)	Infection control unit	011 2411284 Ext.264
Galle	TH – Karapitiya	Pharmacy/ETU	091 2232250 Ext.7813
	STD clinic – Galle	STD Clinic	091 2245998



Cont., table 15: Location information of ART for PEP in Sri Lanka during 2016

District	Institution	Unit of location	Contact Number
<b>Gampaha</b>	TH – Ragama	ICU	011 2959261
	STD clinic – Ragama	STD clinic	011 2960224
	DGH – Gampaha	Primary care unit(PCU)	033 2296897 Ext.112, 113
	DGH – Negombo	MICU	031 2222261, Ext.104
	Chest hospital - Welisara	OPD/ETU	011 2960509
<b>Hambantota</b>	DGH - Hambantota	PCU	047 2222247
	STD clinic - Hambantota	STD clinic	047-2222247
<b>Jaffna</b>	Teaching hospital Jaffna	OPD	021 2222261
	STD clinic - Jaffna	STD clinic	021-2217756
<b>Kalutara</b>	GH - Kalutara	Accident & emergency unit	034 2222261, Ext.250
	STD Clinic - Kalutara	STD clinic	034 2236937
	BH - Panadura	ETU	038 2222261, Ext.243
	BH- Horana	Theatre	034 2261261, Ext.319
<b>Kandy</b>	TH- Kandy	ETU	081 2233338, 0812234208
	STD clinic - Kandy	STD clinic	081 2203622
	BH - Gampola	ICU	081 2352261
	BH - Nawalapitiya	ETU	054 2222261
	TH- Kegalle	ETU	035 2222261
<b>Kegalle</b>	STD clinic - Kegalle	STD clinic	035 2231222
	BH - Mawanella	ETU	035 2247835
	BH - Karawanella	ETU	036 2267374
	BH - Warakapola	ETU	035 2267261
<b>Kilinochchi</b>	BH -Kilinochchi	STD clinic	021 2285327
<b>Kurunegala</b>	TH - Kurunegala	ICU-Accident & Emergency	037 2233906, Ext.907, 208
	STD clinic - Kurunegala	STD clinic	037 2224339
<b>Mannar</b>	STD clinic - Mannar	STD clinic	023 2250573
<b>Matale</b>	STD clinic - Matale	STD clinic	066 2222261
<b>Matara</b>	DGH - Matara	ETU	041 2222261, Ext.161
	STD clinic - Matara	STD clinic	041 2232302

Cont., table 15: Location information of ART for PEP in Sri Lanka during 2016

District	Institution	Unit of location	Contact Number
Monaragala	STD clinic - Monaragala	Primary care unit	055 2276261, Ext.215, 213
Mullaitivu	STD clinic - Mullaitivu	STD clinic	021-2061414
Nuwara Eliya	GH Nuwara Eliya	PCU	052 2234393, Ext.321
	STD clinic – Nuwara Eliya	STD clinic	052 2223210
Polonnaruwa	GH- Polonnaruwa	Infection control unit	027 2222384, Ext.121
Puttalam	STD clinic - Chilaw	STD clinic	032 2220750
Ratnapura	STD clinic - Ratnapura	Clinic	045 2226561
	GH - Ratnapura	ICU	045 2225396, Ext.225, 337
	BH - Embilipitiya	ICU	047 2230261, Ext.126, 129
Trincomalee	STD clinic-Trincomalee	ICU	026 2222261
Vavuniya	DGH, Vavuniya	ETU	024 2224575

Figure 34: Some of the antiretroviral medicine available at NSACP



*“Controlling Sexually transmitted infections (STIs) remains a cornerstone of any HIV control programme.*

*Unlike many other countries Sri Lanka continued to maintain a strong commitment to combat STIs.*

## Situation of STIs during 2016

Monitoring and evaluation of STD services are carried out by the Strategic Information Management unit of the National STD/AIDS Control Programme. In low level HIV epidemics, STIs act as a sensitive marker of high risk sexual activity. Therefore, monitoring STI rates can help to identify vulnerability to HIV and also help to evaluate the success of prevention programmes. In addition, STI services are critical entry points for HIV prevention in low-level epidemics. Early diagnosis and treatment of STI will decrease related morbidity and reduce the likelihood of HIV transmission.

National STD/AIDS control programme provides comprehensive care for sexually transmitted infections (STIs) other than HIV. The most common sexually transmitted infections (STIs) are genital herpes, genital warts, non-gonococcal infections, syphilis, gonorrhoea, chlamydial infection and trichomoniasis. People who have contracted STIs are encouraged to seek services from STD clinics distributed throughout the island. All service delivery points are equipped with specially trained staff who provide curative and preventive services.

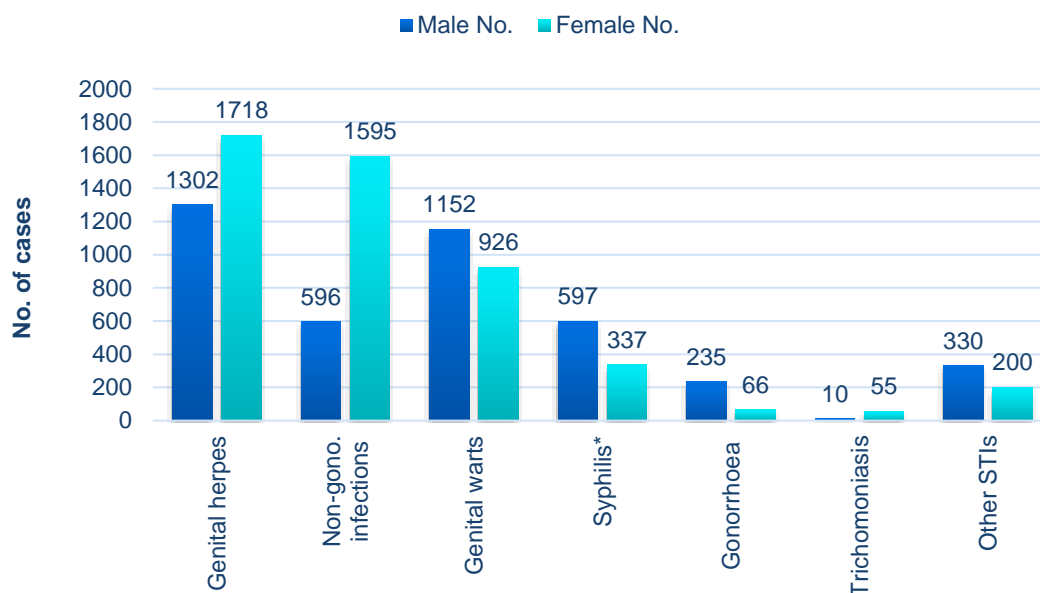
**Table 16: Diagnoses reported from STD clinics during 2016**

Diagnosis	Male		Female		Total	
	No.	%	No.	%	No.	%
<b>Genital Herpes</b>	1,302	31%	1,718	35%	3,020	33%
<b>Non-gono. infections</b>	596	14%	1,595	33%	2,201	24%
<b>Genital Warts</b>	1,152	27%	926	19%	2,078	23%
<b>Syphilis*</b>	597	14%	337	7%	934	10%
<b>Gonorrhoea</b>	235	6%	66	1%	301	3%
<b>Trichomoniasis</b>	10	0%	55	1%	65	1%
<b>Other STIs</b>	330	8%	200	4%	530	6%
<b>Total STIs</b>	4,222	100%	4,897	100%	9,129	100%

A total of 21,973 new patients had received services from the National STD/AIDS Control Programme during 2016 while a total of 65,820 clinic visits were paid by all STD attendees. Among them 9,129 STI diagnoses were made as summarized in the table above. Genital herpes has been reported as the commonest STI presentation.

The Central clinic Colombo is the clinic with the highest service utilization serving the highly populated capital of the country. These patients are managed according to the standard guidelines on STD management, which include appropriate treatment, contact tracing, regular follow up and defaulter tracing. Out of the 31 STD clinics, 21 clinics have the capacity to provide antiretroviral treatment services for people living with HIV (PLHIV) at the end of 2016.

Figure 35: Diagnoses reported from STD clinics by sex during 2016



\* all forms of syphilis

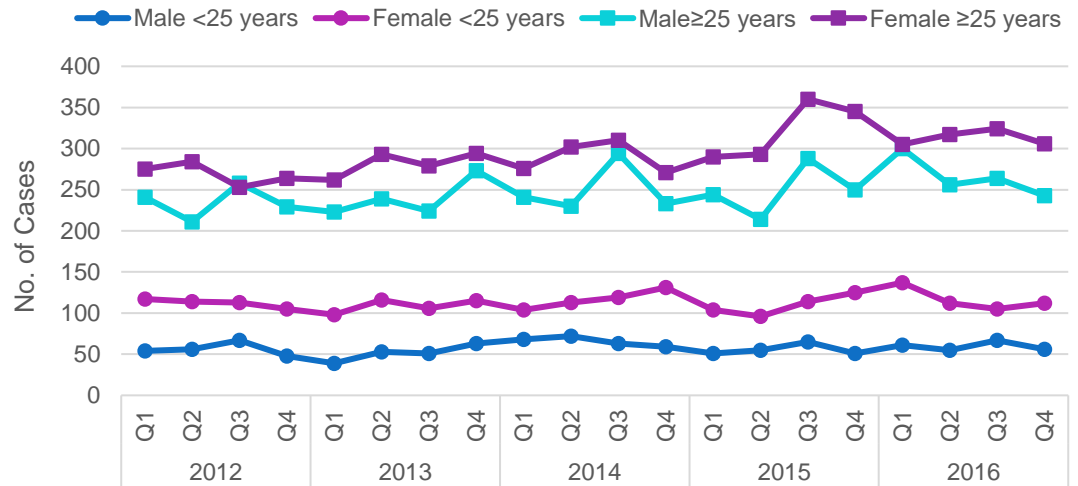
Genital herpes, non-gonococcal infections and trichomoniasis were more among females. All other STIs e.g. genital warts, syphilis, gonorrhoea and other STIs were more commonly reported among men.

## 1. Genital herpes

Similar to previous year, genital herpes had been the commonest diagnosis among those who attended STD services. The graph below summarizes the total number of male and female patients reported during the last five-years according to sex and age. There are more females than males among reported cases on both age groups. There is an upward trend of number of reported cases over the years among those over 25 years.

More female cases may be due to more frequent recurrences among females. The possibility of neonatal herpes is a concern for pregnant women with genital herpes. They need regular follow up and may need suppressive therapy to avoid fetal complications in the newborn baby.

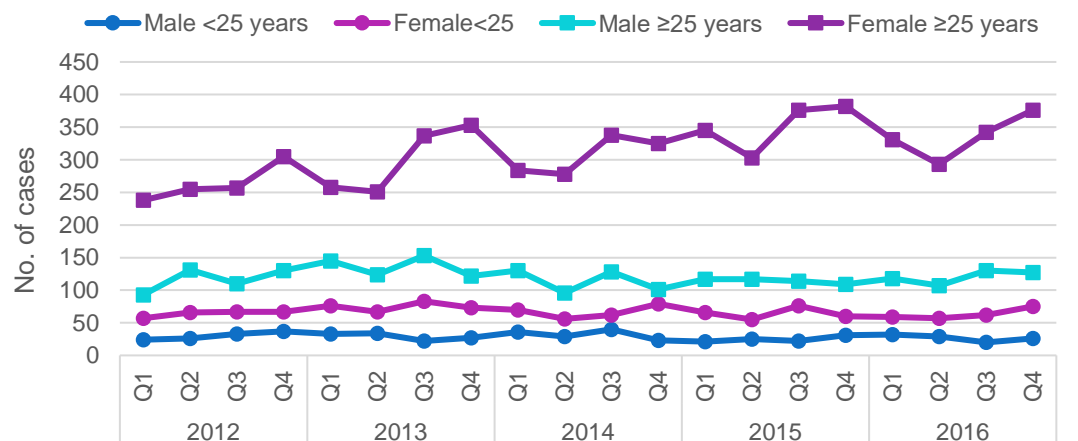
Figure 36: Age and sex of patients with genital herpes from all STD Clinics



## 2. Non-gonococcal urethritis and cervicitis.

Non-gonococcal urethritis and cervicitis are caused by a number of infectious agents other than *Neisseria gonorrhoeae*. *Chlamydia trachomatis* is one of the commonest causative agents. Currently specific diagnostic tests for *C. trachomatis* are not available in most of the STD clinics and a tentative diagnosis is arrived using microscopy. The following graph indicates the trend seen among patients who were diagnosed with non-gonococcal infections during the last five years., A rising trend is observed among females more than 25 years of age.

Figure 37: Non-gonococcal urethritis cases in all STD clinics, 2012-2016



The graph mentioned below illustrates the trend of non-gonococcal cervicitis in females diagnosed clinically and microscopically. Similar to males, higher numbers have been reported among females older than 25 years.

### 3. Syphilis

Syphilis is an important bacterial STI which a potential for in utero infection resulting in adverse pregnancy outcomes. Highly effective treatment is available which reduce the risk of mother to child transmission. The following map summarize the total number of early and late syphilis infections reported from all STD clinics during 2016.

Figure 38: Syphilis cases (early and late) reported from STD clinics during 2016

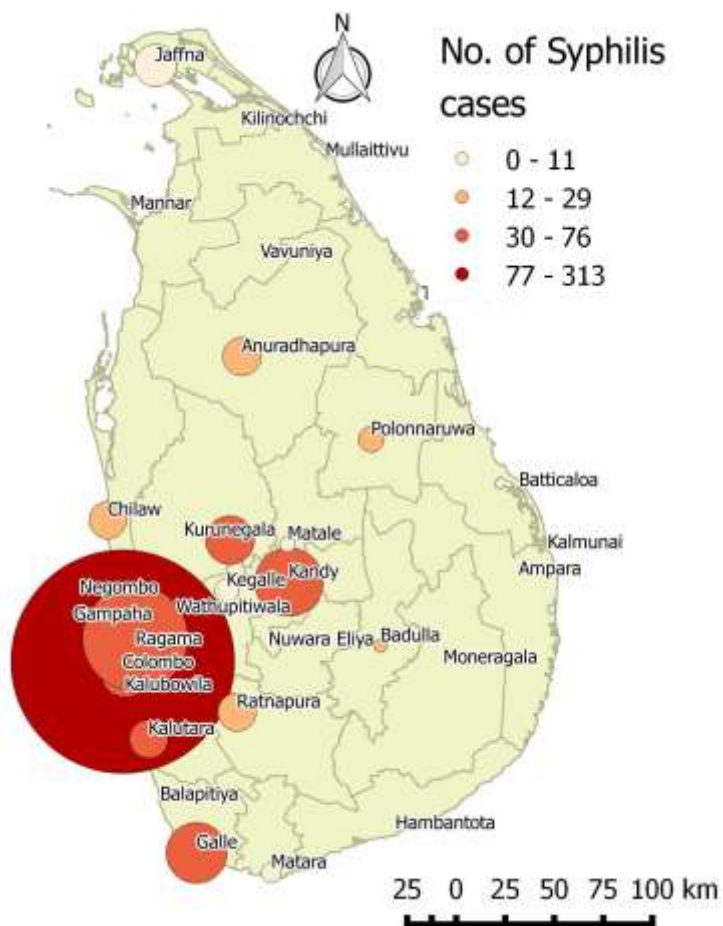
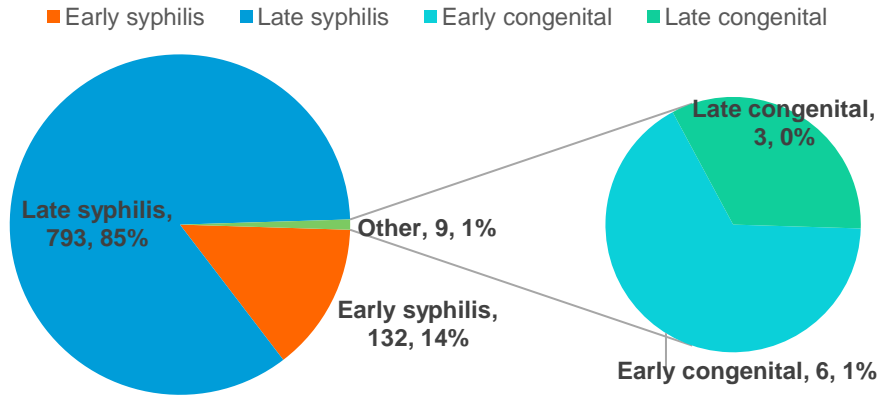
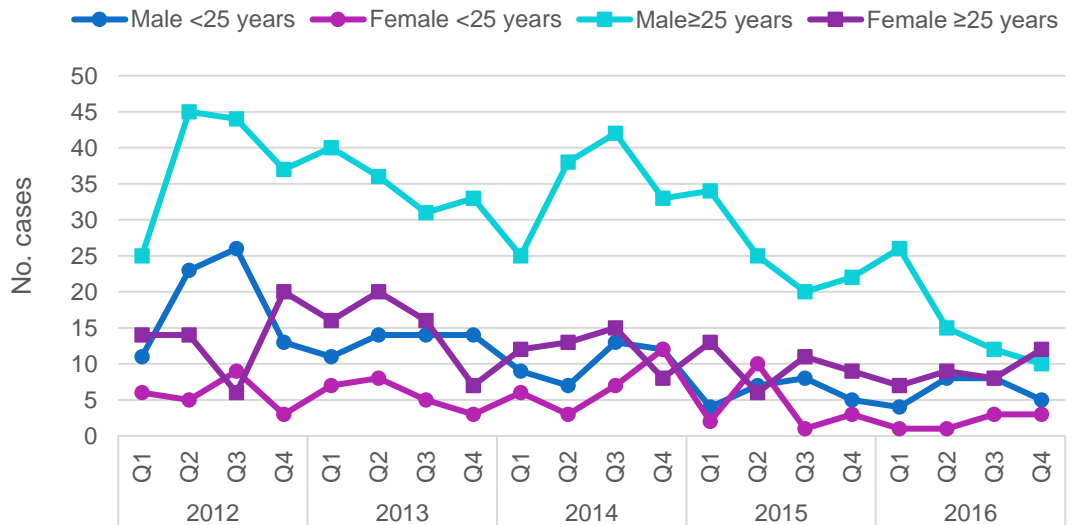


Figure 39: Classification of syphilis cases reported during 2016



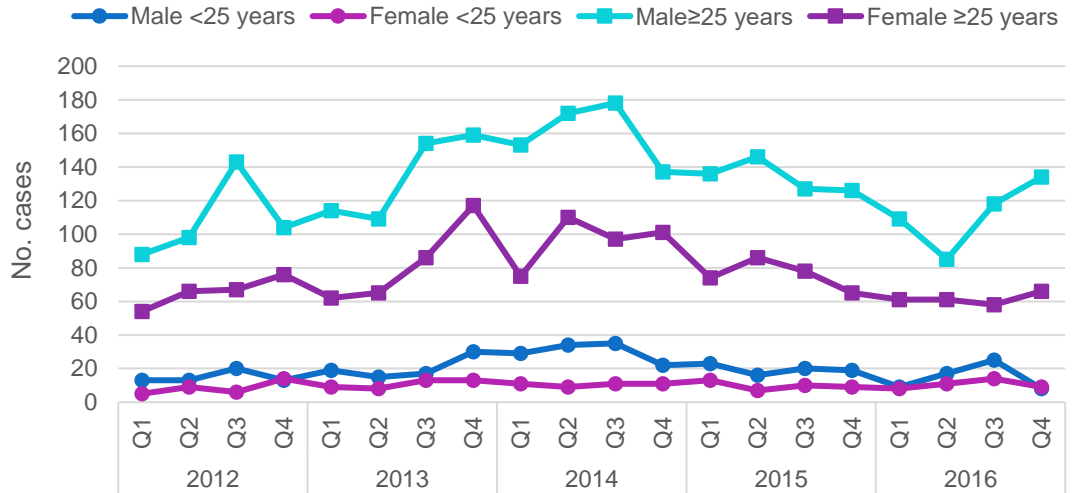
Majority of the syphilis cases were late syphilis cases (85%) followed by early syphilis cases (14%). Other cases were congenital syphilis cases.

Figure 40: Age and sex of early syphilis cases in all STD clinics 2012-2016



Early syphilis (infectious syphilis) is defined as infections acquired within 2 years. According to above graph, a descending trend is observed among males over 25 years over last 2-3 years.

Figure 41: Age and sex of cases of late syphilis from all STD clinics, 2012- 2016

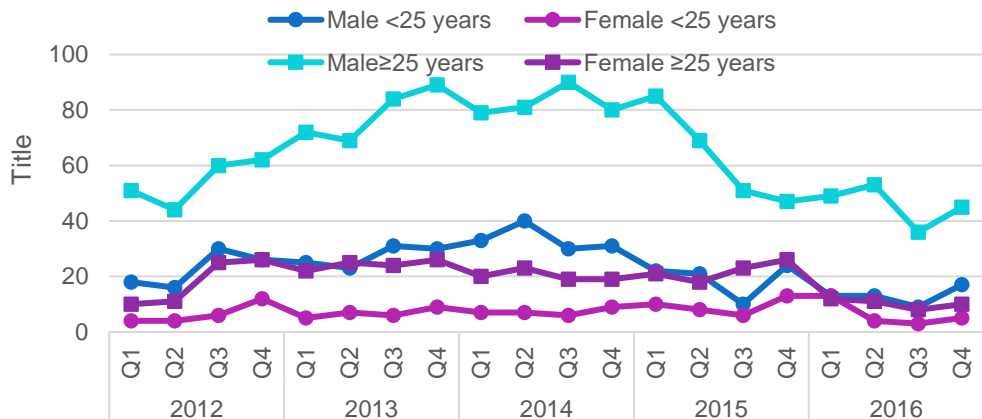


Syphilis diagnoses made two years after the infection are named late or non-infectious syphilis. According to the above graph, more cases are among patients over 25 years for both males and female.

#### 4. Gonorrhoea

The graph below indicates the number of total gonorrhoea and presumptive gonorrhoea cases reported during the last five years. Where culture facilities are not available presumptive gonococcal infections are diagnosed using microscopy. A declining trend is observed among males over 25 year until 3<sup>rd</sup> quarter of 2016.

Figure 42: Age and sex of gonorrhoea cases from all STD clinics, 2012-2016

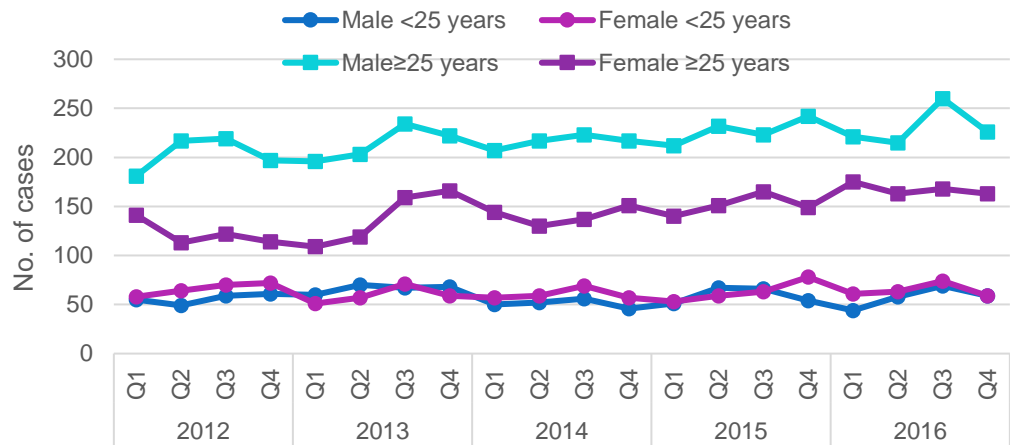




### 6. Genital warts.

Genital warts are mainly caused by Human Papilloma virus, types 6 and 11. The following graph indicates the number of patients that received services for genital warts during last six years. A slightly upward trend is observed among cases who are over 25 years.

Figure 43: Age and sex of genital wart cases from all STD clinics, 2012 - 2016



### 7. Trichomoniasis

Trichomoniasis is a curable sexually transmitted disease which is usually symptomatic only in females. The graph below demonstrates the trend of trichomoniasis case reported over last five years. Dramatical reduction of cases is observed among female over 25 years during last three quarters of 2016.

Figure 44: Trichomoniasis cases from all STD clinics, 2012- 2016

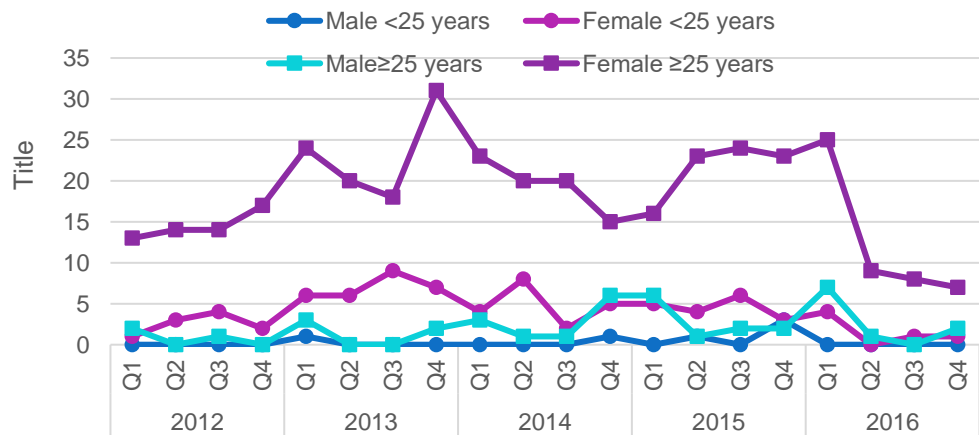


Table 17. Number of Early (Infectious) Syphilis cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016			
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Central Province	Kandy	7	3	10	10	6	16	9	3	12	6	6	12	
	Matale	4	2	6	2	2	4	1	0	1	1	0	1	
	Nuwara Eliya	5	5	10	2	2	4	3	6	9	3	1	4	
Eastern Province	Ampara	0	0	0	0	0	0	1	1	2	2	2	4	
	Batticaloa	1	0	1	2	3	5	0	0	0	1	0	1	
	Kalmunai	1	0	1	0	0	0	0	0	0	0	1	1	
	Trincomalee	1	0	1	0	0	0	0	0	0	1	0	1	
North Central province	Anuradhapura	2	2	4	1	0	1	0	0	0	0	0	0	
	Polonnaruwa	1	0	1	0	0	0	0	0	0	0	0	0	
North Western Province	Chilaw	0	0	0	4	2	6	0	0	0	0	0	0	
	Kurunegala	3	0	3	1	0	1	0	0	0	2	0	2	
Northern Province	Jaffna	2	2	4	0	0	0	3	2	5	1	1	2	
	Kilinochchi	-	-	-	-	-	0	1	1	2	0	0	0	
	Mannar	0	0	0	0	0	0	0	1	1	2	5	7	
	Mullaitivu	-	-	-	-	-	-	-	-	0	0	0	0	
	Vavuniya	0	0	0	0	0	0	0	0	0	0	1	1	
Sabaragamuwa Province	Kegalle	2	3	5	6	6	12	4	2	6	1	0	1	
	Ratnapura	0	0	0	0	0	0	2	1	3	0	0	0	
Southern Province	Balapitiya	2	1	3	3	0	3	4	3	7	4	2	6	
	Galle	8	6	14	20	8	28	8	6	14	2	1	3	
	Hambantota	2	0	2	0	3	3	4	2	6	0	0	0	
	Matara	6	3	9	2	3	5	1	0	1	1	1	2	
Uva Province	Badulla	3	2	5	0	0	0	0	0	0	1	1	2	
	Monaragala	2	1	3	0	1	1	0	0	0	0	0	0	
Western Province	Colombo	104	37	141	83	25	108	47	13	60	36	11	47	
	Gampaha	1	0	1	0	0	0	9	1	10	0	0	0	
	Kalubowila	13	1	14	20	7	27	13	6	19	3	1	4	
	Kalutara	2	3	5	3	2	5	4	2	6	13	8	21	
	Negombo	3	3	6	7	2	9	4	2	6	3	1	4	
	Ragama	16	7	23	13	4	17	7	3	10	5	1	6	
Wathupitiwala	2	1	3	0	0	0	0	0	0	0	0	0		
<b>Total</b>		<b>193</b>	<b>82</b>	<b>275</b>	<b>179</b>	<b>76</b>	<b>255</b>	<b>125</b>	<b>55</b>	<b>180</b>	<b>88</b>	<b>44</b>	<b>132</b>	

Table 18. Number of Late Syphilis cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	37	18	55	31	17	48	44	23	67	28	20	48
	Matale	0	2	2	1	3	4	5	2	7	1	0	1
	Nuwara Eliya	0	0	0	2	0	2	0	0	0	0	0	0
Eastern Province	Ampara	7	2	9	6	7	13	4	4	8	3	2	5
	Batticaloa	5	8	13	7	5	12	12	5	17	12	4	16
	Kalmunai	1	0	1	1	1	2	0	0	0	1	0	1
	Trincomalee	2	2	4	4	1	5	0	1	1	7	3	10
North Central province	Anuradhapura	12	8	20	15	19	34	6	5	11	8	8	16
	Polonnaruwa	1	0	1	21	5	26	8	2	10	18	12	30
North Western Province	Chilaw	10	11	21	24	15	39	14	5	19	9	10	19
	Kurunegala	20	19	39	33	32	65	31	27	58	28	24	52
Northern Province	Jaffna	2	3	5	1	3	4	6	1	7	8	2	10
	Kilinochchi	-	-	-	-	-	0	0	0	0	0	1	1
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	-	-	0	0	0	0
Sabaragamuwa Province	Vavuniya	9	4	13	5	3	8	3	4	7	2	5	7
	Kegalle	8	3	11	14	5	19	1	2	3	3	3	6
Southern Province	Ratnapura	18	15	33	10	11	21	14	13	27	15	5	20
	Balapitiya	3	2	5	5	5	10	2	2	4	5	3	8
	Galle	48	13	61	38	16	54	35	16	51	36	13	49
	Hambantota	23	13	36	7	1	8	0	1	1	0	1	1
Uva Province	Matara	11	3	14	4	5	9	14	4	18	6	3	9
	Badulla	25	23	48	33	10	43	18	18	36	14	11	25
Western Province	Monaragala	0	1	1	4	5	9	1	5	6	4	2	6
	Colombo	239	145	384	264	150	414	244	139	383	182	84	266
	Gampaha	8	11	19	27	11	38	2	6	8	5	5	10
	Kalubowila	34	17	51	71	38	109	48	21	69	44	29	73
	Kalutara	21	13	34	16	14	30	15	6	21	13	10	23
	Negombo	16	16	32	31	12	43	18	7	25	15	11	26
	Ragama	56	19	75	74	23	97	56	13	69	32	15	47
Wathupitiwala	1	2	3	11	8	19	12	10	22	6	2	8	
<b>Total</b>		<b>617</b>	<b>373</b>	<b>990</b>	<b>760</b>	<b>425</b>	<b>1185</b>	<b>613</b>	<b>342</b>	<b>955</b>	<b>505</b>	<b>288</b>	<b>793</b>

Table 19. Number of Gonorrhoea cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	26	12	38	25	6	31	13	0	13	12	2	14
	Matale	4	0	4	1	2	3	1	0	1	2	1	3
	Nuwara Eliya	20	22	42	9	3	12	3	3	6	4	1	5
Eastern Province	Ampara	4	0	4	1	0	1	2	0	2	1	0	1
	Batticaloa	13	3	16	1	0	1	6	4	10	2	1	3
	Kalmunai	1	0	1	0	0	0	3	1	4	5	9	14
	Trincomalee	11	0	11	4	1	5	2	0	2	2	0	2
North Central province	Anuradhapura	24	1	25	18	4	22	15	3	18	9	0	9
	Polonnaruwa	3	1	4	8	0	8	25	12	37	31	16	47
North Western Province	Chilaw	3	1	4	3	0	3	1	0	1	3	2	5
	Kurunegala	18	3	21	6	1	7	12	3	15	8	1	9
Northern Province	Jaffna	7	0	7	3	0	3	10	1	11	1	1	2
	Kilinochchi	-	-	-	-	-	0	4	1	5	1	0	1
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	-	-	0	1	0	1
	Vavuniya	10	2	12	13	0	13	1	0	1	7	0	7
Sabaragamuwa Province	Kegalle	23	11	34	11	5	16	10	3	13	6	2	8
	Ratnapura	10	2	12	5	1	6	8	3	11	6	1	7
Southern Province	Balapitiya	9	1	10	5	1	6	4	2	6	3	1	4
	Galle	10	3	13	14	12	26	10	7	17	5	1	6
	Hambantota	15	18	33	19	23	42	9	19	28	5	4	9
	Matara	10	2	12	13	5	18	7	2	9	9	2	11
Uva Province	Badulla	4	1	5	4	1	5	5	4	9	1	0	1
	Monaragala	4	2	6	6	2	8	7	0	7	2	0	2
Western Province	Colombo	108	18	126	168	26	194	81	36	117	60	11	71
	Gampaha	13	1	14	7	0	7	7	1	8	6	0	6
	Kalubowila	39	13	52	53	10	63	38	9	47	17	6	23
	Kalutara	10	1	11	9	0	9	10	5	15	8	1	9
	Negombo	6	1	7	17	1	18	13	2	15	7	0	7
	Ragama	16	5	21	32	3	35	22	4	26	11	3	14
	Wathupitiwala	2	0	2	9	3	12	0	0	0	0	0	0
<b>Total</b>		<b>423</b>	<b>124</b>	<b>547</b>	<b>464</b>	<b>110</b>	<b>574</b>	<b>329</b>	<b>125</b>	<b>454</b>	<b>235</b>	<b>66</b>	<b>301</b>

Table 20: Number of Non-Gonococcal infections reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	24	242	266	30	230	260	25	184	209	17	106	123
	Matale	5	3	8	5	4	9	4	8	12	6	14	20
	Nuwara Eliya	18	14	32	4	6	10	0	5	5	2	7	9
Eastern Province	Ampara	14	0	14	7	1	8	8	1	9	5	0	5
	Batticaloa	2	3	5	4	4	8	16	15	31	7	14	21
	Kalmunai	1	0	1	0	0	0	0	0	0	0	0	0
	Trincomalee	2	0	2	0	0	0	1	0	1	3	0	3
North Central province	Anuradhapura	51	2	53	24	7	31	36	10	46	24	19	43
	Polonnaruwa	0	0	0	1	0	1	4	3	7	2	1	3
North Western Province	Chilaw	16	60	76	7	85	92	7	95	102	6	154	160
	Kurunegala	70	237	307	35	204	239	61	290	351	89	364	453
Northern Province	Jaffna	3	0	3	9	3	12	6	1	7	12	3	15
	Kilinochchi	-	-	-	-	-	0	0	0	0	1	0	1
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	-	-	0	2	0	2
Sabaragamuwa Province	Vavuniya	8	0	8	10	0	10	8	0	8	6	1	7
	Kegalle	77	50	127	73	14	87	39	34	73	11	8	19
	Ratnapura	12	4	16	16	5	21	12	9	21	13	10	23
Southern Province	Balapitiya	7	12	19	7	4	11	2	2	4	2	10	12
	Galle	23	100	123	18	89	107	12	65	77	11	31	42
	Hambantota	13	4	17	15	4	19	25	14	39	14	1	15
	Matara	14	30	44	18	14	32	33	12	45	10	8	18
Uva Province	Badulla	6	6	12	9	1	10	1	3	4	3	2	5
	Monaragala	2	0	2	4	12	16	4	10	14	4	36	40
Western Province	Colombo	144	290	434	142	341	483	108	421	529	162	327	489
	Gampaha	17	103	120	13	108	121	6	113	119	24	128	152
	Kalubowila	57	82	139	42	114	156	61	127	188	91	81	172
	Kalutara	5	45	50	7	17	24	7	11	18	14	35	49
	Negombo	42	124	166	33	150	183	33	118	151	22	104	126
	Ragama	22	60	82	46	50	96	32	89	121	23	116	139
	Wathupitiwala	5	27	32	4	25	29	5	23	28	3	15	18
<b>Total</b>		<b>660</b>	<b>1498</b>	<b>2158</b>	<b>583</b>	<b>1492</b>	<b>2075</b>	<b>556</b>	<b>1663</b>	<b>2219</b>	<b>589</b>	<b>1595</b>	<b>2184</b>

Table 21. Number of Genital Herpes cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	69	95	164	65	122	187	69	129	198	53	105	158
	Matale	13	32	45	12	39	51	12	24	36	27	30	57
	Nuwara Eliya	8	12	20	8	7	15	6	10	16	4	11	15
Eastern Province	Ampara	26	34	60	28	42	70	21	44	65	22	37	59
	Batticaloa	11	11	22	6	12	18	12	14	26	7	21	28
	Kalmunai	2	4	6	2	2	4	1	10	11	4	9	13
	Trincomalee	21	13	34	22	18	40	13	14	27	15	10	25
North Central province	Anuradhapura	53	70	123	66	69	135	56	67	123	78	68	146
	Polonnaruwa	29	50	79	43	52	95	39	42	81	49	63	112
North Western Province	Chilaw	38	55	93	25	43	68	30	58	88	33	63	96
	Kurunegala	79	101	180	92	138	230	99	162	261	90	150	240
Northern Province	Jaffna	2	3	5	17	3	20	14	6	20	13	14	27
	Kilinochchi	-	-	-	-	-	0	7	5	12	4	6	10
	Mannar	0	0	0	0	0	0	0	1	1	1	1	2
	Mullaitivu	-	-	-	-	-	-	-	-	0	4	2	6
	Vavuniya	26	22	48	41	20	61	44	37	81	43	29	72
Sabaragamuwa Province	Kegalle	33	54	87	44	85	129	47	87	134	44	59	103
	Ratnapura	71	97	168	52	68	120	62	85	147	56	64	120
Southern Province	Balapitiya	29	48	77	19	39	58	23	41	64	18	38	56
	Galle	26	78	104	41	73	114	40	66	106	58	74	132
	Hambantota	18	38	56	37	21	58	24	26	50	28	39	67
	Matara	45	49	94	51	44	95	28	67	95	31	63	94
Uva Province	Badulla	32	73	105	38	71	109	20	58	78	28	83	111
	Monaragala	4	13	17	9	26	35	5	33	38	9	36	45
Western Province	Colombo	227	182	409	224	183	407	212	182	394	220	180	400
	Gampaha	29	55	84	55	52	107	54	83	137	58	76	134
	Kalubowila	133	150	283	139	167	306	142	154	296	145	166	311
	Kalutara	33	76	109	22	57	79	19	49	68	30	73	103
	Negombo	35	36	71	26	52	78	31	61	92	26	44	70
	Ragama	53	85	138	54	81	135	68	80	148	89	77	166
	Wathupitiwala	20	27	47	22	40	62	20	32	52	15	27	42
<b>Total</b>		<b>1165</b>	<b>1563</b>	<b>2728</b>	<b>1260</b>	<b>1626</b>	<b>2886</b>	<b>1218</b>	<b>1727</b>	<b>2945</b>	<b>1302</b>	<b>1718</b>	<b>3020</b>

Table 22. Number of Genital warts cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	52	39	91	41	41	82	56	48	104	54	48	102
	Matale	15	10	25	10	7	17	9	12	21	10	5	15
	Nuwara Eliya	3	2	5	6	2	8	5	2	7	4	2	6
Eastern Province	Ampara	18	20	38	19	11	30	15	19	34	16	19	35
	Batticaloa	4	8	12	4	5	9	5	2	7	5	9	14
	Kalmunai	0	3	3	0	1	1	2	0	2	2	1	3
	Trincomalee	17	10	27	5	4	9	4	7	11	8	7	15
North Central province	Anuradhapura	65	40	105	39	30	69	63	34	97	56	41	97
	Polonnaruwa	25	26	51	28	18	46	32	20	52	29	27	56
North Western Province	Chilaw	37	25	62	34	23	57	38	29	67	41	27	68
	Kurunegala	68	78	146	73	66	139	93	89	182	93	116	209
Northern Province	Jaffna	3	1	4	11	6	17	19	2	21	24	7	31
	Kilinochchi	-	-	-	-	-	0	1	2	3	1	2	3
	Mannar	0	1	1	0	0	0	3	0	3	1	1	2
	Mullaitivu	-	-	-	-	-	-	-	-	0	4	0	4
Sabaragamuwa Province	Vavuniya	15	6	21	12	5	17	16	8	24	25	10	35
	Kegalle	58	43	101	43	34	77	39	36	75	23	31	54
Ratnapura		40	26	66	29	33	62	39	37	76	28	28	56
	Balapitiya	17	7	24	15	13	28	14	16	30	18	16	34
Southern Province	Galle	36	33	69	54	42	96	49	35	84	48	46	94
	Hambantota	26	21	47	38	17	55	25	31	56	41	55	96
	Matara	39	21	60	25	28	53	35	30	65	32	30	62
Uva Province	Badulla	14	23	37	12	20	32	24	29	53	24	27	51
	Monaragala	5	4	9	8	5	13	4	12	16	10	11	21
Western Province	Colombo	275	110	385	253	122	375	250	108	358	237	100	337
	Gampaha	35	42	77	35	31	66	23	31	54	33	35	68
	Kalubowila	90	58	148	102	86	188	118	76	194	110	65	175
	Kalutara	50	42	92	37	41	78	34	48	82	34	45	79
	Negombo	44	35	79	46	39	85	37	32	69	52	42	94
	Ragama	59	47	106	72	66	138	86	37	123	76	57	133
	Wathupitiwala	10	10	20	17	8	25	9	26	35	13	16	29
<b>Total</b>		<b>1120</b>	<b>791</b>	<b>1911</b>	<b>1068</b>	<b>804</b>	<b>1872</b>	<b>1147</b>	<b>858</b>	<b>2005</b>	<b>1152</b>	<b>926</b>	<b>2078</b>

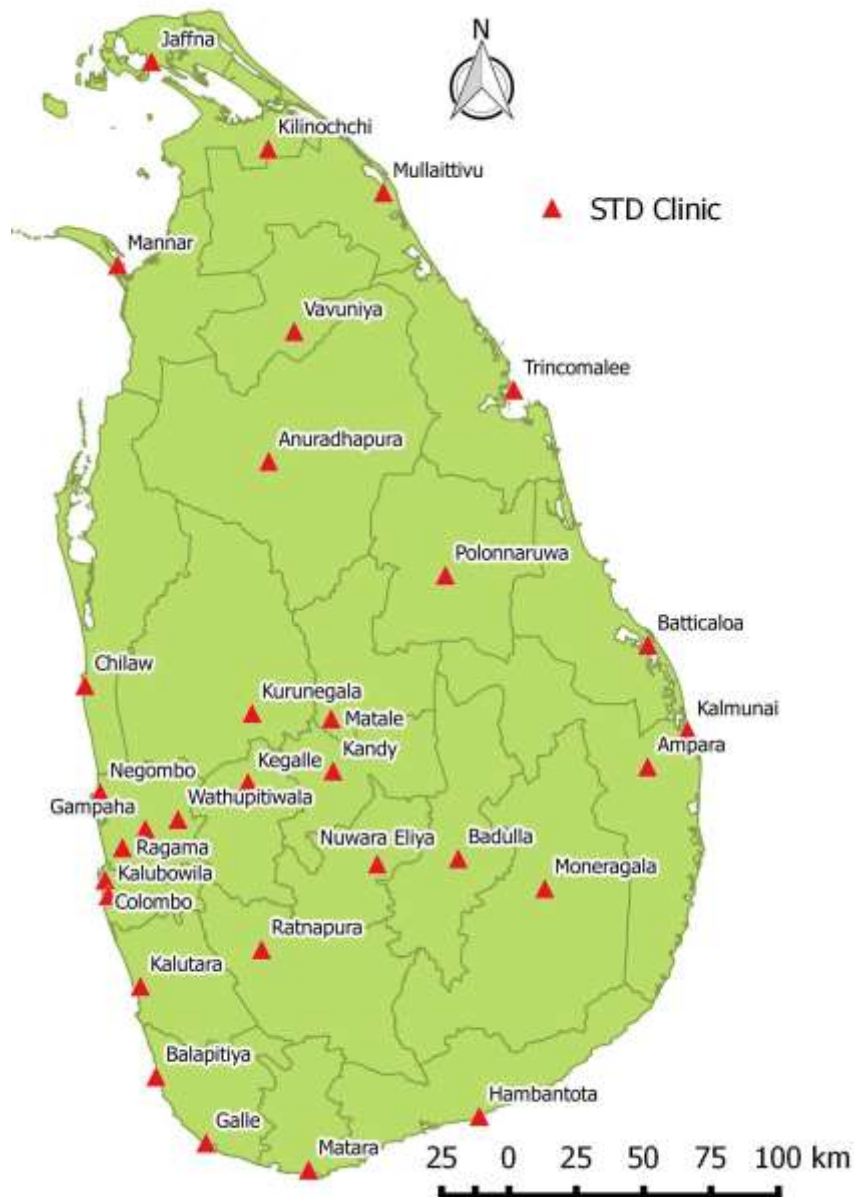
Table 23. Number of Trichomonas cases reported from STD clinics during 2013-2016

Province	Clinic	2013			2014			2015			2016		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	15	15	2	0	2	1	5	6	0	5	5
	Matale	0	0	0	1	0	1	0	0	0	0	0	0
	Nuwara Eliya	0	1	1	0	0	0	0	0	0	0	0	0
Eastern Province	Ampara	0	0	0	0	0	0	0	1	1	0	0	0
	Batticaloa	0	1	1	2	6	8	1	8	9	1	7	8
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0	7	1	8
North Central province	Anuradhapura	2	1	3	0	1	1	0	0	0	0	1	1
	Polonnaruwa	0	0	0	0	0	0	0	2	2	0	1	1
North Western Province	Chilaw	0	0	0	0	1	1	0	1	1	0	2	2
	Kurunegala	0	17	17	0	8	8	0	3	3	0	4	4
Northern Province	Jaffna	0	0	0	0	0	0	0	0	0	0	0	0
	Kilinochchi	-	-	-	-	-	0	0	0	0	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	-	-	0	0	0	0
	Vavuniya	0	3	3	0	1	1	0	0	0	0	0	0
Sabaragamuwa Province	Kegalle	0	15	15	1	16	17	0	15	15	0	3	3
	Ratnapura	2	4	6	0	2	2	0	0	0	0	1	1
Southern Province	Balapitiya	0	1	1	0	2	2	0	0	0	0	0	0
	Galle	0	2	2	0	0	0	0	3	3	0	3	3
	Hambantota	0	1	1	0	0	0	0	1	1	0	0	0
	Matara	0	0	0	0	1	1	0	0	0	0	0	0
Uva Province	Badulla	1	10	11	0	3	3	1	2	3	0	0	0
	Monaragala	0	0	0	0	0	0	0	0	0	0	11	11
Western Province	Colombo	0	31	31	5	20	25	7	41	48	0	7	7
	Gampaha	0	3	3	0	2	2	0	4	4	0	1	1
	Kalubowila	1	6	7	0	15	15	3	10	13	1	4	5
	Kalutara	0	1	1	0	1	1	2	2	4	0	1	1
	Negombo	0	5	5	0	11	11	0	3	3	1	3	4
	Ragama	0	4	4	1	7	8	0	3	3	0	0	0
	Wathupitiwala	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>		<b>6</b>	<b>121</b>	<b>127</b>	<b>12</b>	<b>97</b>	<b>109</b>	<b>15</b>	<b>104</b>	<b>119</b>	<b>10</b>	<b>55</b>	<b>65</b>



## Monitoring STD services – 2016

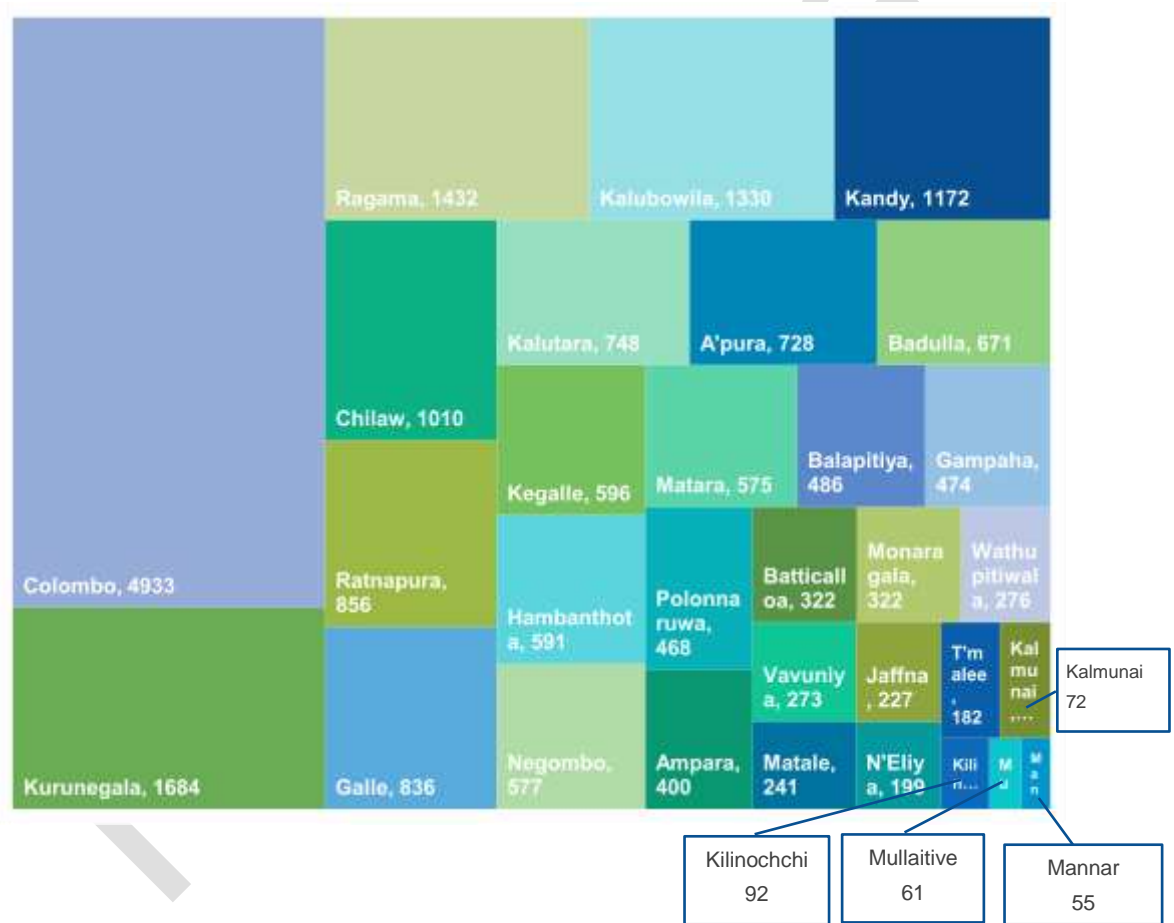
Figure 45: Full-time of STD clinics in Sri Lanka, 2016



Services on sexual health are provided to people by the central and peripheral STD clinics situated throughout the island. Those who come to get services belongs to most at risk populations (including female sex workers, men who have sex with men and drug users

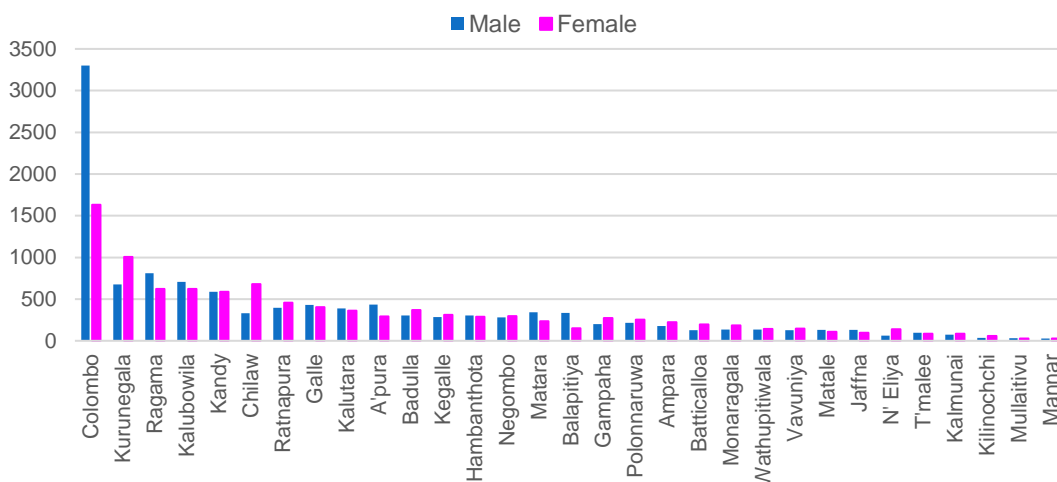
etc.), the vulnerable populations (migrant workers, prisoners etc.) and various the general population group populations such as antenatal mothers and those who come for pre-employment screening . The data on the services delivered are collected regularly and analyzed strategically for the purpose of monitoring and evaluation of the whole programme. Recording and reporting formats maintained by the clinics are the primary sources of data for the Strategic Information Management unit of the National STD/AIDS Control Programme.

**Figure 46: New patients registered at STD clinics during 2016 (Total 21,973)**



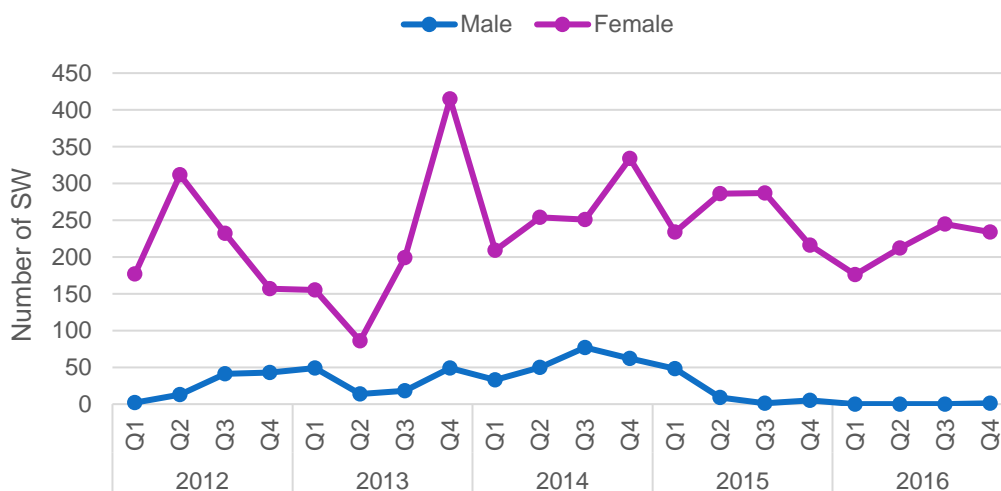
Above graph shows the number of new patients (excluding previously attended patients or clinic attendees at subsequent visits) registered at STD clinics. Colombo, Kurunegala, Ragama, Kalubowila, Kandy and Chilaw clinics had more than 1000 new patients newly registered during 2016.

Figure 47: Sex distribution of new patients registered at STD clinics in 2016



Majority of new STD clinic attendees in Colombo were males. However, over 50% of other clinics had more female among new attendees.

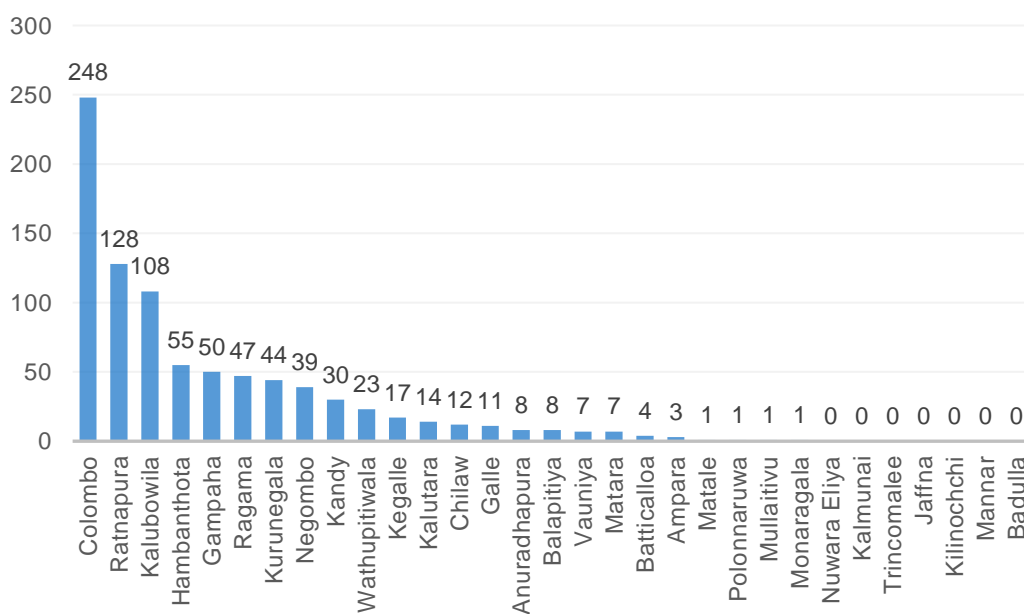
Figure 48: New sex workers registered in all STD clinics 2012-2016



The above graph shows the number of new male and female sex workers registered at all STD clinics for services. All these clinic attendees were provided a comprehensive care package including screening and treatment for STIs, counselling and testing for HIV, education on safer sexual behavior and promotion and provision of condoms. They were encouraged to come for services on a regular basis for STI /HIV screening. Number of male

sex workers have declined to almost zero during 2016. Most of male sex workers could be misclassified to MSM or to other population groups.

**Figure 49: No. of new female sex workers registered in STD clinics 2012-2016**

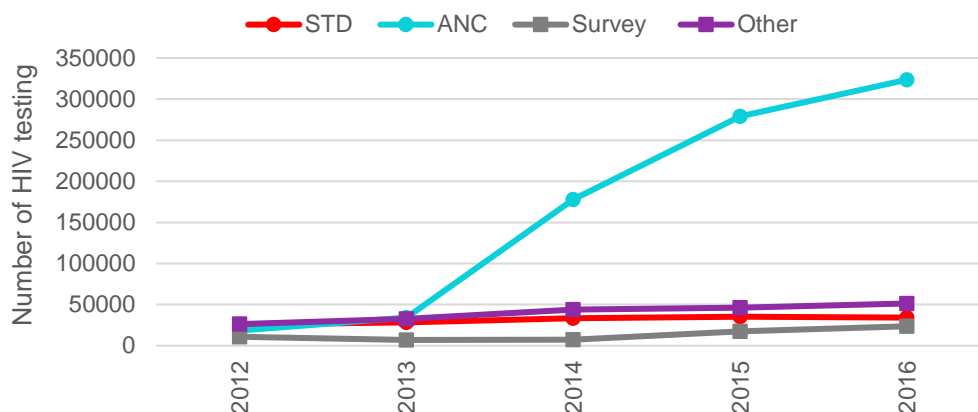


Above graph shows the number of female sex workers newly registered in STD clinics. Only three clinics had over 100 new female sex workers during 2016. Most of STD clinics in Northern and Eastern provinces continues to enroll new female sex workers similar to previous years.

### HIV screening services

HIV screening services at the STD clinics are monitored through quarterly STD returns by the SIM unit of NSACP. The following graph illustrates the number of different types of samples screened for HIV during the year 2016. Screening of antenatal samples have increased dramatically since 2013 during scaling up programme of prevention of mother to child transmission of HIV and syphilis.

Figure 50: Number and type of samples screened for HIV, 2012 - 2016



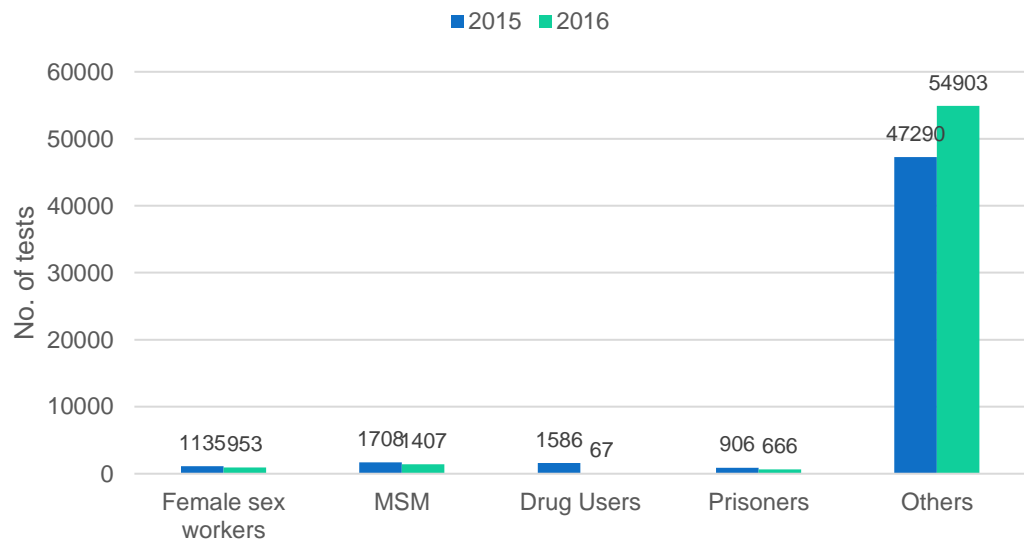
### HIV testing services for most at risk populations

The National STD/AIDS control programme conducts targeted interventions for Key population groups to increase the HIV testing in order to detect of early infections. The following table illustrates HIV testing and counselling services provided by the NSACP for STD clinic attendees including most-at-risk populations.

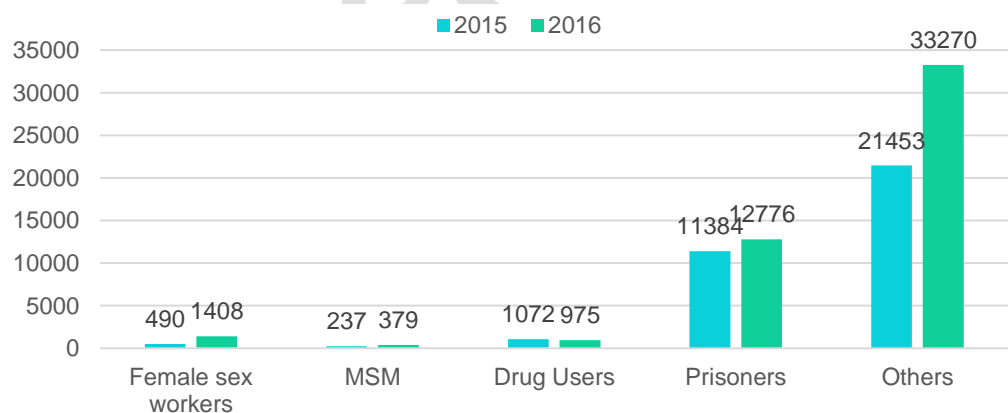
Table 24: HIV testing and counselling services for most at risk populations

	Clinic Based testing	Outreach testing	Clinic based testing	Outreach testing
<b>Female sex workers</b>	1135	490	953	1408
<b>MSM</b>	1708	237	1407	379
<b>Drug Users</b>	1586	1072	67	975
<b>Prisoners</b>	906	11384	666	12776
<b>Others*</b>	47290	21453	54903	33270
<b>Total</b>	52625	34636	57996	48808

\* STD clinic attendees other than Key populations, antenatal screening, visa screening, PEP screening etc.

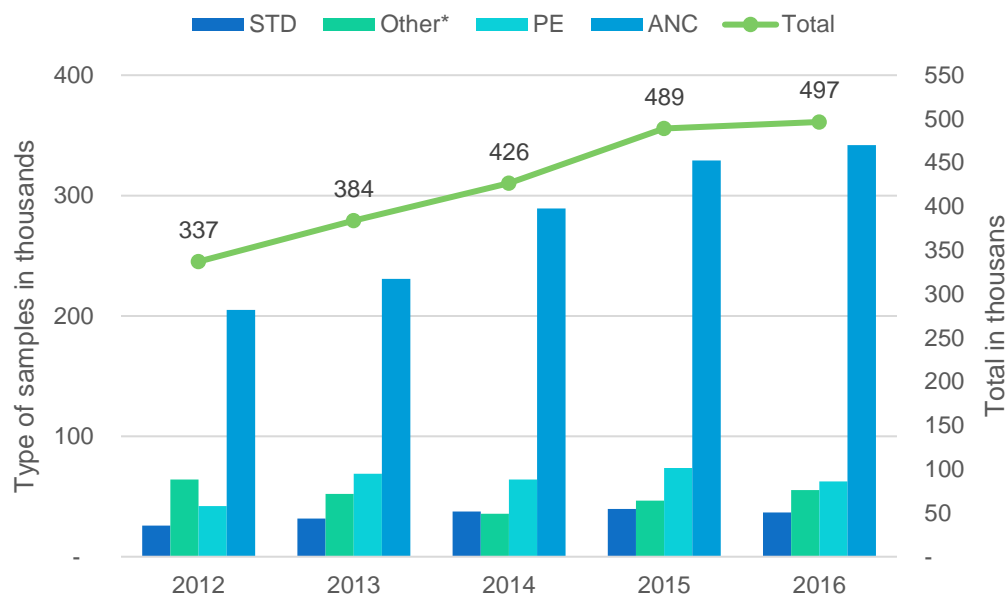
**Figure 51: Clinic based HIV testing and counselling for most at risk populations**

Above graph compares clinic based HIV testing done in 2015 and 2016. Most of Key populations testing have been reduced in 2016. Only improvement seen in HIV testing is in the “Other” category which comprised of a mixed group of antenatal women and persons who come for visa screening, PEP screening etc.

**Figure 52: Outreached HIV testing and counselling for most at risk populations**

Above graph shows that except drug users, all other category of HIV testing showed an improvement of HIV testing via outreach testing ser

Figure 53: Number and type of samples screened for syphilis (in thousands)



\* *visa screening, surveys, ward referrals etc.*

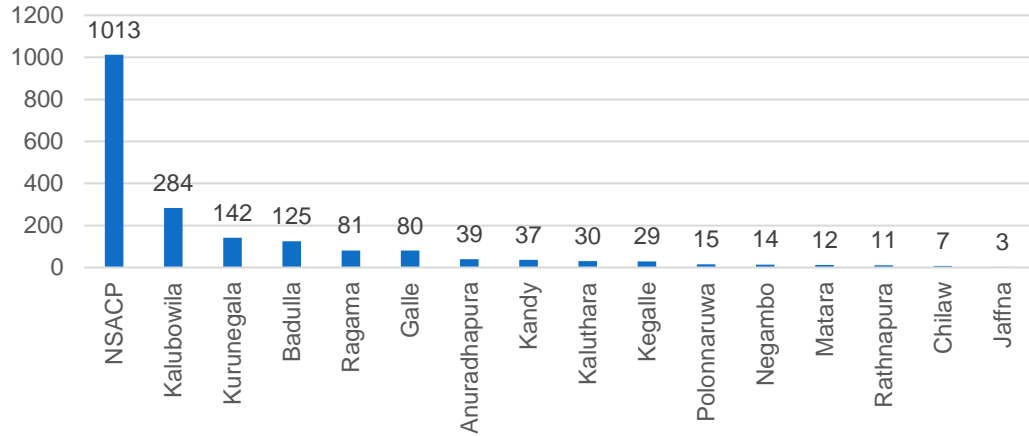
The STD clinic attendees are routinely offered screening services and blood samples from antenatal mothers are screened for syphilis at the laboratories of local STD clinics.

The above graph summarizes the total number of samples from each category tested for syphilis during the last six years. It is notable that the total number of syphilis testing has increased with an upward trend. Scaling up of antenatal syphilis screening is the biggest contributor to this upward trend.

### Pap smear (Cervical cytology) screening services in 2016

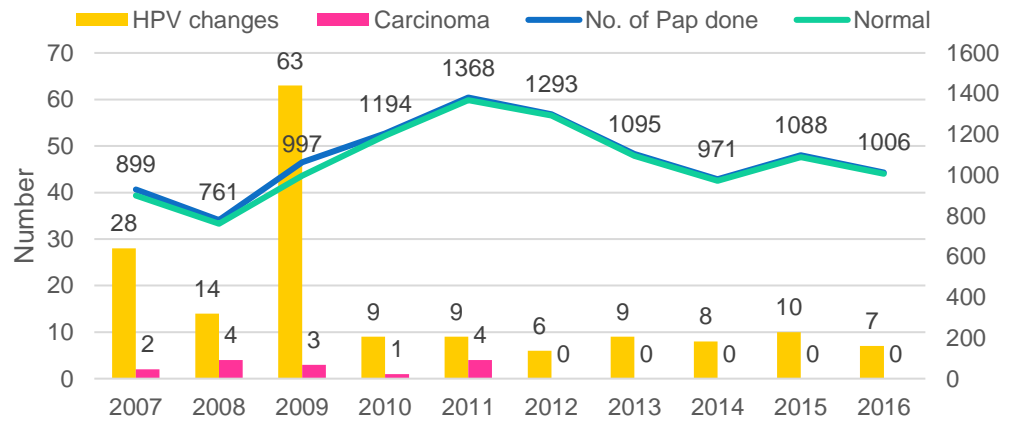
During 2016, the Central STD clinic, Colombo and 16 peripheral STD clinics provided Pap smear screening facilities to female clinic attendees. Of the 1,922 pap smears performed at these clinics, majority (52.7%) of pap smears were done in Colombo STD clinic. Only 35 smears (1.8%) were reported as CIN I and no carcinomas were detected among STD clinic attendees during 2016. Timely reporting of Pap smear results has been a challenge due to limited resource allocation for this activity.

Figure 54: Number of PAP smear tests done during 2016



Graph below shows the total Pap smear tests done at the Central STD clinic, Colombo with the diagnosis.

Figure 55: Results of Pap smear tests done at Colombo STD clinic, 2007-2016



Those with suspicious cellular changes are referred to gynecology clinics for colposcopy and further management. Clinic attendees with normal Pap smears are referred to the local Well-women clinic for future pap smear screenings after completing the STD clinic follow up.

Following tables give details of monitoring data on individual STD clinics as reported in the quarterly STD returns.



Table 25. Number of clinic attendees and details of clinic attendances for STD clinics during 2016

Province	Clinic	New patients registered			New patients with STIs			Total no. of clinic visits by STD patients			Total no. of visits by others		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	586	586	1172	234	329	563	1823	2284	4107	2405	4771	7176
	Matale	132	109	241	56	63	119	278	222	500	921	1299	2220
	Nuwara Eliya	61	138	199	20	39	59	112	242	354	494	707	1201
Eastern Province	Ampara	178	222	400	72	109	181	336	448	784	1421	5331	6752
	Batticaloa	127	195	322	45	63	108	983	979	1962	1901	624	2525
	Kalmunai	72	84	156	12	20	32	105	129	234	2588	488	3076
	Trincomalee	96	86	182	63	33	96	218	187	405	3941	6614	10555
North Central Province	Anuradhapura	434	294	728	225	188	413	816	685	1501	5417	4478	9895
	Polonnaruwa	215	253	468	161	218	379	429	443	872	2962	3296	6258
North Western Province	Chilaw	331	679	1010	164	493	657	648	855	1503	1242	747	1989
	Kurunegala	677	1007	1684	422	819	1241	1744	2203	3947	2022	2153	4175
Northern Province	Jaffna	130	97	227	81	34	115	243	129	372	1570	5532	7102
	Kilinochchi	34	58	92	17	13	30	30	40	70	699	3038	3737
	Mannar	27	28	55	4	7	11	36	31	67	344	2375	2719
	Mullaitivu	33	28	61	22	9	31	63	86	149	1164	1605	2769
	Vavuniya	127	146	273	93	56	149	403	354	757	1299	3623	4922
Sabaragamuwa Province	Kegalle	283	313	596	89	168	257	778	902	1680	1218	1580	2798
	Ratnapura	397	459	856	138	131	269	350	462	812	2266	1946	4212
Southern Province	Balapitiya	334	152	486	66	92	158	489	545	1034	965	1590	2555
	Galle	431	405	836	200	203	403	1345	1479	2824	1044	829	1873
	Hambantota	303	288	591	124	129	253	406	395	801	1624	2616	4240
	Matara	341	234	575	110	139	249	942	936	1878	1775	6011	7786
Uva Province	Badulla	303	368	671	96	185	281	1095	1714	2809	2015	4676	6691
	Monaragala	136	186	322	34	119	153	292	512	804	947	823	1770
Western Province	Colombo	3302	1631	4933	1179	829	2008	12911	5251	18162	6363	3296	9659
	Gampaha	201	273	474	138	222	360	757	828	1585	866	797	1663
	Kalubowila	706	624	1330	447	434	881	3525	2558	6083	1105	1059	2164
	Kalutara	388	360	748	151	317	468	1282	1286	2568	2451	2791	5242
	Negombo	280	297	577	142	210	352	1011	1050	2061	1033	963	1996
	Ragama	810	622	1432	296	309	605	2735	1910	4645	961	887	1848
	Wathupitiwala	134	142	276	70	97	167	208	282	490	549	655	1204
<b>Total</b>		<b>11609</b>	<b>10364</b>	<b>21973</b>	<b>4971</b>	<b>6077</b>	<b>11048</b>	<b>36393</b>	<b>29427</b>	<b>65820</b>	<b>55572</b>	<b>77200</b>	<b>132772</b>

Table 26. Treatment of Contacts for Syphilis, Gonorrhoea , Chlamydia &amp; Trichomoniasis in 2016

Province	Clinic	Contacts of Syphilis treated			Contacts of Gonorrhoea treated			Contacts of Chlamydia* treated			Contact of Trichomoniasis treated		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	2	2	1	0	1	13	2	15	1	0	1
	Matale	0	0	0	0	0	0	0	0	0	0	0	0
	Nuwara Eliya	3	1	4	4	1	5	0	0	0	0	0	0
Eastern Province	Ampara	1	0	1	0	0	0	0	0	0	0	0	0
	Batticaloa	3	8	11	3	1	4	0	0	0	2	3	5
	Kalmunai	1	1	2	0	0	0	0	0	0	0	0	0
	Trincomalee	0	3	3	0	0	0	0	0	0	0	0	0
North Central province	Anuradhapura	8	8	16	8	0	8	0	0	0	0	0	0
	Polonnaruwa	5	6	11	0	1	0	0	0	0	0	0	0
North Western Province	Chilaw	4	2	6	0	0	0	0	0	0	0	2	2
	Kurunegala	13	4	17	1	0	1	0	0	0	0	0	0
Northern Province	Jaffna	3	2	5	0	0	0	0	0	0	0	0	0
	Kilinochchi	1	0	1	0	0	0	0	0	0	0	0	0
	Mannar	2	6	8	0	0	0	0	0	0	0	0	0
	Mullaitivu	0	1	1	0	0	0	0	0	0	0	0	0
	Vavuniya	3	1	4	0	0	0	0	0	0	2	1	3
Sabaragamuwa Province	Kegalle	3	0	3	4	0	4	0	0	0	1	0	1
	Ratnapura	6	9	15	3	1	4	0	0	0	0	0	0
Southern Province	Balapitiya	8	5	13	0	1	1	0	0	0	0	0	0
	Galle	12	8	20	0	1	1	0	0	0	1	0	1
	Hambantota	0	1	1	4	4	8	0	0	0	0	0	0
	Matara	1	0	1	0	0	0	0	0	0	0	0	0
Uva Province	Badulla	7	8	15	0	0	0	0	0	0	2	2	4
	Monaragala	2	0	2	0	1	1	0	0	0	0	0	0
Western Province	Colombo	22	4	26	4	0	4	0	0	0	0	0	0
	Gampaha	2	1	3	0	0	0	0	0	0	0	0	0
	Kalubowila	7	4	11	0	7	7	0	0	0	2	1	3
	Kalutara	13	8	21	3	3	6	0	0	0	0	0	0
	Negombo	6	3	9	2	4	6	0	0	0	0	0	0
	Ragama	5	3	8	1	1	2	0	0	0	0	0	0
	Wathupitiwala	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>		<b>141</b>	<b>99</b>	<b>240</b>	<b>38</b>	<b>26</b>	<b>63</b>	<b>13</b>	<b>2</b>	<b>15</b>	<b>11</b>	<b>9</b>	<b>20</b>

Table 27. Samples screened for syphilis - 2016

Province	Clinic	Number screened				Number positive				Number confirmed				Number treated			
		STD	ANC	Pre-Emp.	Other	STD	ANC	Pre-emp.	Other	STD	ANC	Pre-emp.	Other	STD	ANC	Pre-emp.	Other
Central Province	Kandy	2619	21767	3510	2616	91	65	5	21	46	6	0	22	31	5	0	10
	Matale	243	5815	1319	200	2	0	0	1	2	0	0	1	0	0	0	0
	Nuwara Eliya	236	12776	947	430	4	10	0	1	4	2	0	0	4	2	0	0
Eastern Province	Ampara	538	4290	1946	33	36	3	3	0	20	2	1	0	7	2	1	0
	Batticaloa	322	9561	2029	1261	5	25	5	1	14	1	0	1	17	1	0	1
	Kalmunai	260	7789	3076	3134	0	0	0	0	2	0	0	0	2	0	0	0
North Central province	Trincomalee	182	7788	2002	748	20	41	16	19	6	0	2	6	6	0	2	4
	Anuradhapura	719	20722	5935	3150	24	5	1	0	17	1	0	0	14	1	0	0
North Western Province	Polonnaruwa	1036	8773	3105	3901	69	56	31	82	29	6	21	21	14	3	7	7
	Chilaw	1133	15630	1545	2014	15	5	0	0	22	1	0	0	15	1	0	0
Northern Province	Kurunegala	2032	26405	3344	1330	61	41	4	7	59	1	0	4	52	1	0	0
	Jaffna	227	8360	1315	2830	10	62	14	22	8	3	1	2	8	2	1	1
	Kilinochchi	92	2263	1530	228	0	1	0	0	0	0	0	0	0	1	0	0
	Mannar	55	2	0	355	2	0	0	1	4	2	0	1	4	2	0	1
	Mullaitivu	218	1122	877	1903	1	2	0	0	0	0	0	0	1	2	0	0
Sabaragamuwa Province	Vavuniya	708	2914	1466	654	7	5	4	2	6	3	0	3	3	2	0	1
	Kegalle	821	11489	2334	674	26	25	0	8	27	3	0	4	5	3	0	0
Southern Province	Ratnapura	2185	19389	3733	3718	89	189	36	40	47	2	0	11	16	2	0	2
	Balapitiya	507	4718	445	437	22	12	1	11	25	1	0	10	15	1	0	7
	Galle	1456	8918	1590	1418	175	85	32	23	43	7	1	8	40	6	1	4
	Hambantota	623	10961	2207	1181	20	99	0	6	3	3	0	0	1	1	0	0
Uva Province	Matara	747	11472	2055	229	5	0	0	3	22	0	0	5	11	0	0	0
	Badulla	1042	22518	1831	3059	104	171	8	20	39	8	0	6	17	9	0	1
Western Province	Monaragala	323	2665	1395	737	9	24	12	2	6	0	1	1	4	0	1	1
	Colombo	8888	48678	6496	14105	680	444	40	727	509	24	10	514	219	6	2	0
	Gampaha	1147	13730	1019	1040	15	21	0	11	40	21	0	9	6	0	0	0
	Kalubowila	2965	195	245	1323	72	0	0	16	74	0	0	28	63	0	0	8
	Kalutara	1232	19084	2705	977	105	30	5	5	52	10	1	5	36	9	0	2
	Negombo	1183	5817	835	366	68	28	4	0	24	4	1	0	20	4	1	0
	Ragama	2644	5943	1025	1215	41	4	0	10	41	3	0	10	32	2	0	8
Wathupitiwala	276	398	684	157	8	0	0	0	8	0	0	2	6	0	0	0	
<b>Total</b>		<b>36659</b>	<b>341952</b>	<b>62545</b>	<b>55423</b>	<b>1786</b>	<b>1453</b>	<b>221</b>	<b>1039</b>	<b>1199</b>	<b>114</b>	<b>39</b>	<b>674</b>	<b>669</b>	<b>68</b>	<b>16</b>	<b>58</b>

\* visa screening, surveys, ward referrals etc.

Table 28: Sex workers Among Clinic Attendees in 2016

Province	Clinic	New sex workers registered			New sex workers with STI			Total no. of Sex workers attended			Total Clinic visits by Sex workers		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	30	30	0	13	13	0	57	57	0	74	74
	Matale	0	1	1	0	0	0	0	1	1	0	1	1
	Nuwara Eliya	0	0	0	0	0	0	0	0	0	0	0	0
Eastern Province	Ampara	0	3	3	0	1	1	0	3	3	0	3	3
	Batticaloa	1	4	5	0	0	0	1	4	5	1	4	5
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0	0	0	0
North Central Province	Anuradhapura	0	8	8	0	2	2	0	42	42	0	50	50
	Polonnaruwa	0	1	1	0	1	1	0	5	5	0	7	7
North Western Province	Chilaw	0	12	12	0	10	10	0	30	30	0	67	67
	Kurunegala	0	44	44	0	33	33	0	51	51	0	126	126
Northern Province	Jaffna	0	0	0	0	0	0	0	0	0	0	0	0
	Kilinochchi	0	0	0	0	0	0	0	0	0	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	0	1	1	0	0	0	0	1	1	0	1	1
	Vavuniya	0	7	7	0	2	2	0	16	16	0	22	22
Sabaragamuwa Province	Kegalle	0	17	17	0	10	10	0	32	32	0	35	35
	Ratnapura	0	128	128	0	2	2	7	61	68	7	141	148
Southern Province	Balapitiya	0	8	8	0	0	0	0	10	10	0	10	10
	Galle	0	11	11	0	3	3	0	59	59	0	99	99
	Hambantota	0	55	55	0	0	0	0	61	61	0	61	61
	Matara	0	7	7	0	2	2	0	25	25	0	32	32
Uva Province	Badulla	0	0	0	0	5	5	0	22	22	0	27	27
	Monaragala	0	1	1	0	0	0	0	1	1	0	1	1
Western Province	Colombo	0	248	248	0	162	162	0	367	367	0	988	988
	Gampaha	0	50	50	0	25	25	0	61	61	0	87	87
	Kalubowila	0	108	108	0	75	75	0	260	260	0	313	313
	Kalutara	0	14	14	0	11	11	1	32	33	1	32	33
	Negombo	0	39	39	0	28	28	3	79	82	6	93	99
	Ragama	0	47	47	0	24	24	0	83	83	0	84	84
	Wathupitiwala	0	23	23	0	9	9	0	30	30	0	30	30
<b>Total</b>		<b>1</b>	<b>867</b>	<b>868</b>	<b>0</b>	<b>418</b>	<b>418</b>	<b>12</b>	<b>1393</b>	<b>1405</b>	<b>15</b>	<b>2388</b>	<b>2403</b>

Table 29: Civil Status of New STD Clinic attendees during 2016

Province	Clinic	Single/ Never married			Married /Living together			Separated /Divorced /Widowed			Not Known		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	288	198	486	288	333	621	10	55	65	0	0	0
	Matale	49	15	64	82	95	177	1	0	1	0	1	1
	Nuwara Eliya	20	41	61	40	95	135	1	1	2	0	1	1
Eastern Province	Ampara	73	83	156	104	136	240	1	3	4	0	0	0
	Batticaloa	37	87	124	89	103	192	1	5	6	0	0	0
	Kalmunai	19	25	44	53	59	112	0	0	0	0	0	0
	Trincomalee	39	40	79	56	46	102	1	0	1	0	0	0
North Central Province	Anuradhapura	141	47	188	282	231	513	11	16	27	0	0	0
	Polonnaruwa	71	49	120	132	190	322	10	12	22	2	2	4
North Western Province	Chilaw	137	223	360	188	408	596	6	47	53	0	1	1
	Kurunegala	255	164	419	405	751	1156	16	91	107	1	1	2
Northern Province	Jaffna	57	55	112	73	42	115	0	0	0	0	0	0
	Kilinochchi	11	32	43	23	26	49	0	0	0	0	0	0
	Mannar	6	13	19	21	14	35	0	1	1	0	0	0
	Mullaitivu	12	8	20	20	19	39	0	1	1	1	0	1
	Vavuniya	44	71	115	76	59	135	7	12	19	0	4	4
Sabaragamuwa Province	Kegalle	112	52	164	167	245	412	4	16	20	0	0	0
	Ratnapura	165	132	297	222	290	512	9	33	42	1	4	5
Southern Province	Balapitiya	235	39	274	98	107	205	1	6	7	0	0	0
	Galle	206	126	332	216	272	488	9	7	16	0	0	0
	Hambantota	166	122	288	134	162	296	3	3	6	0	1	1
	Matara	170	69	239	159	157	316	11	6	17	1	2	3
Uva Province	Badulla	143	159	302	152	203	355	3	6	9	5	0	5
	Monaragala	51	81	132	81	101	182	4	4	8	0	0	0
Western Province	Colombo	1518	314	1832	1722	985	2707	62	332	394	0	0	0
	Gampaha	96	50	146	99	177	276	6	46	52	0	0	0
	Kalubowila	364	191	555	332	427	759	10	6	16	0	0	0
	Kalutara	183	78	261	184	268	452	14	14	28	7	0	7
	Negombo	119	51	170	154	186	340	7	59	66	0	1	1
	Ragama	328	143	471	448	399	847	34	78	112	0	2	2
Wathupitiwala	71	20	91	57	96	153	6	26	32	0	0	0	
<b>Total</b>		<b>5186</b>	<b>2778</b>	<b>7964</b>	<b>6157</b>	<b>6682</b>	<b>12839</b>	<b>248</b>	<b>886</b>	<b>1134</b>	<b>18</b>	<b>20</b>	<b>38</b>

Table 30: Occupational Status of New STD clinic attendees in 2016

Province	Clinic	Unemployed			Employed			Student			Retired			Not known		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	80	330	410	451	134	585	45	120	165	10	2	12	0	0	0
	Matale	5	66	71	118	41	159	7	2	9	2	1	3	0	1	1
	Nuwara Eliya	9	84	93	48	33	81	3	21	24	1	0	1	0	0	0
Eastern Province	Ampara	14	134	148	149	29	178	14	58	72	1	0	1	0	1	1
	Batticaloa	40	125	165	72	11	83	14	59	73	1	0	1	0	0	0
	Kalmunai	15	53	68	41	16	57	12	12	24	3	2	5	1	1	2
	Trincomalee	24	46	70	64	10	74	7	30	37	1	0	1	0	0	0
North Central province	Anuradhapura	21	207	228	397	67	464	13	19	32	3	1	4	0	0	0
	Polonnaruwa	61	206	267	142	35	177	6	11	17	2	0	2	4	1	5
North Western Province	Chilaw	30	338	368	276	221	497	21	119	140	4	0	4	0	1	1
	Kurunegala	80	645	725	516	255	771	52	73	125	6	1	7	23	33	56
Northern Province	Jaffna	65	58	123	56	14	70	9	25	34	0	0	0	0	0	0
	Kilinochchi	15	29	44	17	11	28	1	18	19	0	0	0	1	0	1
	Mannar	21	21	42	5	1	6	0	5	5	1	1	2	0	0	0
	Mullaitivu	0	22	22	32	1	33	1	5	6	0	0	0	0	0	0
	Vavuniya	39	79	118	82	20	102	5	47	52	1	0	1	0	0	0
Sabaragamuwa Province	Kegalle	15	189	204	237	96	333	22	28	50	9	0	9	0	0	0
	Ratnapura	39	286	325	332	103	435	23	70	93	3	0	3	0	0	0
Southern Province	Balapitiya	121	96	217	188	27	215	19	22	41	6	0	6	0	7	7
	Galle	51	253	304	319	105	424	45	46	91	16	0	16	0	1	1
	Hambantota	91	132	223	172	112	284	30	42	72	3	0	3	7	2	9
	Matara	47	154	201	254	40	294	34	40	74	6	0	6	0	0	0
Uva Province	Badulla	132	241	373	141	60	201	15	65	80	9	0	9	6	2	8
	Monaragala	79	115	194	46	12	58	5	59	64	6	0	6	0	0	0
Western Province	Colombo	391	898	1289	2652	632	3284	164	83	247	95	17	112	0	1	1
	Gampaha	19	133	152	162	114	276	14	25	39	6	1	7	0	0	0
	Kalubowila	119	290	409	528	283	811	51	49	100	8	2	10	0	0	0
	Kalutara	172	211	383	172	91	263	23	44	67	8	12	20	13	2	15
	Negombo	16	140	156	249	142	391	8	14	22	4	0	4	3	1	4
	Ragama	68	348	416	672	192	864	43	78	121	27	2	29	0	0	2
	Wathupitiwala	27	76	103	88	63	151	15	3	18	4	0	4	0	0	0
<b>Total</b>		<b>1906</b>	<b>6005</b>	<b>7911</b>	<b>8678</b>	<b>2971</b>	<b>11649</b>	<b>721</b>	<b>1292</b>	<b>2013</b>	<b>246</b>	<b>42</b>	<b>288</b>	<b>58</b>	<b>54</b>	<b>114</b>

Table 31: Reason for attendance Among New STD clinic attendees in 2016

Province	Clinic	Contact of patients			Voluntarily			Referral magistrate/court from			Others		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	14	17	31	255	67	322	2	9	11	315	493	808
	Matale	3	3	6	49	36	85	1	6	7	79	66	145
	Nuwara Eliya	19	15	34	18	14	32	1	20	21	23	89	112
Eastern Province	Ampara	35	9	44	47	26	73	41	48	89	55	139	194
	Batticaloa	7	10	17	8	2	10	10	56	66	102	127	229
	Kalmunai	10	4	14	9	3	12	5	5	10	48	72	120
	Trincomalee	2	5	7	24	5	29	7	44	51	63	32	95
North Central province	Anuradhapura	8	5	13	218	113	331	41	8	49	167	168	335
	Polonnaruwa	13	8	21	119	143	262	16	30	46	67	72	139
North Western Province	Chilaw	62	47	109	90	92	182	65	196	261	114	344	458
	Kurunegala	87	87	174	308	275	583	54	84	138	228	561	789
Northern Province	Jaffna	4	5	9	25	8	33	15	38	53	86	46	132
	Kilinochchi	2	0	2	8	0	8	0	13	13	24	45	69
	Mannar	0	2	2	3	1	4	4	0	4	20	25	45
	Mullaitivu	2	2	4	15	11	26	0	4	4	16	11	27
	Vavuniya	12	9	21	28	6	34	4	59	63	83	72	155
Sabaragamuwa Province	Kegalle	49	22	71	121	53	174	4	1	5	109	237	346
	Ratnapura	26	19	45	150	87	237	98	117	215	123	236	359
Southern Province	Balapitiya	19	6	25	47	18	65	0	12	12	268	116	384
	Galle	47	34	81	135	61	196	45	81	126	204	229	433
	Hambantota	30	16	46	90	102	192	124	54	178	59	116	175
	Matara	19	6	25	87	34	121	109	46	155	126	148	274
Uva Province	Badulla	38	21	59	69	40	109	66	88	154	130	219	349
	Monaragala	19	4	23	36	35	71	43	87	130	38	60	98
Western Province	Colombo	114	134	248	1794	453	2247	15	137	152	1379	907	2286
	Gampaha	17	12	29	71	55	126	15	20	35	98	186	284
	Kalubowila	29	19	48	387	149	536	45	122	167	245	334	579
	Kalutara	83	95	178	148	146	294	92	50	142	65	69	134
	Negombo	26	18	44	73	77	150	50	52	102	131	150	281
	Ragama	51	46	97	152	45	197	42	84	126	565	447	1012
	Wathupitiwala	2	4	6	80	61	141	2	1	3	50	76	126
<b>Total</b>		<b>849</b>	<b>684</b>	<b>1533</b>	<b>4664</b>	<b>2218</b>	<b>6882</b>	<b>1016</b>	<b>1572</b>	<b>2588</b>	<b>5080</b>	<b>5892</b>	<b>10972</b>

Table 32: Details of the Awareness Programmes conducted by STD clinics in 2016

Province	Clinic	Lectures		Exhibitions		Workshops		Other	
		No. of Programmes	No. of participants	No. of Programmes	No. of participants	No. of Programmes	No. of participants	No. of Programmes	No. of participants
Central Province	Kandy	90	10180	1	500	11	585	0	0
	Matale	50	6809	4	1090	1	50	13	1205
	Nuwara Eliya	37	3165	0	0	0	0	1	500
Eastern Province	Ampara	82	7134	10	2130	0	0	1	408
	Batticaloa	114	5361	0	0	0	0	1	250
	Kalmunai	26	1663	0	0	0	0	0	0
North Central province	Trincomalee	44	3520	0	0	1	35	1	350
	Anuradhapura	64	8333	0	0	0	0	0	0
North Western Province	Polonnaruwa	25	4424	0	0	0	0	0	0
	Chilaw	66	7056	2	2915	1	140	5	431
Northern Province	Kurunegala	100	10045	3	8700	7	375	21	401
	Jaffna	36	1750	0	0	6	300	0	0
	Kilinochchi	8	665	24	1668	2	80	3	136
	Mannar	4	260	0	0	0	0	3	440
	Mullaitivu	13	1449	0	0	2	69	0	0
Sabaragamuwa Province	Vavuniya	121	8784	2	1000	0	0	1	250
	Kegalle	50	5137	0	0	12	466	10	11900
Southern Province	Ratnapura	78	7380	0	0	0	0	4	14000
	Balapitiya	39	3053	1	3800	4	370	1	3500
	Galle	49	3370	2	6500	0	0	30	1650
	Hambantota	13	2220	0	0	67	8794	2	63
Uva Province	Matara	19	891	1	7000	6	930	0	0
	Badulla	148	15374	0	0	0	0	0	0
Western Province	Monaragala	77	2377	17	924	6	1011	27	2405
	Colombo	67	3075	12	149450	4	100	106	4855
	Gampaha	123	8433	0	0	2	200	0	0
	Kalubowila	26	1286	4	665	5	138	33	887
	Kalutara	79	7390	1	700	7	1720	2	390
	Negombo	20	2925	1	2500	0	0	5	1918
	Ragama	63	3405	0	0	0	0	16	891
Wathupitiwala	12	5310	0	0	0	0	5	270	
<b>Total</b>		<b>1743</b>	<b>152224</b>	<b>85</b>	<b>189542</b>	<b>144</b>	<b>15363</b>	<b>291</b>	<b>47100</b>



Table 33: HIV Testing and Counselling Details from STD clinics during 2016

Province	Clinics	Sex Workers		MSM		Drug Users		Prisoners		Other	
		No. received HIV Testing	No. receive HIV result	No. received HIV Testing	No. received HIV result	No. received HIV Testing	No. received HIV result	No. received HIV Testing	No. received HIV result	No. received HIV Testing	No. received HIV result
Central Province	Kandy	17	15	93	72	0	0	12	12	867	716
	Matale	1	1	6	6	0	0	0	0	236	236
	Nuwara Eliya	0	0	0	0	0	0	0	0	256	256
Eastern Province	Ampara	2	2	0	0	0	0	0	0	810	810
	Batticaloa	5	5	0	0	0	0	0	0	817	817
	Kalmunai	0	0	0	0	0	0	0	0	146	146
	Trincomalee	0	0	0	0	0	0	0	0	1349	1349
North Central province	Anuradhapura	0	0	0	0	0	0	49	49	6604	6604
	Polonnaruwa	10	10	4	4	18	18	7	7	431	431
North Western Province	Chilaw	22	22	22	21	0	0	0	0	1557	1327
	Kurunegala	54	54	8	8	0	0	30	30	3285	3285
Northern Province	Jaffna	0	0	27	27	2	2	3	3	1208	1208
	Kilinochchi	0	0	0	0	0	0	0	0	92	28
	Mannar	0	0	0	0	0	0	0	0	2436	2385
	Mullaitivu	1	1	0	0	0	0	0	0	1885	1885
	Vavuniya	7	7	0	0	0	0	5	5	3748	3748
Sabaragamuwa Province	Kegalle	26	26	49	49	2	2	4	4	859	859
	Ratnapura	59	59	16	16	10	0	59	51	1453	1453
Southern Province	Balapitiya	23	23	137	137	0	0	0	0	2238	2238
	Galle	26	19	23	15	4	3	42	39	1495	1020
	Hambantota	55	53	0	0	0	0	0	0	1477	1380
	Matara	19	19	2	2	0	0	122	122	1084	837
Uva Province	Badulla	0	0	0	0	0	0	51	51	3472	2772
	Monaragala	1	1	0	0	0	0	0	0	542	542
Western Province	Colombo	87	56	399	356	0	0	144	120	7566	6710
	Gampaha	55	31	27	18	0	0	1	1	769	539
	Kalubowila	303	253	399	211	21	2	4	4	2276	1337
	Kalutara	25	25	44	44	8	4	34	34	2046	2046
	Negombo	81	51	62	54	0	0	69	55	1115	1031
	Ragama	61	15	64	39	0	0	30	16	2071	845
	Wathupitiwala	23	23	25	25	2	2	0	0	713	713
<b>Total</b>		<b>963</b>	<b>771</b>	<b>1407</b>	<b>1104</b>	<b>67</b>	<b>33</b>	<b>666</b>	<b>603</b>	<b>54903</b>	<b>49553</b>

*“Sri Lanka is getting ready for the application of validation for elimination of the mother to child transmission (EMTCT) of syphilis and HIV as suggested by the WHO”*

## EMTCT of syphilis and HIV

The elimination of Mother to Child Transmission (EMTCT) of syphilis and HIV programme was scaled up to cover the whole country during 2016. This programme was officially launched in the Eastern province, and Districts of Matale and Nuwara-Eliya. During 2016 the EMTCT programme was carried out mainly with government funds while UNICEF assisted in printing IEC material, conducting review meetings and purchasing safe delivery kits.

**Figure 56: A healthy baby is the dream of every mother**



A special meeting was held in Bangkok, Thailand by WHO SEARO and WEPRO, in September 2016 to discuss the progress of EMTCT programmes in the region. Thailand has been validated as the first country in the Asian Region which reached elimination of MTCT of HIV and syphilis targets. As Sri Lanka has achieved satisfactory impact indicator targets, it was advised to expedite the scaling up of EMTCT programme to reach process targets as early as possible. On invitation of the MOH, Sri Lanka, the Regional Advisor for SEARO, WHO visited Sri Lanka in October 2016 to review the country EMTCT programme.

According to reported available data, Sri Lanka has achieved the required status in relation to indicators for validation of EMTCT of syphilis by end 2016 and will satisfy indicators for EMTCT of HIV by end 2017. However, Sri Lanka need to officially apply for validation.

A decision was taken to pay emphasis on achieving the process indicator targets for HIV and syphilis by end 2017 and to initiate process to apply for validation in 2017. A special meeting was conducted to introduce the process of validation to important stakeholders.

Table 34: Minimum global indicators for validation of EMTCT

Impact indicators	
<b>a. HIV</b>	Less than 50 new paediatric infections per 100,000 live births and a transmission rate of either <5% in breastfeeding populations or <2% in non-breastfeeding populations;
<b>b. Syphilis</b>	Less than 50 cases of congenital syphilis per 100,000 live births
<p>Additionally, to accomplish EMTCT of HIV, there are <b>four process targets</b> that need to be met.</p> <ol style="list-style-type: none"> <li>1. Antenatal care coverage (at least one visit) of more than or equal to 95%</li> <li>2. Coverage of HIV and/or syphilis testing of pregnant women of more than or equal to 95%</li> <li>3. Antiretroviral treatment coverage of HIV-positive pregnant women more than or equal to 90%</li> <li>4. Treatment of syphilis-seropositive pregnant women more than or equal 95%.</li> </ol>	

Table 35: Sri Lankan status with regards to EMTCT validation during 2016

Sri Lankan Status with regard to EMTCT validation during 2016	
<b>a. HIV</b>	New HIV paediatric infections 0.6 per 100,000 live births
<b>b. Syphilis</b>	Congenital syphilis 2.5 cases per 100,000 live births
<p><b>Process targets for 2016</b></p> <ol style="list-style-type: none"> <li>1. Antenatal care coverage (at least one visit) 94.7%</li> <li>2. <b>Coverage of HIV</b> testing of pregnant women 87.7%</li> <li>3. <b>Coverage of syphilis</b> testing of pregnant women 93%</li> <li>4. Antiretroviral treatment coverage of HIV-positive pregnant women 100%</li> <li>5. Treatment of syphilis-seropositive pregnant women 96%.</li> </ol>	

## Development of guidelines on EMTCT of syphilis and HIV

The guidelines on management of pregnant women with HIV was first published in 2008. This was further improved in 2012. During recent years many changes have taken place in the management of pregnant women with HIV. **Option B+** regimen has been introduced by the WHO for all pregnant women with HIV irrespective of clinical stage or CD4 counts. Efavirenz has been approved to be used among women of child bearing age and during pregnancy. These have been practiced in the country by including as amendments to the existing guidelines. The guidelines on management of syphilis in pregnancy was first developed in 2012. However, this was not printed and was available only online. Therefore, the two guidelines on management of pregnant women with syphilis and HIV were developed including recent advances and printed in the year 2016. This activity was funded by GOSL.

## IEC material

A CD was developed with power point presentations to be used by the MCH staff in programmes for advocacy, training of health care workers and to educate pregnant as well as non- pregnant women and girls in the community. This is supported by a booklet which gives information to the HCW as a facilitators guide. Four hundred sets were developed and distributed among MOH offices in the country through venereologists working in provincial STD clinics.

Figure 57: IEC material developed on EMTCT during 2016



## Meetings on EMTCT process

Four steering committee meetings of EMTCT were conducted during 2016. The same committee was renamed as National validation committee to facilitate validation process. There were six meetings to discuss the plan of validation. The annual review meeting was conducted on 7<sup>th</sup> and 8<sup>th</sup> December with the participation of all venereologists. Provincial situation with regard to EMTCT programme was discussed. These meetings helped to improve EMTCT of HIV and syphilis programme in provinces.

## Mother to child transmission of syphilis

A total of 11 cases of congenital syphilis were reported during 2016. Of these 9 were early congenital syphilis cases and 2 were late congenital syphilis cases.

Table 36: Data related to mother to child transmission of syphilis during 2016

Indicator	Value in 2016
1. Number of VDRL tests done among pregnant women in 2016 (by STD clinics)	341,952
2. Number of pregnant women with syphilis	77
3. Number of pregnant women provided adequate treatment before 36 weeks of POA	74
4. Number of congenital syphilis cases reported during 2016	11

## Elimination of mother to child transmission of HIV

Since 2011, all pregnant women diagnosed with HIV infection, who received services for EMTCT, delivered HIV uninfected babies. Option B+ with triple ART was provided to all pregnant women diagnosed with HIV which has to be continued for the life time. The pregnant women were managed by a team including obstetricians, venereologists, pediatricians and anesthetists. All babies were offered ARV prophylaxis with syrup Nevirapine for 6 weeks or longer if necessary. All mothers were counselled in appropriate feeding practices. Formula milk was provided by an NGO National AIDS Foundation. All babies of mothers who received EMTCT services were negative for DNA PCR.

## Indicators on EMTCT of HIV

Table 37: Indicators on EMTCT of HIV

Indicators on HIV positive pregnant women and their babies in 2016	Number
1. Number of HIV tests done among pregnant women	323,518
2. Number of pregnant women with HIV reported (4 known, 11 newly diagnosed from ANC screening)	15
3. Number of HIV positive women who received EMTCT services (15 got pregnant in 2016, 8 got pregnant in 2015 and delivered in 2016)	23
4. Number of abortions among all pregnant women with HIV	1
5. Number of live births among all pregnant women with HIV in 2016 (8 from women got pregnant in 2015, 8 in 2016)	16
6. Number of babies born to HIV positive women who received EMTCT services on exclusive formula feeding (8 from women got pregnant in 2015, 8 in 2016)	16
7. Number of babies born to HIV positive mothers who were tested with DNA PCR (8 from women got pregnant in 2015, 8 in 2016)	16
8. Number of DNA PCR test positives	0

## Early infant diagnosis (EID)

WHO recommends early diagnosis based on DNA PCR tests in children due to rapid progression of HIV in children. Dried Blood spots are sent to India for DNA PCR testing. All babies exposed to HIV have been tested with RNA PCR test at birth followed by DNA PCR at 8 and 16 weeks and HIV antibody tests at 9, 18 months. All have shown negative results so far.

## Children living with HIV

All children diagnosed with HIV are registered at the STD clinics and managed in collaboration with pediatricians. According to the latest ART guidelines of WHO, all children were offered ART during 2016. However, there are few families having adherence issues. A report was prepared on the status of children and submitted to the Ministry of health and HIV care subcommittee. Housing and security issues regarding few children were highlighted. Services of a social care worker is important to improve social services aspect of management. There are no special institutions for children affected by HIV/AIDS.

Two orphans are cared for by an NGO, all other identified children with HIV are living with their parents or extended families.

**Table 38: Children living with HIV receiving HIV care services as of end 2016**

Name of the clinic	Age category				Total	%
	<1	1-4	5-9	10-14		
Colombo	-	-	12	5	17	41%
Ragama	-	-	2	4	6	15%
Galle	-	1	1	1	3	7%
Gampaha	-	-	3	-	3	7%
Kandy	-	-	2	1	3	7%
Anuradhapura	-	-	2	-	2	5%
Chilaw	-	-	-	1	1	2%
IDH	-	-	1	-	1	2%
Kalutara	-	-	-	1	1	2%
Kegalle	1	-	-	-	1	2%
Kurunegala	-	-	1	-	1	2%
Negombo	-	-	1	-	1	2%
Ratnapura	-	-	1	-	1	2%
<b>Grand Total</b>	<b>1</b>	<b>1</b>	<b>26</b>	<b>13</b>	<b>41</b>	<b>100%</b>

### Training of health care workers on EMTCT

During the year 2016, the EMTCT programme was scaled up to cover the Eastern province, Matale and Nuwara-Eliya Districts. Consultative meetings were conducted in Matale, Nuwara-Eliya, Badulla, Kegalle, Ratnapura, Batticaloa, Ampara and Polonnaruwa to introduce the programme to provincial authorities as well as maternal and child health and public health staff. Training programmes for health care workers (HCW) were conducted for staff attached to maternity units of GH Kuliyaipitiya, Negombo, Galle, Ratnapura, Kurunegala, Gampaha, Panadura and Matara and NSACP. These programmes were conducted with the financial support from government of Sri Lanka (GOSL).

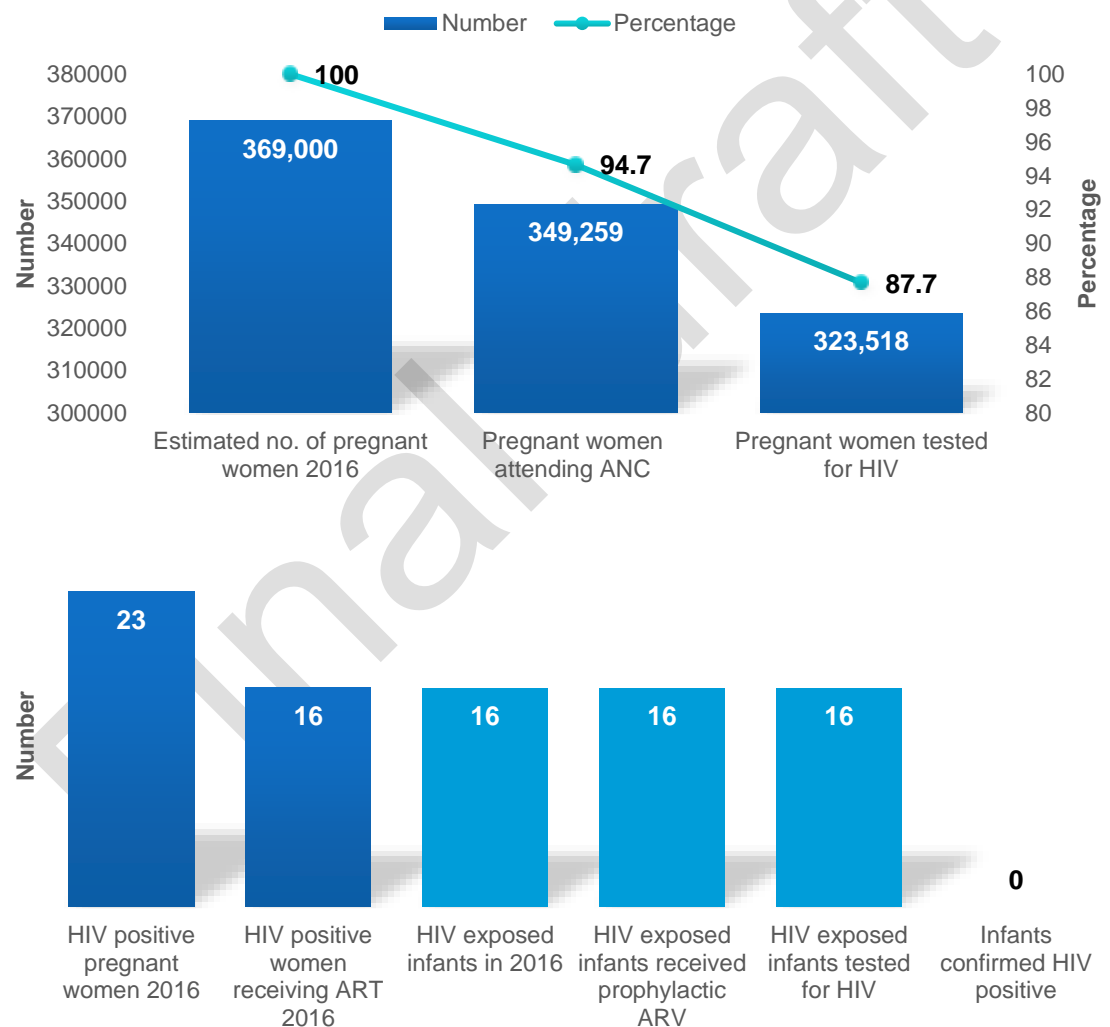
Information education and communication (IEC) materials were printed and safe delivery kits were procured and distributed to all the districts involved in the programme which was funded by UNICEF. The steering committee of EMTCT of HIV and Syphilis met once in three months to review the programme. To facilitate these programmes a medical officer was appointed to the EMTCT unit of NSACP in 2016.

During the year 2016 the EMTCT programme covered more than 95% of the pregnant population in the country. The remarkable feature of this programme is the collaboration among several institutions at different levels. At the central level, under the guidance of the Director General of Health Services and Deputy Director General of Public Health Services the unit responsible for maternal and child health in the country; the Family Health Bureau, worked closely with the National STD/ AIDS Control Programme to provide the leadership to

this initiative. At the provincial level, Community Physicians and Medical Officers of Maternal and Child Health together with the support from Venereologists and the staff of District STD clinics and MOH Offices implement the programme in the community. At the grass root level, field health staff from MOH Offices conducts awareness programmes and collect blood for testing, while the District STD clinic staff provides testing and treatment facilities. The success of the programme is mainly due to the intra-sectoral collaboration of many organizations within the health sector.

### Cascade analysis in EMTCT

Figure 58: Cascade graphs for elimination of mother-to-child transmission of HIV

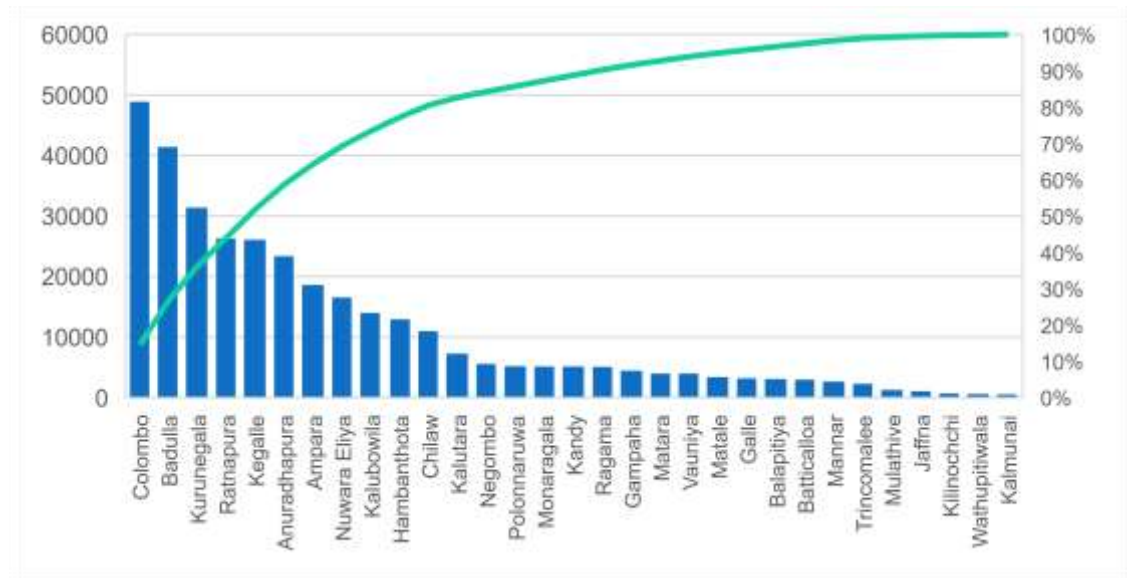


Above graph shows the cascade analysis of PMTCT services for HIV. A coverage of 88 % pregnant women were tested for HIV. Services have been given to all 16 HIV exposed infants during 2016. None of them were infected with HIV.

## Condom promotion

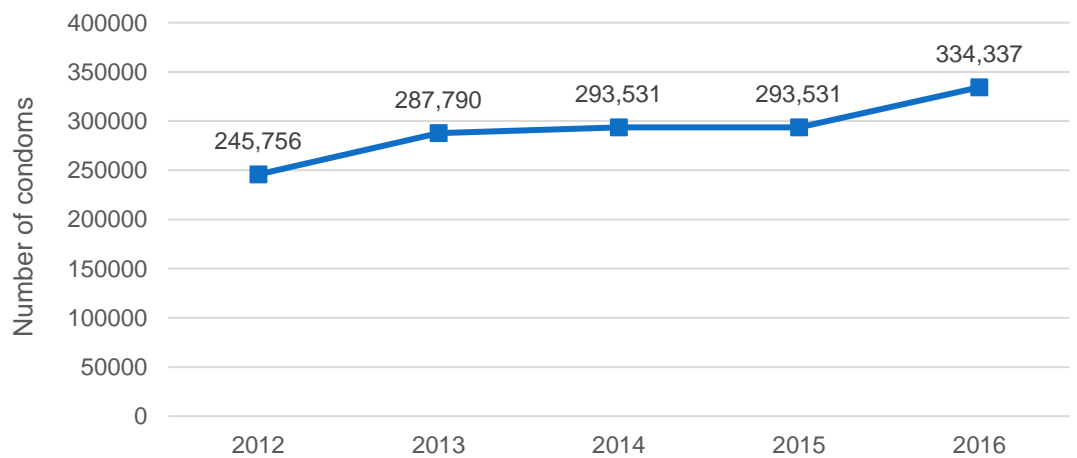
Condom promotion remains an effective method of prevention of STIs including HIV throughout the world. Use of condoms has the added advantage of protection against unnecessary pregnancies. The NSACP promotes condoms through its network of STD clinics and peer-led targeted intervention programmes among Key populations.

**Figure 59: Number of condoms distributed by STD clinics during 2016**



Above graph shows the number of condoms distributed by STD clinics during 2016. As shown in the graph about 80% of condoms have been distributed by less than 10 clinics.

**Figure 60: Number of condoms distributed by all STD clinics 2012-2016**



There is gradual increase in condom distribution as shown in the graph above. During 2016, 334,337 condoms have been distributed by STD clinics.

*During 2016, 334,337 condoms have been distributed by STD clinics among Key populations as well as among vulnerable populations.*



### Condom promotion through peer-led targeted interventions

There are many players who promote condoms in the country for different purposes. It was stated above that the objective of NSACP is to prevent STIs and HIV/AIDS. Family Health Bureau (FHB) promotes condoms as a family planning method. Private sector players promote condoms on commercial basis, nevertheless, contribute above stated both sexual and re-productive health objectives. Following table shows the number of condoms distributed to Key population under peer-led targeted interventions under Global Fund support by NGO sector.

**Table 39: Number of condoms distributed to most-at-risk populations 2013 - 2016**

Risk population	Number of condoms distributed			
	2013	2014	2015	2016
Female sex workers (FSW)	566,439	828,460	964,244	900,306
Men who have sex with men (MSM)	217,738	402,509	299,127	250,128
Beach boys (BB)	52,972	87,845	123,673	111,939
Drug users (DU)	27,411	102,142	140,400	150,330
<b>Total</b>	<b>864,560</b>	<b>1,420,956</b>	<b>1,527,444</b>	<b>1,412,703</b>

**Figure 61: Condom promotion by Family planning association on the World AIDS Day**



*NSACP provides a range of laboratory services that extends from the detection of sexually transmitted infections including HIV to evaluation and monitoring of the clinical management of these conditions.*

## Laboratory services

The laboratory services for HIV and STIs are provided by the National reference laboratory (NRL) of NSACP and the peripheral laboratories of the STD clinics. NRL provides technical guidance for diagnostic laboratory services of the country and plays the role of a reference centre.

The range of laboratory services extends from the detection of sexually transmitted infections and HIV to evaluation and monitoring of the clinical management of these conditions. In addition, biochemical and haematological tests are also provided for the HIV patients while PAP smear services are offered to eligible patients.

Introduction of new tests related to STI and HIV is always considered in the programme while improving the quality of the existing tests. All the peripheral laboratories are planned to be equipped with ELISA technique for HIV screening. This was addressed in 2016 with the distribution of 10 ELISA machines to the peripheral clinics. In reference laboratory, new testing with real time PCR technology for Chlamydia, Gonorrhoea and HSV was introduced in year 2016. In addition, to facilitate HIV management at peripheral level, two CD4 machines were provided to Kandy and Galle STD clinics while two automated real time PCR machines for viral load testing were introduced to Galle and Anuradhapura.

The workload of the laboratory system has tremendously increased since 2013. This is mainly due to the implementation of EMTCT programme throughout the country in stepwise manner. The laboratory is expected to work towards the accreditation with the intention of maintaining its standards especially for EMTCT validation procedure. Some of the existing work setups are adversely affecting the path of accreditation process.

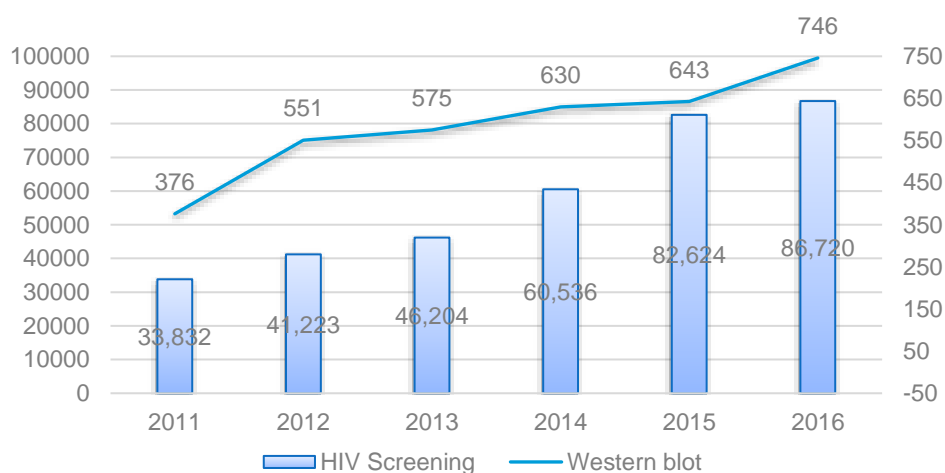
### Laboratory services of National Reference Laboratory

#### Screening, diagnosis and monitoring of HIV

Tests in use for screening of HIV (ELISA, particle agglutination and rapid strip tests) are performed on routine basis in the NRL as well as in most of the peripheral STD clinic laboratories. The confirmatory test for HIV is performed only in the reference laboratory. In order to improve the case detection and diagnosis of HIV in the country, the NRL provides HIV confirmation services to the National Blood Transfusion Service and to private sector laboratories free of charge. NRL is the only laboratory in the government sector, which performs the HIV viral load testing and CD<sub>4</sub> testing for the management of people living with HIV. In addition, the haematological and biochemical investigations are carried out for Colombo HIV clinic.

The graph below illustrates the number of CD4 and viral load tests carried out by the NRL from 2014 – 2016.

**Figure 62: HIV testing at NRL, 2011-2016**



## Screening and diagnosis of Syphilis and other STDs

The NRL provides screening and diagnostic tests for syphilis including IgM ELISA test. Most of the peripheral STD laboratories also perform screening and diagnostic tests for syphilis and the NRL supports the Colombo STD clinic and few other peripheral STD clinics with inadequate facilities. The new developments designed in 2016 include real time PCR testing for HSV, GC and Chlamydia. The facility is already installed and the testing will be available in near future.

## EMTCT of syphilis and HIV

NRL and the peripheral STD laboratories provide the continuous laboratory support for the EMTCT programme since 2013. Antenatal syphilis and HIV screening tests of all mothers attending the antenatal clinics are performed in the respective district STD laboratories.

Places where the facilities not available to perform the testing or whenever their routine system is disturbed due to lack of medical laboratory technologists or due to machine breakage, NRL do not hesitate to undertake testing services of peripheral STD laboratories as well to maintain uninterrupted EMTCT services.

The essential equipment including ELISA machines, test kits and reagents are purchased and distributed among the district STD clinics to maintain all the district STD laboratories well equipped to make the EMTCT programme success in their respective districts.

### **Outreach HIV testing**

Improving HIV testing services and follow up is the Key to manage the HIV epidemic in the country. Therefore, NRL successfully managed to introduce HIV antigen /antibody dual rapid test for the first time in Sri Lanka. With that, the NSACP could reach the most-at-risk groups with HIV testing services and the staff of the NRL gave their contribution to the entire outreach programme conducted during 2016.

### **HIV and Syphilis Surveillance and Research activities**

Other than carrying out routine diagnostic services, the NRL contributes to HIV surveillance and research activities on a regular basis and perform all HIV sentinel surveillances. In 2016, NRL and peripheral STD laboratories contributed to sentinel sero-surveillance.

### **Quality assessment**

External quality assessment (EQA) of a laboratory is an essential component in laboratory services. The NRL participates in the EQA twice every year for HIV screening and confirmatory testing conducted by the National reference laboratory for HIV, Australia to maintain the high quality of testing.

Proficiency testing for syphilis serology is under the preview of Center for Disease Control, Atlanta, USA and is performed once in every two months. The liaison for Gonococcal Anti-microbial Susceptibility Programme quality assessment is with the WHO collaborative center in Australia.

The NRL of NSACP conducts External Quality assessment programme on HIV serology, syphilis serology twice a year for all STD clinics laboratories, blood banks and some private hospitals where they are assessed periodically and a detail report is issued. The EQA for microscopy services are provided by the NRL on a monthly basis to the peripheral STD laboratories.

### **Procurement of requirements for peripheral STD clinics**

Most of the requirements of district STD clinics are supplied by the NRL. All the reagents and test kits for screening and diagnosis are supplied via the NRL after accessing the yearly consumption. The essential equipment are purchased and distributed among the district STD clinics to maintain all the district STD clinic laboratories well equipped to provide the satisfactory laboratory services.

### **Training and capacity building**

Refresher training programmes are organized annually by the NRL for training and capacity building of the laboratory staff of NRL and the peripheral STD laboratories in order to improve the quality of laboratory system. In 2016, both MLTs and PHLTs were trained in two programmes which included a sensitization on the laboratory accreditation and EMTCT validation as well. During 2016, NRL manage to conduct a training programme on HIV rapid

testing for healthcare workers of prison. Other than the training of government staff, NRL organized two workshops on HIV testing for private sector laboratory staff. Pre-service training is an activity that is carried out annually by NRL on regular basis in collaboration with the Colombo STD clinic. Various healthcare worker trainees receive training in NRL. These include medical students, MLT students, PHLT students. In addition, postgraduate medical trainees in Venereology, Microbiology, Health informatics, Family Medicine and Forensic Medicine also received training in NRL during 2016.

**Table 40: Number of microscopic tests carried out in 2016**

Name of the test	Number of tests	Name of the test	Number of tests
HIV screening	86720	SGOT	1491
Western Blot	746	SGPT	1489
HIV Viral load	1728	ALP	1390
CD4/CD8 count	2133	Serum bilirubin	774
VDRL	79187	Total protein	116
TPPA	10837	Serum albumin	91
GC culture	6936	Serum globulin	89
GC ABST	67	Direct bilirubin	519
Chlamydia PCR	0	Cholesterol	647
Cervical cytology	1013	Triglycerides	639
Full blood count	1603	HDL	624
ESR	246	LDL	603
HBSAg	706	Pregnancy test	124
Blood sugar	745	EID	23
Blood urea	1202	Indirect Bilirubin	519
Serum creatinine	1484	Drug Resistance	31

**Table 41: Number of microscopic tests carried out in 2016**

Name of the test	Central clinic laboratory	Peripheral labs	Total
Dry Smears	7,823	26,039	33,862
Wet Smears	4,190	9,767	13,957
Urine tests	2,799	3,371	6,170
EQA smears	4,977	-	4,977
<b>Total</b>	<b>19,789</b>	<b>39,177</b>	<b>58,966</b>

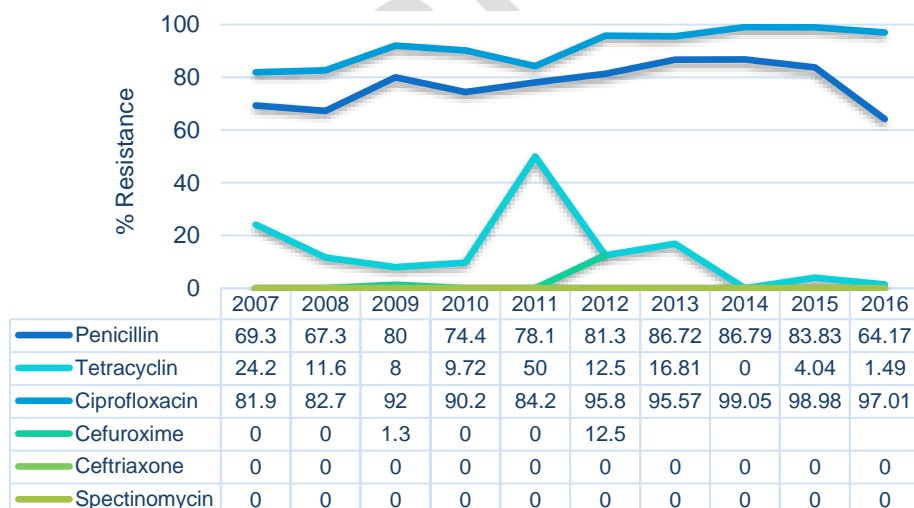
## Collaboration with funding agencies

The NRL has to play a significant role in organizing STD and HIV services to the country in collaboration with various funding agencies. The World Bank funding the purchase of test kits for EMTCT programme while Global fund financially supports the provision of HIV viral load tests. In addition, WHO supported the HIV drug resistance testing during 2016.

**Figure 63: Medical Laboratory Technologists at NRL**



**Figure 64: Gonococcal antibiotic resistance pattern 2007-2016**



## Towards the accreditation

Quality improvement and scaling up of the laboratory system towards the accreditation is the main challenge for NRL. During 2016, NRL conducted several workshops for laboratory staff to make them aware about the importance of laboratory accreditation. Several steps has already been taken in to action (preparation of SOPs etc) to make the above event a success in 2017.

***NSACP coordinates and provides technical support for advocacy, capacity building, awareness and internalization of STI and HIV prevention activities of the multi-sectoral institutions.***

## Multi-sectoral collaboration

This programme area has its focus mainly on the activities conducted aiming the vulnerable groups which has been identified in the National HIV Strategic plan 2013-2017. It oversees, coordinates and provides technical support for advocacy, capacity building, awareness and internalization of STI and HIV prevention activities of the multi-sectoral institutions.

### Capacity building at district level public health leaders

Considering the increasing trend in the Sri Lankan HIV epidemic, especially among the youth population within the age of 15-24 years, NSACP has decided to incorporate already established services of the public health system as preventive strategies to curb the future epidemic.

It is essential to develop the skills on STI/HIV among the public health staff attached to the MOH offices and other relevant public health staff at the district level. These resources can be mobilized to sensitize school children during school medical sessions or on request basis. In order to achieve the above target, 12 consultative workshops have been conducted on behaviour change communication in HIV prevention in 12 districts for public health staff. Five hundred and eighty one (581) staff members were trained during the programmes. All MOHs and district level staff were given Pen drives which contain life skills based HIV prevention lectures and the series of telefilms which will be helpful for them as resource material during sessions conducted for school children.

### Prison sector (“Light for life” HIV prevention programme)

The objective of the prison sector programme is to prevent HIV/AIDS and other sexually transmitted infections among the prison community in Sri Lanka, through life skills based education and health promotion. Island-wide prison intervention programmes were conducted during 2011 and 2015 under the theme of "Light for life", with funding support from the Global Fund (Round 9). New funding model of Global Fund supported the prison programme from year 2016 and the prison community received an intervention package which was improved under the same theme of "Light for Life". The interventions were based on a communication strategy developed for the prison sector.

There were 10,671 convicted prisoners occupying Sri Lankan prisons, by the end of year 2014. In 2014, there were 27,588 direct admissions of convicted prisoners and 90,251 remand prisoners to prisons all over Sri Lanka. On an average, 19,108 prisoners were occupying the prisons in Sri Lanka per day, whereas 10,144 of them were convicted prisoners and the remaining 8,964 were remand prisoners. Out of the admissions of convicted prisoners in 2014, 78% entered prison to serve short term sentences which was less than one year. Around 55% were first offenders, while the others have served prison

sentences before. Narcotic drug offenders consisted of 43.5% of the convicted prisoner admissions.

Interventions done for these prisoners were overseen by a steering committee consisting of members of the prison department and the National STD/AIDS control programme (NSACP). The steering committee has met three times during 2016. During year 2016 the NSACP has conducted several advocacy meetings for prison authorities.

The preventive need assessment was done among welfare officers, peer educators and prison inmates with the objectives of revising the curricula for trainers and peer leaders. Based on the findings of preventive need assessment and separate consultative meetings with prison authority, training module has been revised, printed and distributed among trainers (Rehabilitation officers). This training module was a life skill based sexual health promotion with series of case studies, group works which are developed based on the evidence. All rehabilitation officers and counselors (130) in prison setup were given three days training with the use of revised training module on sexual health promotion for prisoners.

Two day, training programmes for prison peer educators were conducted in thirty prisons by trained rehabilitation officers.

#### **Life skill based peer educator training in prison sector**

There are 30 prisons island-wide with more than 20,000 prison inmates. Commercial sex workers, drug users, men who have sex with men are admitted to these prisons for various offences. Therefore prison set up has been identified as one of the most important places where successful HIV prevention programme is necessary. In addition to training rehabilitation officers, prison set up needs more peer educators to cover all the inmates in the prisons.

In order to achieve this target, two-day life skills based peer educator training was given to the inmates of the 30 prisons situated island-wide, at which 3600 peer educators were trained during the year 2016. These trainings were given based on a meticulously developed curriculum and used the life skill based participatory approach. The peer educators were supposed to conducted both formal and informal sessions for fellow inmates, using audio-visual communication methods which are provided by NSACP. The peer educators have developed leadership qualities for prevention of HIV among the inmates. An assessment was carried out to assess the challenges among peer educators about the peer education in selected prisons during each quarter of the year concerned.

Two training programmes for young offenders at Watareka and young prisoners at Pallansena were carried out based on life skills development. Adolescent and youth factors were considered during life skill development. An interactive session was conducted at which the real life case histories were discussed with reference to promotion of sexual and



reproductive health. At the end of each programme, young offenders were given a token of appreciation as an encouragement for their improved life skills.

#### **HIV testing promotion in the prison setup**

Prison inmates volunteered for HIV testing after the formal and informal discussions carried out by Peer Educators. Testing was done according to the "HIV testing guidelines for the prison setup". This guideline was circulated among both STD and relevant prison staff previously. During 2016, thirty mobile HIV testing clinics were held every month by 22 STD clinics. The confirmed positive cases were referred for treatment and care services at the STD clinics. To assess the syphilis infectivity status among prison inmates, the same blood samples were used. Group counseling method was adopted for counseling prisoners prior to the drawing of blood for HIV testing with their consent. Negative test results were conveyed to the prisoners by the prison medical officer after conducting the post-test counseling. Positive results were conveyed by a trained medical officer of the relevant STD clinic. During 2016, a total of 12,776 prison inmates underwent voluntary HIV testing and counseling in the prisons situated island-wide. Of them, six (6) were HIV positive. The sero-positive rate among the prison inmates in 2016 was 0.05%.

Two consultative workshops on behaviour change communication were carried out for medical officers and staff members in the prison sector for promotion of safe sex & HIV testing. These workshops were useful to update their knowledge on HIV prevention and enhanced their critical thinking skills.

#### **Prison HIV Prevention, Treatment and Care Policy**

National STD/AIDS Control Programme developed the Policy on prison HIV prevention, treatment and care. after several consultative meetings with stake holders and support from the international expert. It was a need with a long term requirement. This activity was supported by the Global Fund.

The main objectives of the Prison HIV Prevention, Treatment and Care Policy are as follows:

1. Prevent HIV among all prisoners and prison staff to ensure no new HIV transmissions occur in prison settings
2. Enable prisoners to know their HIV status by promoting voluntary, confidential HIV counselling and testing and follow up
3. Provide access to treatment, care and support for HIV, Hepatitis, Tuberculosis and STI;
4. Preserve and protect the rights of people living with and affected by HIV;
5. Ensure the prison environment is conducive to promote and preserve the health of the prisoners and prison staff
6. Conduct regular assessments to ensure the policy and programmes are effective

Several guiding principles were identified for development of the strategy which reflects the following thematic areas:

- Prevent HIV among all prisoners and prison staff
- Enable prisoners to know their HIV status
- Provide access to treatment, care and support for people living with HIV
- Preserve and protect the rights of people living with and affected by HIV
- Ensure the prison environment is conducive to promote and preserve the health of the prisoners and prison staff
- Conducting regular surveillance and assessments

Under each thematic area, several strategies were developed to fulfill the objectives, to achieve better health status for the Sri Lankan prison population. Consultative workshops to review the existing prison HIV prevention curriculum were carried out.

#### **HIV prevention through entertainment in prisons**

Two hundred 'dam' boards and 100 carom boards were purchased to distribute among island wide prisons, stickers containing HIV testing promotion and stigma reduction were printed to be distributed among prisons.

#### **Armed forces - HIV prevention programmes**

Interventions for three Armed forces are identified in the National HIV Strategic plan and majority of them belong to the sexually active population.

The main objective of the Armed forces training was to promote HIV testing while promoting behavior change with the emphasis of safe sexual behaviours. Training of trainers programmes using the training module were carried out among armed forces across the country. These trainers were given three days training, and were provided with all necessary communication material to carry out programmes in their respective duty stations using formal and informal communication methods. During the year 2016, 167 armed forces personnel were trained as trainers through these programmes.

All three armed forces carried out activities to commemorate the World AIDS Day 2016. The NSACP facilitated these initiatives by providing communication material (posters, banners and leaflets).

#### **Police Sector – HIV prevention programmes**

Police officers have to deal with Key population groups. Although they have to implement the existing laws, they need to understand to avoid unnecessary harassments and protect the human rights of Key population groups. This will able to develop a conducive environment and better access for healthcare services.

Three day residential consultative work shops were conducted to train the police officers as trainers. Four such workshops were conducted by the participation of resource persons from NSACP and high ranking officers from police sector.

An advocacy programme for high rank police officers in Colombo district was conducted in which 110 police officers participated. Three consultative work shops were carried out to train police officers for prevention of HIV among sex workers and 143 officers participated.

Fifteen training programmes for police officers on HIV prevention and most at risk populations (MARPS) in 14 districts were held and there were 40 participants in each programme.

### **Media seminars**

It is a timely necessity to sensitize the media personnel on achieving 90-90-90- targets for HIV. Two media seminars were conducted and the first one was held at the Health Education Bureau to disseminate the evidence of the first ever situation assessment of condom programming in Sri Lanka in 2015. It was planned to conduct to improve the knowledge on current condom programming in Sri Lanka among the media personnel.

Further, media seminar on stripping off obstacles for HIV prevention was held on 11<sup>th</sup> November, 2016 to achieve the zero new infections by 2025. Parallel to the media seminar, communication material were also lounged.

### **Youth sector- HIV prevention programmes**

The Youth Steering Committee for HIV prevention was established under the guidance of the Secretary of Health at the National AIDS Committee in 2010. This committee recognized the need to take early action to prevent an HIV epidemic among the youth.

Training of trainers programmes based on the training module were conducted for island-wide Youth Parliamentarians, Youth Council officers and Youth Corps officers. A total of 28 Youth Parliamentarians, 130 Youth Corps trainers and 36 Youth Council officers were trained during 2016 as trainers.

Youth Parliamentarians, officers from the Youth Corps and the Youth Council were given three day training and all necessary communication material were provided to carry out programmes at the peripheral level. These trainers were instructed to implement HIV/STD programmes in their respective areas, using both formal and informal methods.

There are 35 Youth Corps centers island-wide and 12,000 youth get trained each year for career guidance under the Youth Ministry. The selected officers were trained as trainers under the Multi Sectoral unit, based on the training module. Sexual health has been incorporated into their regular training curriculum. In addition, the Multi sectoral unit facilitated special awareness programmes in all the Youth Corp centers with the support of the respective MO/STD.

All these youths were given communication materials on HIV prevention and leaflets on condoms.

### Education sector programmes

The National STD/AIDS control programme was involved in revising the curriculum of the health and physical education and was successful in including some aspects of sexual health education related to HIV and STI prevention.

The National STD/AIDS control programme has initiated school awareness programmes to educate school children on sexually transmitted diseases, HIV and life skill development for sexual health promotion through the MO/STD. Relevant communication materials were developed and distributed among the MO/STD.

### Migrant Sector Programmes

Recent review of available data of the NSACP clearly shows a steady rise in reported HIV cases among both males and females who have a history of external migration during past few years. Thus, carrying out HIV prevention activities among migrant worker population, in collaboration with Sri Lanka Foreign Employment Bureau was given priority.

An advocacy programme for high rank officers in migrant sector was done at Sri Lanka Foreign Employment Bureau. Focus group discussions for assessment of HIV prevention needs among migrant men and women were conducted. Consultative meetings on development of guides for assessment of migrant women and men on HIV prevention needs were held. A three day work shop to revise the HIV prevention curriculum for female migrant workers was done. Another two day work shop to revise the HIV prevention curriculum for male migrant workers was also carried out. Four workshops for training of trainers on HIV prevention curriculum for migrant women were held and a total of 102 trainers were trained. A two day work shop for training of trainers on HIV prevention curriculum for migrant men was held and a total of 37 trainers were trained. Printing of a training module, development of IEC material (leaflets, booklets) for migrant men and women were completed.

Three leaflets were distributed among migrant worker families through Foreign Employment Bureau, titled as follows;

- HIV/AIDS - Be Aware - Take Care
- Duties and Responsibilities as a loving husband when your loving wife is away from home for a foreign employment
- Ensure the safety of your children before leaving for the foreign employment

All these leaflets were published in all three languages. A training module to promote sexual health among female migrant workers, was developed in collaboration with Sri Lanka Foreign Employment Bureau.

### **Tourism sector programmes**

The goal of this programme is to sensitize leaders and Key influencers in professional training in the tourism sector. The integration of HIV/STI prevention education in the fast growing tourism industry is expected to minimize the exposure to HIV risk.

A sensitization advocacy work shop for tourism sector on HIV prevention was conducted for 35 participants in collaboration with Sri Lanka Institute of Tourism and Hotel Management (SLITHM) which provides training to young professionals entering tourism industry.

### **Distribution of communication and teaching material**

Communication and teaching material that consists of lectures, books, booklets, leaflets, posters and songs for different target groups were distributed in 2016.

The main objective of these are to create sensitization among relevant target groups on prevention of HIV and STD. These material were distributed to all STD clinics and MOHs island-wide.

Following booklets were distributed to Family Health Bureau, library of the Ministry of Health, Postgraduate institute of medicine, Family Planning Association, all STD clinics, prisons police sector, tri-forces, Sri Lanka Foreign Employment Bureau and to several NGOs.

Details of following booklets are described in the section on publications.

- No One Left Behind
- Comforting Condomization
- Condom education and development guideline book
- Let us Know about HIV and AIDS – Achieving Triple Zeros

**National STD/AIDS Control Programme and members of provincial health services together with other provincial stakeholders continue to improve STI and HIV services in the these two provinces.**

## Review of Northern & Eastern Provinces

The National STD/AIDS Control Programme (NSACP) have been focusing on strengthening sexual health services in Northern and Eastern provinces with strategies to create awareness and HIV/STI screening. Goals of strengthening sexual health services include improving infrastructure, developing stable user friendly sexual health services, improving coverage of services within each district and strengthening STD clinic information management systems.

Provincial Director of Health Services, Regional Director of Health Services and STD clinic staff supported NSACP on improving sexual health services in these provinces. Commitment of all stakeholders at national, provincial and district level are needed in scaling up sexual health services.

**Table 42: Performance in STD clinic services in 2016**

Name of STD clinic	Provincial Review 2016	Provincial AIDS Committee	NSACP Clinic supervision visits	Office equipment procurement	Lab. services establishment	Staff appointment	Staff Training	Building renovation
Jaffna	Green	Green	Green	Green	Green	Green	Green	Green
Kilinochchi	Green	Green	Green	Green	Yellow	Green	Green	Green
Mannar	Green	Green	Green	Green	Red	Red	Red	Yellow
Mullaitivu	Green	Green	Green	Green	Red	Green	Yellow	Green
Vavuniya	Green	Green	Green	Green	Green	Green	Green	Green
Ampara	Green	Green	Green	Green	Green	Green	Green	Green
Batticaloa	Green	Green	Green	Green	Yellow	Yellow	Green	Green
Kalmunai	Green	Green	Green	Green	Yellow	Yellow	Green	Green
Trincomalee	Green	Green	Green	Green	Green	Green	Green	Green

**Table 43: STD clinic performance in clinic activities in 2016**

Name of STD clinic	Prevention Programme	Treatment services	Outreach HIV testing	Clinic level Strategic Information	Routine reporting	Training and education by STD clinic	Participation in meetings at RDHS level	Participation in meetings at central level
Jaffna	Yellow	Green	Green	Green	Yellow	Green	Green	Green
Kilinochchi	Yellow	Green	Green	Green	Yellow	Green	Green	Green
Mannar	Yellow	Red	Green	Green	Yellow	Green	Green	Yellow
Mullaitivu	Yellow	Green	Green	Green	Red	Green	Green	Red
Vavuniya	Green	Green	Green	Green	Green	Green	Green	Green
Ampara	Green	Green	Green	Green	Green	Yellow	Green	Green
Batticaloa	Green	Green	Green	Green	Green	Green	Green	Green
Kalmunai	Green	Green	Green	Green	Yellow	Green	Green	Yellow
Trincomalee	Green	Green	Green	Green	Green	Yellow	Green	Green

 Activities smoothly running

 Activities need improvement

 Activities with challenges

In order to align with the National HIV Strategic Plan (NSP) 2013- 2017, Provincial targets were decided based on the facilities available at each district. Each STD clinic performance has been progressing well in prevention, treatment, care and support services since first Provincial review in 2015.

### **HIV testing day 2016**

HIV testing day was introduced for the first time in Sri Lanka in 2016. It was observed in Jaffna on 28<sup>th</sup> June 2016. The testing day was a great opportunity to create public awareness on HIV and HIV testing mainly through Rapid Diagnostic Tests, to train health care personal on HIV rapid testing, to provide evidence and experience that rapid testing is feasible and suitable in the community to enhance testing and most importantly with minimum reluctance and refusal of going to the STD clinic.

The media conference organized on 13<sup>th</sup> June 2016, not only created opportunity for advocating policy and planning level individuals in community level testing by participation of Provincial Health Minister and provincial and district health authorities but also provided enormous support in smooth running of testing centers throughout Jaffna district. This media conference was organized at the office of Regional Director of Health Services with the participation of approximately 100 participants from all media and district health staff from each Medical Officer of Health areas in Jaffna.

The mass media programme was conducted through local television and radio; Dan TV and Yarl FM radio. Testing day articles were published in local newspapers Udayan and Valampuri. Public awareness was made to its fullest use through all media. Since mass media public awareness campaign was extending almost two weeks from media conference to the testing day, the event captured population really targeted to be tested; testing day covered each corner; reach and unreached, met and unmet as far as HIV testing is concern. Moreover, on the testing day, the programme was conducted smoothly from 8 a.m. to 2 p.m. In order to facilitate testing coverage, eighty community testing sites had been organized in 12 MOH areas covering Jaffna district.

The programme would not have been realistic without the district health team. Eighty-six medical students, 100 Public Health Midwives, 45 Public Health Inspectors and 10 Nursing Officers were trained on performing HIV rapid testing in a two-day training programme conducted at the RDHS office Jaffna by NSACP specialist medical officer and medical officer STD clinic Jaffna. Partial financial support from the Hatton National Bank was timely to make this event a success. Total of 4774 HIV tests were done, among them only 303 tests were ELISA tests and others were HIV Rapid Tests. The two individuals who were diagnosed as HIV positive were linked with Jaffna HIV clinic for treatment and care.

Figure 65: HIV testing center



Figure 66: Media conference



Figure 65 shows HIV testing taking place at a HIV testing center established at the Jaffna Teaching Hospital. Figure 66 is from a media conference held at RDHS office, Jaffna with the participation of provincial health minister, media personal and district health team held on the HIV testing day in 2016.

In order to conduct the programmes smoothly and to achieve the goals and objectives of the national response to its maximum the NSACP, the Provincial Directorates, Regional Directorates and the District STD clinics in the North and East Provinces together have already laid out a plan for the year 2017 including a HIV testing date for 2017. According to the plan, the HIV testing day in 2017 will be held in Mullaitivu district on 27<sup>th</sup> June, 2017 due to reasons of health services challenges existing in the district. According to HIV case notification data for 2016, four (04) HIV cases have been newly reported from Mullaitivu. However, due to low population in the district, Mullaitivu ranked as the district with the highest HIV case rate in 2016 (4.2/100,000 population). The risk factors in the districts are poverty, women headed families, single women, lack of education and job opportunities, excessive substance abuse, returnee migrants and gaps in service provisions. Further there are many ex-LTTE members who are both injured and non-injured returned to civilian life. They are cornered in the society or by themselves due to several reasons. There is lack of services such as HIV testing from routine healthcare system. Therefore, it is expected that a “testing day” would facilitate the needy population to get tested at their own door step.



*The Global Fund to fight AIDS, Tuberculosis & Malaria (GFATM) has been working with the National STD/AIDS Control Programme (NSACP) closely during 2016.*

## Global Fund supported activities in 2016

The Global Fund to fight AIDS, Tuberculosis & Malaria (GFATM) has been working with the National STD/AIDS Control Programme (NSACP) closely for many years. The NSACP was offered a grant of US\$ 5,323,102 for the period of 2016 - 2018 under the New Funding Model proposal for the HIV component where the NSACP act as the Principal Recipient-1 (PR1).

The Global Fund HIV grants are utilized to achieve two (02) main objectives:

- Preventing new HIV infections in Key population and vulnerable groups.
- Ensuring high quality provision of continuum of prevention, treatment and care services to all populations in need.

The strategic areas that has been identified to achieve these goals are,

- Prevention programmes for Key populations and other vulnerable groups
- Treatment, care and support
- Health Information System and M&E
- Programme Management

A detailed activity plan was prepared for the period of 3 years (2016 - 2018). During 2016, the NSACP with the support of the other partners was able to carry out many activities according to this activity plan. Sri Lanka Family Planning Association (FPA) also received grants through the GFATM as the Principal Recipient-2 (PR2) who works synergistically with the NSACP to achieve these goals and objectives.

**Table 44: Financial Progress during the year 2016, by category**

Cost Category	Budget for Reporting Period (US\$)	Expenditure (US\$)	Variance (US\$)
Human Resources	165,701	91,711	73,990
Travel related costs	263,621	68,299	195,323
External Professional services	237,586	51,673	185,913
Health Products - Pharmaceutical Products	184,967	296,744	-111,777
Health Products - Non-Pharmaceuticals	637,975	198,112	439,863
Health Products - Equipment	354,516	102,098	252,418
Procurement and Supply-Chain Management	182,488	20,191	162,296
Infrastructure	58,421	4,664	53,757
Non-health equipment	310,314	47,537	262,777
Communication Material and Publications	73,355	23,001	50,354
Indirect and Overhead Costs	33,938	7,307	26,632
Living support to client/ target population	0	0	0
Results Based Financing	0	0	0
<b>Total</b>	<b>2,502,883</b>	<b>911,336</b>	<b>1,591,547</b>

Table 45: Financial Progress during the year 2016, by Module

Module	Budget for Reporting Period (US\$)	Expenditure (US\$)	Variance (US\$)
Prevention programmes for general population	0	0	0
Prevention programmes for MSM and TGs	191,104	32,173	158,931
Prevention programmes for sex workers and their clients	237,134	127,754	109,380
Prevention programmes for people who inject drugs and their partners	51,510	0	51,510
Prevention programmes for other vulnerable populations	253,863	82,092	171,771
Treatment, care and support	980,346	499,758	480,587
HSS - Health information systems and M&E	476,967	44,610	432,357
Programme management	311,958	124,949	187,010
<b>Total</b>	<b>2,502,883</b>	<b>911,336</b>	<b>1,591,547</b>

### Peer-led targeted interventions on prevention for Key populations

Peer-led targeted interventions which focused mainly on the preventive aspect of HIV/STD were carried out by the FPA with the technical assistance from NSACP. There were many training programmes conducted for the peer educators from all Key populations including MSMs, sex workers, drug users including the PWID and other vulnerable populations such as Beach boys throughout the year 2016 organized by the FPA in collaboration with the NSACP. The achievement ratios indicate some ups and downs in comparison to the figures during the last year. Outreach programmes conducted by the NSACP with the FPA has also contributed in reaching these Key populations at the community level.

Table 46: Coverage indicators on peer-led interventions by in 2016

Indicator Description	Target	Result Achieved	
		No.	%
Percentage of MSM reached with HIV prevention programmes with a defined package of services	4,197	3,730	89%
Percentage of sex workers reached with HIV prevention programmes with a defined package of services	6,212	4,377	70%
Percentage of PWID reached with HIV prevention programmes with a defined package of services	8,585	8,601	100%
Percentage of other vulnerable populations reached with HIV prevention programmes - defined package of services	1,850	1,278	69%

## Service provision through STD Clinics

There are 31 full time STD clinics and 23 branch clinics island wide providing services related to prevention, diagnosis, treatment and care of HIV and STD by the end of year 2016. These clinics provide services related to HIV and STD to the Key populations as well as the vulnerable and general populations. The funds obtained from the Global Fund are utilized centrally by the NSACP and also peripherally by the peripheral STD clinics. Most of the services related to diagnosis, treatment and care of HIV/STD are provided at the clinic premises while the preventive programmes are conducted as community or outreach programmes. The STD clinic staff also act with the other partners such as FPA and other NGOs in partnerships to obtain the maximum effects of the preventive programmes.

**Table 47: Performance reported through STD clinics for coverage indicators for 2016**

Indicator Description	Baseline (if applicable)			Target		Result		Achievement Ratio
	No	%	Year	No	%	No	%	
Percentage of MSM that have received an HIV test during the reporting period and know their results	1031/7551	14%	2014	4600/7551	61%	1,466/7551	19%	32%
Percentage of sex workers that have received an HIV test during the reporting period and know their results	899/14132	6%	2014	9100/14132	64%	2,095/14132	15%	23%
Percentage of PWID that have received an HIV test during the reporting period and know their results	716/17459	%	2014	1750	10%	929/17459	5%	53%
Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results (Beach boys)	486/1707	28%	2014	1720		492		29%
Percentage of other vulnerable populations (Prisoners) that have received an HIV test during the reporting period and know their results	13256/71723	18%	2014	18000/71723	25%	13373/71723	19%	74%
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	644/3340	19%	2014	1617/3900	41%	1068/4573	23%	56%
Percentage of people living with HIV that initiated ART with CD4 count of <200 cells/mm <sup>3</sup>	29/83	35%	2014	-	22%	72/308	23%	106%
Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)	40/44	91%	2013	-	92%	150/164	91%	99%

Table 48: Performance by planned interventions/major activities in 2016

Module	Intervention	Activity	Activity details- milestones/ targets	Progress Status
Prevention programmes for people who inject drugs (PWID) and their partners	Other interventions for IDUs and their partners - Please specify	Develop action plan for risk and harm reduction services for PWUD/PWID	Rapid assessment of drug use patterns in order to inform risk reduction and harm reduction interventions conducted	Advancing
			National coordination and collaboration strengthened with National Dangerous Drug Control Board.	Completed
			Action plan for tailored harm reduction interventions and service package for PWUD/PWID developed	Not Started
			Action plan for tailored interventions targeting PWUD/PWID rolled-out	Not Started
Prevention programmes for other vulnerable populations	Behavioral change as part of programmes for other vulnerable populations	Training of prison peer educators	900 peer educators trained among prisoners to provide BCC (quarterly)	Completed
Treatment, care and support	Antiretroviral Therapy (ART)	Routine quality assurance and quality control (QA/QC) of ARVs	QA/QC Plan developed and in place	Advancing
HSS - Health information systems and M&E	Routine reporting	Review meetings to establish and maintain standards for quality of data.	Routine Data Quality Assessment system rolled-out nationally	Completed
		Procurement of office equipment for electronic data systems	Preparation not done/not completed' Guidelines, checklists and tools for RDQA developed and included as annexes to the National M&E Plan	Completed
HSS - Health information systems and M&E	Surveys	Conducting studies and surveys among Key populations	Rapid Situation Assessment of Transgender Persons in Sri Lanka conducted	Completed
HSS - Policy and governance	Development and implementation of health legislation, strategies and policies	National HIV Testing Policy developed		Completed
		Prison HIV Policy developed		Completed
Program management	Policy, planning, coordination and management		A sub-committee of the Steering Committee for Prison HIV/AIDS Prevention Program established	Completed
		Joint supervision visits	30 STI clinics receive 1 supervision visit/year	Advancing

*During 2016, a total of 706 peer-educators and 161 field supervisors were engaged in peer-led targeted intervention programme in Sri Lanka.*

## Peer-led targeted interventions in 2016

The report on AIDS in Asia by AIDS Commission highlighted the importance of targeted interventions for prevention of HIV using peer-led interventions. In this approach, leaders of Key population groups are used to educate and provide other interventions to their peers. Sri Lanka launched national level programme of peer-led targeted interventions to provide sexual health services package to Key populations (members of most at risk population groups or potential drivers of HIV epidemic) in 2011. The major underlying justification for this programme was to prevent Sri Lanka moving from 'low prevalence' HIV epidemic level to 'concentrated epidemic' level. The programme was supported by Global Fund. Sri Lanka Family Planning Association and their partner NGOs played a Key role in these intervention programmes. National STD/AIDS control programme provides sexual health services to members of above population groups. Currently this programme is funded through the New Funding Model of the Global Fund programme for 2016-18.

**Table 49: Achievements of the peer-led targeted intervention programme by end 2016**

Key population	Prevention interventions								
	1. Reaching with services			2. Escorting to STD clinics			3. Distribution of condoms in 2016		
	Targets	Results Achieved		Targets	Results Achieved		Targets	Results Achieved	
		Number	%		Number	%		Number	%
FSW	6216	4372	70%	1867	1038	56%	3,276,360	900,306	28%
MSM	4197	3730	89%	1259	1085	86%	894,448	250,128	28%
BB	1850	1275	69%	740	486	66%	325,620	111,939	34%
PWUD	8584	8601	100%	NA	NA	NA	744,090	150,330	20%

Peer-educators (peer-leader) and field supervisor (outreach workers) are responsible for the delivery of the service at the community level for their peers. During 2016, a total of 706 peer-educators and 161 field supervisors were engaged in peer-led targeted intervention programme in following districts in Sri Lanka.

**Table 50: The field level staff and geographic coverage of peer-led programmes**

		Targets	Numbers in position	Districts of coverage
FSW	Peer - educators	313	249	Polonnaruwa, Anuradhapura, Colombo, Gampaha, Galle Kurunegala, Matara, Hambantota, Kandy, Ratnapura
	Field supervisors	62	52	
MSM	Peer - educators	210	175	Colombo, Gampaha, Kalutara, Kandy, Matale, Anuradhapura
	Field supervisors	42	39	
BB	Peer - educators	93	84	Hambantota, Matara, Galle, Kalutara, Colombo, Gampaha, Puttalam
	Field supervisors	18	18	
DU	Peer - educators	215	198	Colombo, Gampaha, Puttalam, Kurunegala, Kandy, Matale, Ratnapura, Galle
	Field supervisors	54	52	

**National  
STD/AIDS  
Control  
programme  
published over  
13 publications  
during 2016.  
This chapter  
briefly  
describes  
these  
publications.**

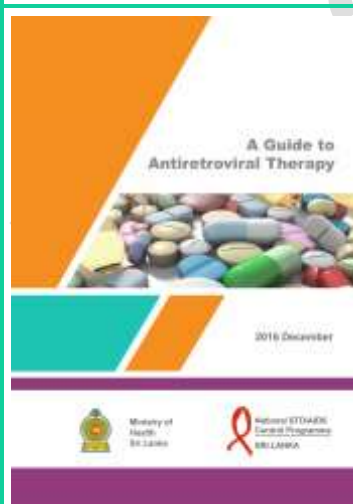
## Publications of NSACP during 2016

The NSACP being the main technical body responsible for guiding the national response to HIV and STD, has launched many publications during year 2016. These will provide guidance to all partners who have teamed up to prevent and provide diagnosis, treatment and care services for HIV and STD. All the functional units of the NSACP has contributed in writing, compiling and publishing these documents.

This chapter describes the publications of NSACP during 2016. Following are the list of publications in alphabetical order.

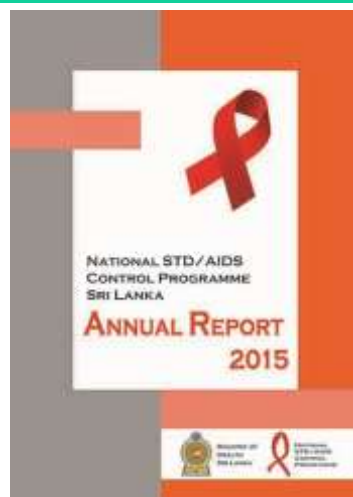
- A Guide to Antiretroviral Therapy
- Annual report 2015
- Comforting Condomization
- Condom Education and Demonstration guideline
- End AIDS by 2030
- Guidelines for management of pregnant women with HIV infection
- Guidelines on management of pregnant women with Syphilis
- National Condom Strategy Sri Lanka 2016-2020
- National HIV Testing Guideline
- No One Left Behind
- Towards Ending AIDS in Sri Lanka – A Road Map
- Training module for training of trainers in Prisons
- Training module to promote sexual health among female migrant workers

### A Guide to Antiretroviral Therapy



This book provides guidance on use of antiretroviral drugs for the prevention and treatment of HIV infection for HIV care providers. All diagnosed PLHIV in Sri Lanka are linked to care at HIV clinics and ART is available and provided free of charge from 2004. At present, HIV care services are available in all provinces of Sri Lanka under the supervision of venereologists. Eligibility criteria for ART have been changed over years and at present the country adhere to “Test and Treat” policy where everyone diagnosed with HIV are eligible for treatment irrespective of CD4 count, viral load or HIV clinical stage. This policy is implemented since 2016.

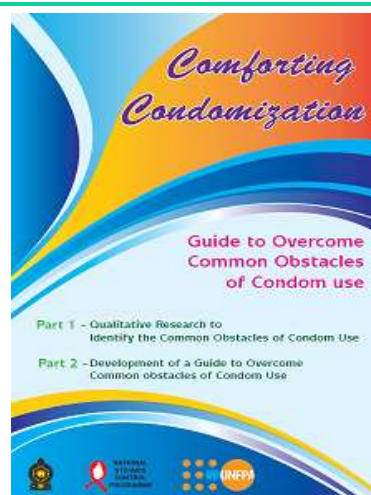
## Annual report 2015



During 2016, NSACP was able to publish previous year's annual report by 31st of March 2016. This is a significant achievement in a national programme where data and information has to collect and present and strategic information from over 30 service delivery points (STD clinics and ART centers).

Annual report 2015 highlights activities conducted by NSACP and peripheral STD clinics while giving useful insight about the HIV and STI epidemic situation of the country.

## Comforting Condomization



This is a guide to overcome common obstacles of condom use, a booklet developed after conducting a qualitative research by the National STD/AIDS Control Programme. It is available in all three languages. This booklet contains two parts;

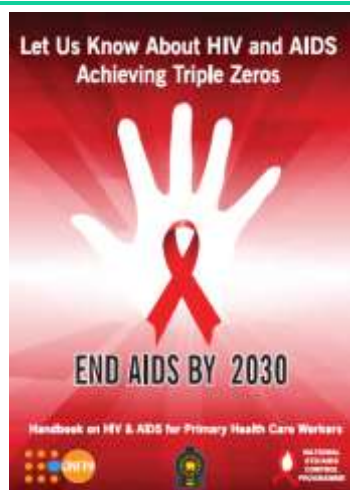
Part 1: Qualitative research to identify the common obstacles of condom use

Part 2: Development of a guide to overcome common obstacles of condom use

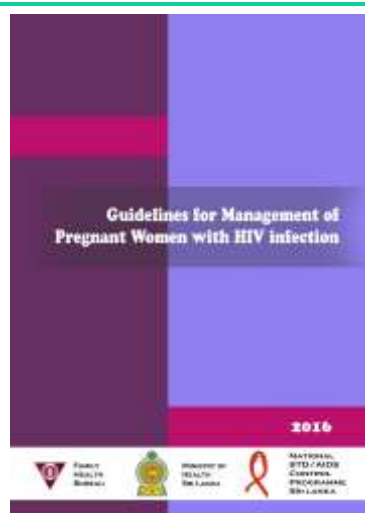
## Condom Education and Demonstration guideline



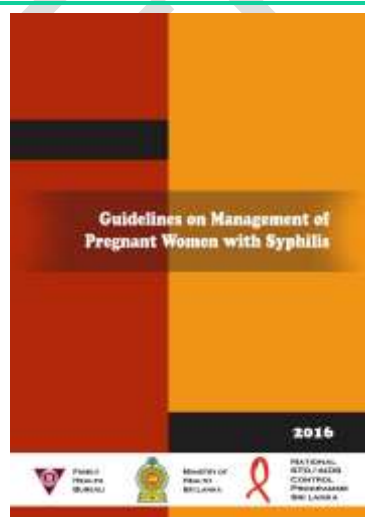
This hand book will complement the programme implementers to carry out education and demonstration of male condoms in correct way. It is expected to overcome some of the barriers in condom use by referring to this booklet. Consistent and correct condom use is the best way to prevent sexually transmitted infections including HIV and unwanted pregnancies, when engaging in sexual activity.

**End AIDS by 2030**

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. This also considered as a significant barrier to 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.

**Guidelines for management of pregnant women with HIV infection**

National STD/AIDS Control Programme (NSACP) of the Ministry of Health Sri Lanka works with a broad vision of providing quality sexual health services including HIV related services for a healthier Nation. Prevention of mother to child transmission of HIV is identified as a Key strategy in HIV care. Sri Lanka is currently working towards achieving the elimination of vertical transmission of HIV infection. This book provides valuable guidance for the healthcare workers who work towards achieving the above national goal.

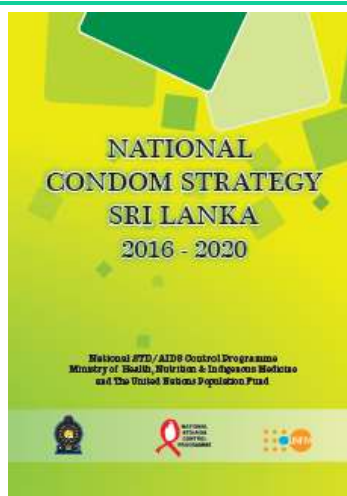
**Guidelines on management of pregnant women with Syphilis**

Screening for Syphilis among pregnant women has been in place in Sri Lanka for decades. Similar to the prevention of vertical transmission of HIV, prevention of congenital syphilis is also identified as a main strategy by the National STD/AIDS Control Programme.

This book provides clear guide to health care workers on management of pregnant mothers with syphilis and the management of the babies born to such women, which is necessary in achieving elimination of mother to child transmission of syphilis.



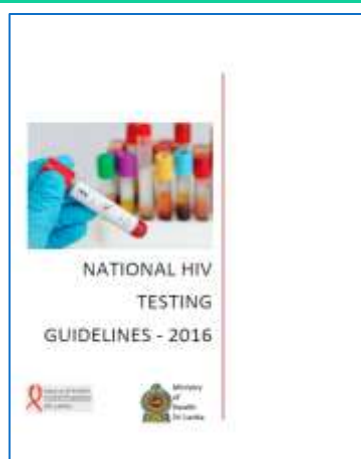
### National Condom Strategy Sri Lanka 2016-2020



Usage of condoms improve sexual health and wellbeing of people, and it is identified as a cost effective strategy for prevention of STIs.

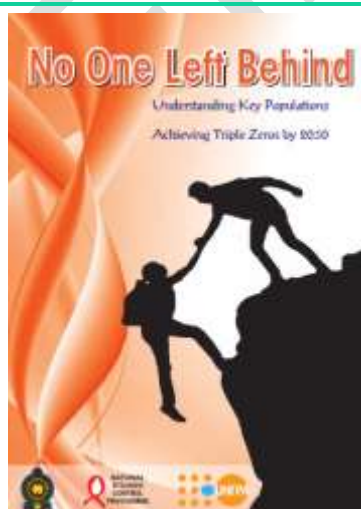
The main aim of the National Condom Strategy is to ensure the availability of quality condoms of individual choice. This may be either free of charge or at an affordable price, through an effective and responsive service delivery system. This will enhance accessibility of quality sexual health services in the country.

### National HIV Testing Guideline



The national HIV testing guidelines is a document that sets out the objectives, principles and arrangements for HIV testing in Sri Lanka. These guidelines are based on the National AIDS Policy and National HIV Strategic Plan 2013-2017. They provide guidance on HIV testing in the country. This ensure quality screening and diagnostic testing become readily accessible, with the aim of identifying HIV infection early so that risk reduction and timely initiation of treatment of infected individuals will be facilitated.

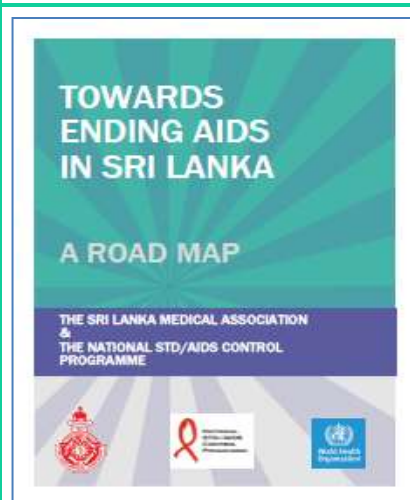
### No One Left Behind



Unless effective strategies are put in place to mitigate the HIV burden in Key populations, the global epidemic will worsen over time, preventing the world from realizing the dream of an "AIDS - free generation". Discriminatory laws and policies often contribute to, and reinforce, the sub-optimal reach of HIV services.

This book, titled "No One Left Behind-Understanding Key Populations: Achieving Triple Zeros by 2030," with new knowledge addresses Key aspects related to HIV and Key populations.

### Towards Ending AIDS in Sri Lanka – A Road Map



Although Sri Lanka has maintained a low-level HIV epidemic since 1987, the reported numbers of new infections continue to rise. Therefore, it is necessary to mount an accelerated response over the next five years to end the AIDS epidemic in Sri Lanka. The road map towards ending AIDS by 2025 consists of strategic directions to be followed to reach the expected goal declared by the UNAIDS.

### Training of trainer module for rehabilitation officers in prison department



Life skill based sexual health training module for trainers in the prison sector was developed with the help of experts of NSACP and prison department. It was revised and updated, based on the evidence gathered from preventive need assessment among prisoners, rehabilitation officers and high rank officers in the prison sector. This module describes group activities, role plays and demonstrations. This is a three-day training module is to be used by rehabilitation officers are the trainers.

### Training module to promote sexual health among female migrant workers



This training module was developed on Life skill based sexual health training module for female training instructors in the Sri Lanka Bureau of Foreign Employment (SLBFE) in year 2006. It was revised and updated, based on the evidence gathered from preventive need assessment among female migrant workers, female training instructors of SLBFE and high rank officers in the SLBFE during year 2016.

*National STD/AIDS Control Programme (NSACP) and peripheral STD clinics provide training and capacity building of healthcare workers and other staff on a regular basis.*

## Training and capacity building

National STD/AIDS Control Programme (NSACP) and peripheral STD clinics provide training and capacity building of healthcare workers and other staff on a regular basis. Undergraduate and postgraduate medical training is one of the most important activities. In recent years, the NSACP has been providing such services increasingly for other groups of stakeholders in the area of STIs and HIV.

### Pre-service training

All categories of staff appointed to STD clinics have to undergo a mandatory induction training programme. This training is conducted at central level at the time of recruiting new staff and include theoretical and practical components as relevant for different categories. Therefore, pre-service training is an activity that is conducted by the NSACP on a regular basis.

### Refresher training

Refresher training programmes are carried out annually for different categories of healthcare providers. Some of these trainings are targeted to special issues. Comprehensive care for HIV/AIDS and EMTCT are two such specific areas that are covered through ongoing training and capacity building programme of the NSACP.

**Figure 67: A training session of Public Health Laboratory Technician students**



**Figure 68: A major staff training event at NSACP**



### **Undergraduate medical training**

Similar to previous years, medical students from the University of Colombo and Kotalawala Defense University (KDU) attended the Central STD clinic for their clinical appointments. Medical students of other universities such as Sri Jayawardenapura, Kelaniya, Ruhuna and Rajarata received training from the relevant STD clinics situated these areas.

### **Training of nursing and other healthcare students**

Nursing students in different training schools are also undergo training in STIs and HIV. They receive both lectures and clinic base training. Students of other healthcare workers such as MLT, PHLT, PHM, social science, physiotherapy and Indigenous medicine received training at the Central clinic as well as other clinics with varying duration of time.

### **Postgraduate medical training**

Postgraduate Diploma and MD trainees from the Postgraduate Institute of Medicine (PGIM) in different specialties undergo training and capacity building in the field of STIs and HIV either at the Central clinic, Colombo or peripheral STD clinics. Every year a batch of medical officers are selected to follow the Postgraduate Diploma in Venereology and one batch of medical officers starts the Doctor of Medicine in Venereology training programme. The theoretical and practical parts of their training are a major activity carried out by the NSACP with the involvement of the peripheral STD clinics in the country.

The trainees who undergo training in other specialties such as dermatology, reproductive health, family medicine, microbiology, virology, forensic medicine, pediatrics, transfusion medicine, medical administration and community medicine also receive training at the NSACP and other STD clinics.

### Peer-led Targeted interventions related capacity building

The NSACP has provided necessary technical support for these training activities as an ongoing basis to NGO partners. Scaling up of intervention programmes targeting most-at risk population (MARPs) groups (female sex workers, men who have sex with men, drug users, beach boys and prisoners) began in 2011. Capacity building such as training of trainers (TOT) and peer-educator training are two important components of these training programmes.

**Table 51: Training and capacity building carried out by the Central clinic, Colombo**

Category of trainees	Number of programme	Number Trained
Major staff in prevention, PMTCT, treatment & care	26	1040
Other Training		
• MO/STD	2	13
• PHLT	2	17
• MLT	2	12
• PHI	2	4
• NOs &PHNS	2	7
• Pharmacist & Intern pharmacist	2	17
• Minor staff	2	16
• Nursing officers	1	50
• Other MOs(NPTCCD)	2	30
Postgraduate Trainees		
• Post-MD Venereology trainees (SRs)	1	4
• Pre-MD Venereology trainees	2	13
• Diploma venereology trainees	2	15
• DFM Trainees		78
• MD Dermatology trainees	1	6
• MD Virology trainees	1	1
• MD Microbiology trainees	1	14
• MD Transfusion medicine	1	4
• MD forensic medicine	1	2
Medical Students		
• University of Colombo	9	136
• Kotalawala Defense University	2	46
Nursing Students	5	200
PHM students	2	120
Students of MSc in Social Science	1	100
Physiotherapy Students	1	30
MLT Trainee students	1	200
Sri Lanka Technical Campus student	1	200
Peer Educator Training		
• FSW	6	240
• MSM	4	100
Total	85	2715

*Information, Education and Communication on STI and HIV is important to raise awareness as well as to achieve desired behavior change among general public as well as the Key populations.*

## IEC and Advocacy programmes

Communication on STI and HIV is important to raise awareness as well as to achieve behavior change among public including the Key populations. These activities are implemented by NSACP and district STD clinics. Some of them are part of planned programmes and others on request from different organizations.

Many modes are used to reach different groups in the community including lectures, discussions, exhibitions, media conferences and newspaper supplements.

Newspaper supplements were published to mark world AIDS day 2016 in Sinhalese, Tamil and English in 'Dinamina', 'Thinakaran' and 'Daily News' respectively to increase the coverage. The capacity building and training activities carried out by NSACP are not included in the above table and they are given in a different chapter.

**Table 52: Awareness activities carried out by NSACP in 2016**

Type of activity & target group	Number of programmes	Number of attendees
School children	2	1200
Factory workers	1	150
Public-Exhibitions	12	149,450
Public-Lectures	3	650
Media conferences	2	200
others	106	4855
Newspaper supplements	3	NA
<b>Total</b>	<b>129</b>	<b>156,505</b>

**Table 53: IEC activities work completed by district STD clinics in 2016**

Type of Participants of Participants	Number of Programmes	Number of attendees
Female Sex Workers	108	1,818
MSM	33	731
Drug Users	39	1,497
Prisoners	140	11,616
Youth (out of school)	232	21,472
School Children	296	66,778
General Public/Mixed Group	603	73,419
Other	697	78,930
<b>Total</b>	<b>2,148</b>	<b>256,261</b>

The NSACP with district STD clinics have provided awareness on STD/HIV/AIDS to over 400,000 persons in the country during 2016.

### Communication Strategy

A national communication strategy on control and prevention of STI/HIV/AIDS is being drafted currently. A steering committee within the IEC, Advocacy and Condom promotion sub-committee of NAC is leading this process. Under this activity following activities were carried out during 2016.

- desk reviews on available research of media usage in Sri Lanka,
- in-depth interviews with selected high level stakeholders and
- focused group discussions on communication of preventive and clinical services
- initiation of drafting the communication strategy

It is expected to finalize the national communication strategy on control and prevention of STI/HIV/AIDS during first half of 2017.

Figure 69: Condom promotion IEC material developed by NSACP

The figure displays several IEC materials developed by NSACP for condom promotion. On the left, there is a list of STD/AIDS clinics across various districts in Sri Lanka, including Colombo, Galle, Kandy, and others, with their respective phone numbers. In the center, there is a poster with the slogan 'ආදරය - සතුට' (Love - Happiness) and 'ආරක්ෂාව - පරිස්සම්' (Safety - Protection), featuring images of condoms and the text 'නොපැනවී මගින් ද්විත්ව ආරක්ෂාවක්' (Dual protection through condoms). On the right, there is another poster with the slogan 'Love & Happiness' and 'Safety - Protection', also featuring images of condoms and the text 'Dual protection through condoms'. The bottom right corner of the figure shows the logo of the National STD/AIDS Control Programme.

*“World AIDS Day is an opportunity for people worldwide to unite to acquire knowledge, good behaviours and promote positive attitudes towards People Living with HIV (PLHIV)”*

## World AIDS Day 2016

Each year the World AIDS Day (WAD) is commemorated on the 1st of December to remember those who were passed away due to /AIDS as well as to re-invigorate determination and dedication for the battle against HIV/AIDS. The theme for this year is ‘Hands up for HIV prevention’.

The National STD/AIDS Control Programme in collaboration with its partner organizations conducted an elaborated programme throughout the country to mark the WAD 2016.

### National level activities

#### World AIDS Day Walk

**Figure 70: Starting point of the world AIDS Day walk in 2016**



The walk was started from the Ministry of Health and ended at the Campbell Park, Colombo with the support of more than 2500 participants. Higher officials and staff of the Ministry of Health, WHO, UNFPA, government and nongovernmental partner organizations, members of the armed forces and the police participated in this walk on the 1st December, 2016. Celebrities from many fields also participated, adding colour to the walk. Students and the staff of the Ananda Vidyalaya and C. W. W. Kannagara Vidyalaya also supported this activity by gathering along the roadside while the walk was passing by their schools. There were numerous banners and placards containing health messages related to HIV/AIDS was displayed throughout the walk and leaflets in all three languages were distributed among the general public by the participants.

At the Campbell Park, the national programme for the WAD 2016 took place providing different stakeholder groups an opportunity to share their views and plans with regard to the



treatment, care, control and prevention of HIV/AIDS in Sri Lanka. During this programme the documents titled 'Road map to ending AIDS in Sri Lanka', 'HIV testing guidelines', 'Guidelines on managing pregnant mothers with Syphilis' and 'Guidelines on EMTCT of HIV' were presented to the DGHS.

In addition, there was an exhibition area with IEC material on STD/HIV and a HIV rapid testing site for the general public organized by the NSACP. A stall for condom demonstration and distribution was organized by the Family Planning Association and the Population Service Lanka at the Campbell Park.

### **Cycle parades**

Three cycle parades were initiated from Kaduwela, Panadura and Ja-Ela joined the national WAD walk at the Campbell Park. These cycle parades were organized by three NGOs i.e. "Mithuru Mithuro", "Saviya" and "Community Strength Development Foundation" respectively. Participants of these parades created general public by distribution of leaflets on their way to Campbell Park .

### **Community based HIV rapid testing**

HIV rapid testing was carried out at 11 sites in parallel to the WAD activities and a total of 1415 people were tested. These sites included Fort railway station, Colombo Harbor area, Mattakkuliya, Slave Island, Meethotamulla, Mt Lavinia, Nugegoda, Kaduwela, Kiribathgoda, Maharagama and Campbell Park.

### **Raising public awareness through mass and social media**

- **Media Conference**

A media conference was conducted on the 22nd November, 2016 with the participation of about 100 members of electronic and print media. It was addressed by DDG (PHS) and consultants from NSACP.

- **Newspaper supplement**

Full page newspaper supplements were published on 'World AIDS Day 2016' in the Daily news, Dinamina and Thinakaran newspapers.

- **Facebook page**

A Facebook page titled 'World AIDS Day Sri Lankan Context' was created and being maintained by the NSACP and currently 2021 people has followed this page.

- **Banners and leaflets**

Nearly 1400 banners containing health messages related to HIV/AIDS in all three languages were displayed all over the country during this period. Around 425,000 leaflets were printed HIV/AIDS in Sinhalese, Tamil and English and distributed them throughout the country.

- **Digital display**

Six health messages in all 3 languages were displayed on digital screens placed at Lipton Circus, Town hall and Thurston Road, Thummulla for a period of one month starting from 28th November, 2016.

Figure 71: Participation of youth at the world AIDS Day walk in 2016



Figure 72: Colourful events from the world AIDS Day walk in 2016



Figure 73: Launching of Books at the world AIDS Day in 2016



Above figures show the launch of several publications at the ceremony held at the end of the walk at Campbell park at Borella. These publications were guidelines on elimination of mother to child transmission of HIV, guidelines on elimination of mother to child transmission of syphilis, HIV testing guidelines and Road map to ending AIDS in Sri Lanka. Dr Palitha Maheepala (DGHS), Dr Sisira Liyanage (Director/NSACP) and Dr Iyanthi Abeyewickreme (SLMA President) are in these photos.

Figure 74: Section of audience at the world AIDS Day event in 2016



The World AIDS Day national programmes in 2016 were contributed by the Ministry of Health, WHO, UNFPA, Hatton National Bank Pvt Ltd, AIDS Foundation of Sri Lanka, Population Service Lanka and Sri Lanka Red Cross. National STD/AIDS control programme would like to acknowledge the support given by all these organizations.

### WAD 2016 activities conducted by district level STD clinics

All peripheral STD clinics conducted activities to mark the WAD 2016 in their locality. The summary of the activities are as below.

**Table 54: Summary of WAD activities conducted by peripheral STD clinics**

No	Clinic	Summary of the activity
1	Ampara	Awareness programme for students of the Hardy Advanced Technological Institute on HIV/AIDS and prevention
2	Anuradhapura	18 Street shows on HIV prevention messages at 18 different locations
3	Badulla	AIDS day street walk and awareness programme for school children on HIV/AIDS
4	Balapitiya	Street drama for general public and distribution of leaflets and stickers related to HIV/AIDS
5	Batticalao	Street walk followed by a public awareness programme, HIV screening and condom distribution
6	Chilaw	Awareness programme for a mixed group of participants
7	Gampaha	Awareness programme for hospital staff members and public on HIV/AIDS
8	Hambantota	A street walk and drama with health messages related to HIV/AIDS at 7 different locations of the area
9	Jaffna	Street drama for general public with health messages related to HIV/AIDS
10	Kalmunai	A street walk and the a meeting with the participation of political leaders, RDHS and STD clinic staff
11	Kalubowila	Street drama for general public with health messages related to HIV/AIDS
12	Kalutara	8 small group discussion on HIV/AIDS and distribution of a Key tag with health messages following the discussion
13	Kandy	A debate and an art competition among school children in the District of Kandy
14	Kegalle	Awareness programme for the health staff and distribution of diaries with health messages among the attendees.
15	Kilinochchi	Awareness programme on HIV/AIDS for army soldiers
16	Kurunegala	Distribution of stickers with messages on HIV/AIDS prevention for display in three-wheels and public transport vehicles, walk in the Municipal area of Kurunegala, awareness and screening programme for three-wheel drivers and in an area with drug users, Awareness program for doctors and ward in-charge nurses in provincial and general hospitals and all MOH in the district to streamline the PMTCT program in the district

17	Galle	Awareness programme for school children on HIV/AIDS
18	Mannar	Awareness programme on HIV/AIDS for a mixed group of persons
19	Matale	Awareness programme for school children
20	Matara	Awareness programme for health care workers and public on HIV/AIDS
21	Monaragala	Street drama and awareness programme for general public with health messages related to HIV/AIDS
22	Mullaitivu	Five HIV/AIDS awareness and screening programmes for different population groups
23	Negombo	Awareness programme for health care workers on HIV/AIDS and three wheeler parade displaying educational material for the general public.
24	Nuwara Eliya	A street walk with the public awareness
25	Polonnaruwa	Awareness programme on HIV/AIDS for different population groups
26	Ragama	Street drama with health messages related to HIV/AIDS
27	Ratnapura	Awareness programme for general public including a quiz related to HIV/AIDS and awarding prizes for the winners at 3 different locations with HIV testing booth at each site
28	Trincomalee	A street walk
29	Vavuniya	An awareness rally around Vavuniya town and public awareness programme with the help of three wheeler drivers and provision of stickers on HIV/AIDS prevention messages to be pasted on public transportation vehicles.
30	Wathupitiwala	Art competition for children under the theme of HIV/AIDS

Figure 75: World AIDS Day walk 2016



## Demolition of old NSACP building

NSACP old building situated opposite the main NSACP building at no.29, De Saram Place, Colombo 10 had been the main NSACP building until 1998-99. This was well known as “Room 33” both among clinic attendees and among healthcare workers. This building had been declared opened by Hon. Minister E.L. Senanayake in 1967.

After building a new building complex for NSACP, this old building used to house GFATM HIV project office, Strategic Information Management unit, Multi-sectoral unit and financial unit. Also this building comprised of a good auditorium.

During 2016, Ministry of Health decided to demolish this old NSACP building to give space to a new outpatient department complex for the National Hospital of Sri Lanka. This created lots of chaos and heartbreaks among staff of NSACP.

Ministry of health provided space in a new building complex to house NSACP units. This new site is situated about 1 km from the main NSACP building. Although new building is provides more space compared to the old building, lack of ready access to main building is affecting day to day work of NSACP staff.

As a way forward, NSACP has prepared a project proposal to build a new 3 story building complex on the front compound of the main NSACP building. This proposal has been accepted by the ministry of health and has sent to the Parliament for allocation of funds.

**Figure 76: Old building of NSACP demolished in 2016**



*During 2016, Ministry of Health decided to demolish the old NSACP building to give space to a new outpatient department complex for the National Hospital of Sri Lanka. This created lots of chaos and heartbreaks among staff of NSACP.*

*New location of the units housed in the building is situated at No. 464, TB Jaya Mawatha, Colombo 10.*

Figure 77: Packing and transporting furniture and other material to the new site



Figure 78: New building and its location map at No. 464, TB Jaya Mw., Colombo 10



## Retirement of NSACP staff in 2016

Retirement of Mr W.M. Chandraratne, Mrs M.S. Sumithra and Mrs Anoma Wimalaratne took place in 2016. All of them have served the NSACP for many years. NSACP wishes all the best of luck for them for their retirement age and highly acknowledge their contributions made to NSACP.

**Figure 79: Mr W.M. Chandrarathe's farewell ceremony On 17.10.2016**



**Figure 80: Mrs M.A. Sumithra's farewell ceremony on 29.8.2016**





Figure 81: Mrs. Anoma Wimalaratne's farewell ceremony on 16/6/2016



Figure 82: Ms. G.M. Chandrawathie's farewell ceremony on 18/12/2016



## Obituary notice

Figure 83: Dr Gowri Manohari Nanthakumar



Dr Gowri Manohari Nanthakumar (18. 10. 1967 - 11.10.2016), Medical Officer in-charge of STD Clinic, District General Hospital, Vavuniya, died under tragic circumstances while travelling from Vavuniya to Colombo for an official meeting at NSACP. This sudden demise of Dr. Gowri has caused deep sorrow among her colleagues in the NSACP.

She was a dedicated medical officer who served the community and the STD/AIDS Control Programme to the fullest of her ability even up to the last moment of her life. NSACP is at a great loss and the space she left cannot be filled. May her soul rest in peace.

Figure 84: Daily Mirror news article on the incident



## News from the peripheral STD clinics

Peripheral STD clinic have been requested to send few photos and a brief description of few salient events conducted during 2016.

Following STD clinics have responded to this request (in alphabetical order),

- Anuradhapura
- Badulla
- Hambantota
- Kalubowila
- Kandy
- Negombo
- Ragama
- Ratnapura

### STD clinic, Anuradhapura

Figure 85: Hands up for HIV prevention in Anuradhapura



Anuradhapura STD clinic in collaboration with the RDHS office of Anuradhapura organized a colourful event on the World AIDS day 2016 using cosplayers and DJ music. The theme of the event was "Hands up for HIV prevention".

## STD clinic, Badulla

Figure 86: Events from Badulla STD clinic



Formulation of the Uva Provincial AIDS Committee was an important event during 2016. The first meeting was held on 7th September 2016 at the PDHS auditorium under the leadership of the Provincial Director of Health services and Director/NSACP. A subsequent meeting held on 17th November 2016 with the participation of a core group members representing the PDHS, both RDHS and the STD clinics to develop a activity plan for the year 2017.

A main highlight of the year was the Street Walk and street dramas conducted in the town of Welimada on 5th December 2016 in commemoration of the World AIDS Day 2016. This event was supported of many stakeholders in the government and private sector.

The medical officers and the Public Health Inspectors of Badulla STD clinic conducted 148 awareness programmes covering 15,374 individuals representing diverse groups such as ANC mothers, estate workers, prisoners, youth and school children and the police.

## STD clinic, Hambantota

World AIDS Day activities at Hambantota included a street walk with the participation of health care workers, school children and the police on 1st of December 2016. A street drama was performed by students of Nursing Training School of Hambantota at the public bus stand and in front of the OPD of district general hospital of Hambantota on the same day. In addition, many awareness programmes were conducted in the district for the general public during that week.

Figure 87: World AIDS day events organized by STD clinic Hambantota.



### STD clinic, Kalubowila

Figure 88: World AIDS Day events organised by STD clinic, Kalubowila



Above photos shows a street drama organised by Kalubowila clinic staff to commemorate the World AIDS Day in 2016. In addition, an exhibition conducted for the general public, programmes conducted for prison inmates, awareness programmes conducted for medical officers at the teaching hospital, Kalubowila and awareness programmes conducted for other health care workers at Teaching Hospital, Kalubowila are shown in the pictures given below.

Figure 89: Training and HIV testing programmes conducted by STD clinic, Kalubowila



### STD clinic, Kandy

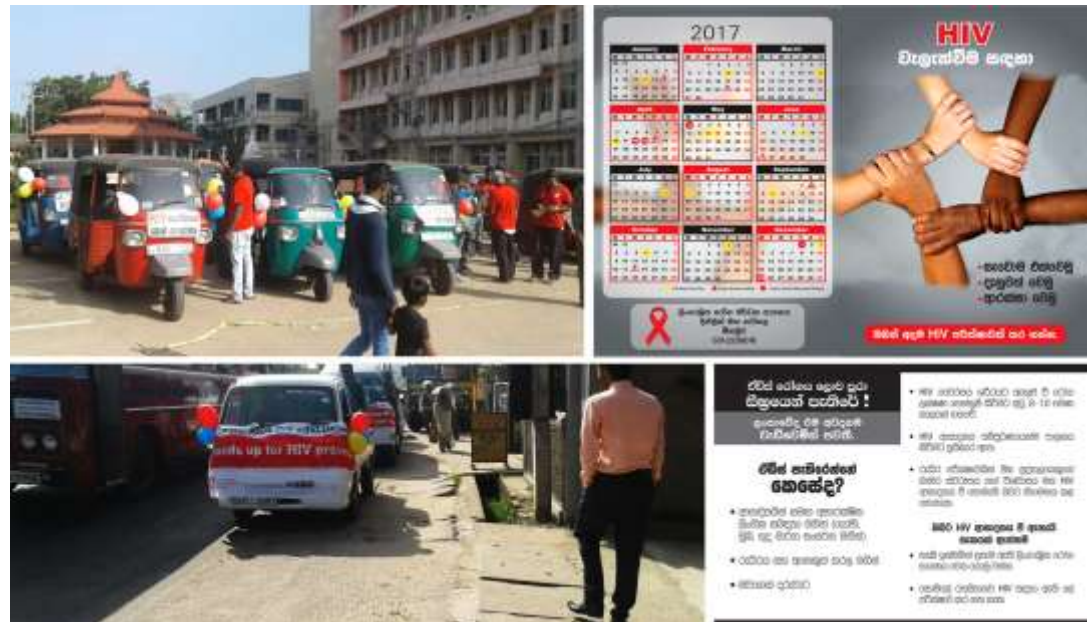
Figure 90: World AIDS day campaign organized by STD clinic, Kandy



STD clinic, Kandy had organised a colourful procession to mark the World AIDS Day 2016. Beautiful Kandyan dancers graced this event which raised awareness of general public on the issues related to HIV/AIDS.

### STD clinic, Negombo

Figure 91: World AIDS Day campaign and IEC material of STD clinic, Negombo



To commemorate the World AIDS Day 2016, STD clinic Negombo organized a three wheel parade covering Negombo town center, hotels and beach side displaying and distributing HIV/AIDS messages on 07<sup>th</sup> December 2016. During this parade, useful HIV/AIDS messages were given to public through loud speakers.

### STD clinic, Ragama

Figure 92: Creating public awareness by the staff of STD clinic, Ragama



STD clinic Ragama is well known to provide HIV and STD related services to Men who have sex with men (MSM) in the area. Clinic staff have identified number of MSM hot spots in and around Ragama hospital. Distribution of posters is a regular event in these identified hot spots by the STD clinic staff. High risk people are actively encouraged to get tested for HIV and STIs via social marketing of the STD services.

### STD clinic, Ratnapura

Figure 93: Awareness and HIV testing events organised by STD clinic, Ratnapura



Staff of Ratnapura STD clinic conducted variety of HIV prevention activities for the community during 2016. These include activities conducted for high risk groups such as sex workers and drug users. In addition, activities were conducted for vulnerable groups such as estate workers, youths, school children, three wheel drivers and gem businessmen in the district. To commemorate the World AIDS day 2016, the clinic conducted awareness programmes in bus stands of Ratnapura, Embilipitya and Balangoda giving opportunities to volunteers to participate in quiz programme on HIV/AIDS. During these activities, screening for HIV was offered and carried out using rapid tests.



## Financial summary - 2016

Table 55: Summary of financial details for 2016

Financial Sources	Description	Fund Allocation (LKR)	Fund Utilization (LKR)
<b>1. Capital Expenditure</b>			
Ministry of Health	Building construction	5,312,973.00	2,832,915.03
	World AIDS Day	8,111,750.00	7,045,000.00
	Prevention of mother and child transmission of HIV addressing high risk groups	30,200,000.00	29,619,458.36
	Service training programmes	57,400.00	57,400.00
	DDG (PH)1	10,000,000.00	9,456,397.81
	Purchase office equipment	761,508.00	622,139.04
	Purchase of laboratory equipment & ELISA Kits	21,888,250.00	22,843,889.00
	Purchase of AC Machines	782,868.00	782,867.79
	<b>Total</b>	<b>77,114,749.00</b>	<b>73,260,067.03</b>
UNFPA	Consultative workshops, advocacy programmes, printing of publication	3,146,179	3,146,179.27
WHO	Consultative workshops, review meetings. training module	3,000,000	1,140,560.82
UNICEF	Prevention of mother to child transmission	625,000	625,000.00
GFATM	Human Resources (HR)	22,038,247.60	12,197,551.18
	Travel related costs (TRC)	35,061,619.17	9,083,713.01
	External Professional services (EPS)	31,598,992.81	6,872,542.78
	Health Products - Pharmaceutical Products (HPPP)	24,600,646.91	39,466,954.79
	Health Products - Non-Pharmaceuticals (HPNP)	84,850,646.64	26,348,831.42
	Health Products - Equipment (HPE)	47,150,601.79	135,790,213.38
	Procurement and Supply-Chain Management costs (PSM)	24,270,845.01	2,685,426.94
	Infrastructure (INF)	7,770,000.00	620,324.66
	Non-health equipment (NHE)	41,271,720.00	6,322,407.73
	Communication Material and Publications (CMP)	9,756,250.00	3,059,102.64
	Indirect and Overhead Costs	4,513,816.67	971,786.02
	<b>Sub Total</b>	<b>332,883,386.60</b>	<b>121,207,662.56</b>
<b>Total Capital Expenditure</b>		<b>409,998,135.60</b>	<b>194,467,729.59</b>
<b>2. Recurrent Expenditure</b>			
Ministry of Health	Personal emoluments (salaries etc.)	110,233,298	109,483,094.08
	Travelling expenses Stationary and office requisites	299,000	305,729.83
	Fuel & supplies	2,152,000	1,885,329.16
	Waste management and other	48,000	41,074.10
	Maintenance expenditure (vehicles etc.)	3,600,000	4,085,428.02
	Electricity and water	6,500,000	6,328,058.30
	Security, cleaning service and other	5,965,000	6,275,446.17
	Loan interest/transfers	1,055,465	1,031,041.46
	<b>Total Recurrent Expenditure</b>	<b>129,852,763</b>	<b>129,435,201.12</b>
<b>Grand Total (LKR)</b>		<b>539,850,898.60</b>	<b>323,902,930.71</b>

(\* LKR to USD conversation rate taken as LKR 133 = 1 USD for GF funds)

Figure 94: Budget allocation for NSACP during 2016

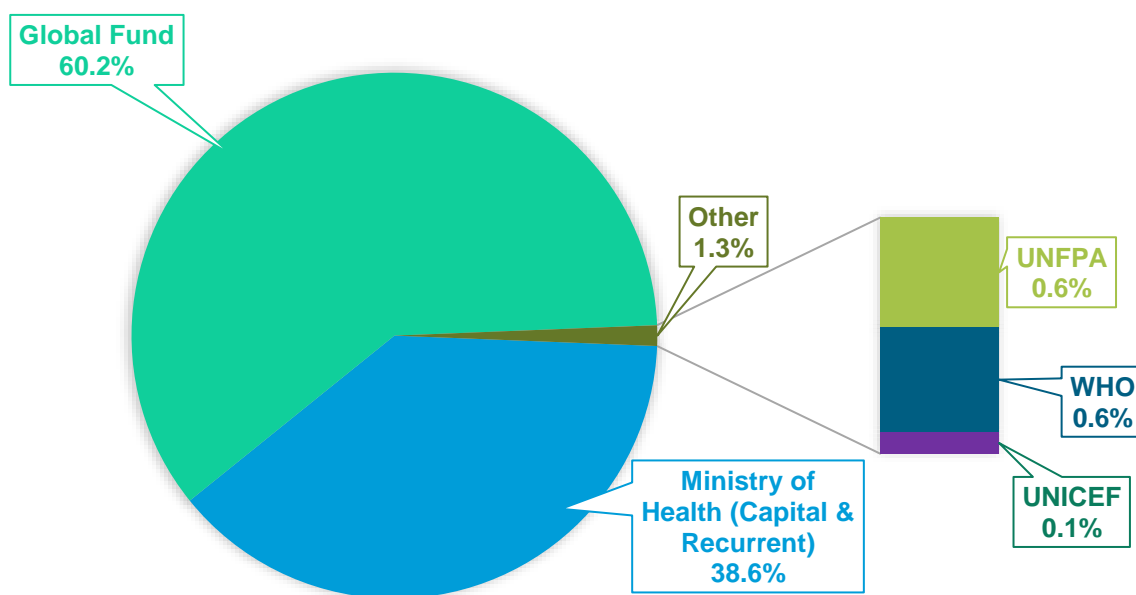
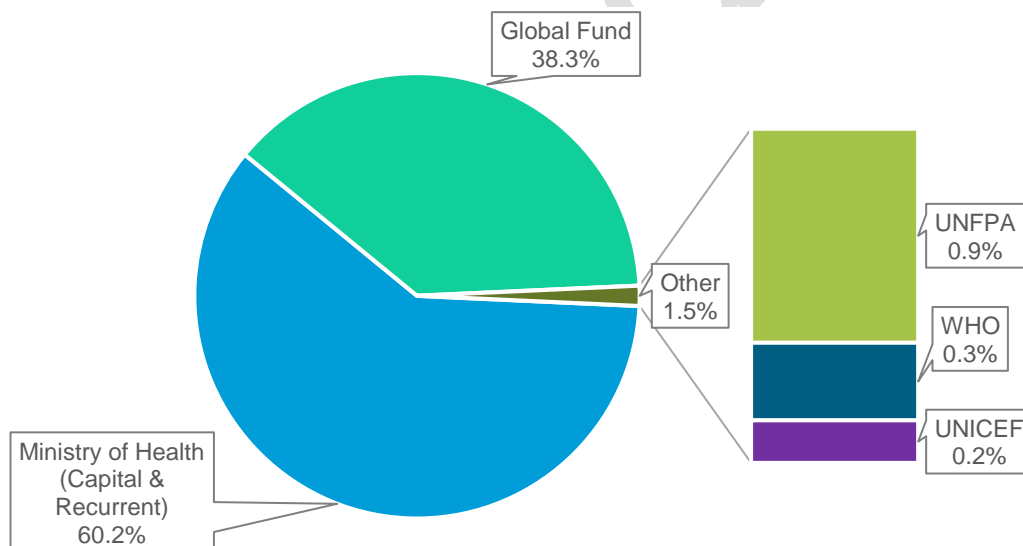


Figure 95: Expenditure of the allocated amount by NSACP during 2016



Figures 94 and 95 shows allocation of funds and utilization of funds for NSACP during 2016. Utilization of fund allocated by Global fund is low as some of the major projects such as conducting IBBS, population size estimations and development of an electronic information management system (EIMS) for NSACP got postponed to next year. Government of Sri Lanka (GOSL) has been funding 100% of all recurrent expenses over the years.

## Contact information of STD clinics- 2016

<b>1</b>	<b>Ampara District</b>
	<b>1. STD clinic – Ampara</b>
Address	STD clinic, General Hospital, Ampara
Email:	<a href="mailto:stdclinic.ampara@gmail.com">stdclinic.ampara@gmail.com</a>
Telephone	063-2224239
Fax	063-2222988
Contact person	Dr (Ms.) Sakunthala de Soyza (Medical officer in charge)
	<b>2. STD clinic – Kalmunai</b>
Address	STD clinic, Ashrooff Memorial Hospital, Kalmunai.
Email:	<a href="mailto:stdclinic.kalmunai@gmail.com">stdclinic.kalmunai@gmail.com</a>
Telephone	067-2223660
Fax	067-2223660
Contact person	Dr A.R.M Haris (Medical officer in charge)
<b>2</b>	<b>Anuradhapura District</b>
	<b>3. STD clinic – Anuradhapura</b>
Address	STD clinic, Teaching Hospital, Anuradhapura
Email:	<a href="mailto:stdclinic.anuradhapura@gmail.com">stdclinic.anuradhapura@gmail.com</a>
Telephone	025-2236461
Fax	025-2222261
Contact persons	Dr Ajith Karawita (Venereologist), Dr H. B. L. P. Dharmasiri (Medical officer in charge)
<b>3</b>	<b>Badulla District</b>
	<b>4. STD clinic – Badulla</b>
Address	STD clinic, Room No 73, Provincial General Hospital, Badulla.
Email:	<a href="mailto:stdclinic.badulla@gmail.com">stdclinic.badulla@gmail.com</a>
Telephone	055-2222578
Fax	055-2222578
Contact persons	Dr (Ms.) Lasanthi Siriwardana (Venereologist) Dr R.D. Sugathadasa (Medical officer in charge)
<b>4</b>	<b>Batticaloa District</b>
	<b>5. STD clinic – Batticaloa</b>
Address	STD Clinic, Teaching Hospital, Batticaloa.
Email:	<a href="mailto:stdclinic.batticaloa@gmail.com">stdclinic.batticaloa@gmail.com</a>
Telephone	065-2222261
Fax	065-2224401
Contact persons	Dr C.D. Dodampegama (Acting Venereologist) Dr S. Anusha (Medical officer in charge)

<b>5 Colombo District</b>	
<b>6. STD clinic – Colombo</b>	
Address	National STD/AIDS Control Programme, 29, De Saram Place, Colombo 10
Email	stdclinic.colombo@gmail.com
Telephone	011-2667163
Hot lines	011-2695420 (Female), 011-2-695430(Male)
Fax	011-5336873
Contact persons	Dr S. Liyanage (Director)
	Dr L.I. Rajapakse (Venereologist)
	Dr K.A.M. Ariyaratne (Venereologist)
	Dr G. Weerasinghe (Venereologist)
	Dr S. Benaragama (Epidemiologist)
	Dr J.P. Elwitigala (Microbiologist)
	Dr J. Vidanapathirana (Community Physician)
	Dr S. Herath (Community Physician)
<b>7. STD clinic – Kalubowila</b>	
Address	STD Clinic, Room 43, Sunandarama Rd, Kalubowila.
Email:	stdclinic.kalubowila@gmail.com
Telephone	011-4891055
Contact person	Dr Nalaka Abeygunasekara (Venereologist)
<b>6 Galle District</b>	
<b>8. STD clinic – Balapitiya</b>	
Address	STD Clinic, Base Hospital, Balapitiya.
Email:	stdclinic.balapitiya@gmail.com
Telephone	091-2256822
Contact person	Dr M.W. Prasad de Silva (Medical officer in charge)
<b>9. STD clinic – Galle</b>	
Address	STD clinic, Teaching Hospital, Mahamodara, Galle
Email:	stdclinic.mahamodara@gmail.com
Telephone	091-2245998
Fax	091-2232088
Contact person	Dr Darshani Wijewickrema (Venereologist)
<b>7 Gampaha District</b>	
<b>10. STD clinic – Gampaha</b>	
Address	STD Clinic, District General Hospital, Gampaha
Email:	stdclinic.gampaha@gmail.com
Telephone	033-2234383
Fax	033-2222179
Contact person	Dr S. B. S. Gamage (Medical officer in charge))
<b>11. STD clinic – Negombo</b>	
Address	STD clinic, District General Hospital, Negombo
Email:	stdclinic.negombo@gmail.com
Telephone	031-2239016
Contact persons	Dr( Ms.) Nimali Jayasooriya (Venereologist)
	Dr Lionel Halahakoon (Medical officer in charge)

<b>12. STD clinic – Ragama</b>	
Address	STD clinic, Room 70, Teaching Hospital, Ragama
Email:	<a href="mailto:stdclinic.ragama@gmail.com">stdclinic.ragama@gmail.com</a>
Telephone	011-2960224
Fax	011-2960224, 0112959266
Contact persons	Dr R.G.J.D. Ranatunga (Venereologist) Dr Anjana Rajapaksha (Medical officer in charge)
<b>13. STD clinic – Wathupitiwala</b>	
Address	STD Clinic, Base Hospital, Wathupitiwala
Telephone	033-2280261
Fax	033-2280927
Contact person	Dr (Ms.) P.G.N. Dhanuska (Medical officer in charge)
<b>8</b>	<b>Hambantota District</b>
<b>14. STD clinic – Hambantota</b>	
Address	STD clinic, General Hospital, Hambantota
Email:	<a href="mailto:stdclinic.hambantota@gmail.com">stdclinic.hambantota@gmail.com</a>
Telephone	047-2222247
Fax	047-2222409
Contact persons	Dr (Ms.) Shama Somawardana (Venereologist) Dr Nalin Chaminda Geeganage (Medical officer in charge)
<b>9</b>	<b>Jaffna District</b>
<b>15. STD clinic – Jaffna</b>	
Address	STD Clinic, Teaching Hospital, Jaffna
Email:	<a href="mailto:stdclinic.jaffna@gmail.com">stdclinic.jaffna@gmail.com</a>
Telephone	021-2217756
Fax	021-2222262
Contact persons	Dr (Ms.) Dilmini Mendis (Acting Venereologist) Dr Tharaneer Guruparan (Medical officer in charge)
<b>10</b>	<b>Kalutara District</b>
<b>16. STD clinic – Kalutara</b>	
Address	STD Clinic, General Hospital, Nagoda, Kalutara
Email:	<a href="mailto:stdclinic.kalutara@gmail.com">stdclinic.kalutara@gmail.com</a>
Telephone	034-2236937
Fax	034-2236937
Contact persons	Dr (Ms.) E.G.R. Samaraweera (Acting Venereologist) Dr S.A.P Nishanthi (Medical officer in charge)
<b>11</b>	<b>Kandy District</b>
<b>17. STD clinic – Kandy</b>	
Address	STD clinic, P.O. Box 207, Kandy
Email:	<a href="mailto:stdclinic.kandy@gmail.com">stdclinic.kandy@gmail.com</a>
Telephone	081-2203622
Fax	081-2203923
Contact Persons	Dr Ganga Pathirana (Venereologist) Dr S.R.K.T. Gamage (Medical officer in charge)

<b>12</b>	<b>Kegalle District</b>
	<b>18. STD clinic – Kegalle</b>
Address	STD clinic, District General Hospital, Kegalle
Email:	<a href="mailto:stdclinic.kegalle@gmail.com">stdclinic.kegalle@gmail.com</a>
Telephone	035-2231222
Fax	035-2231222
Contact persons	Dr (Ms.) Manjula Rajapaksha ( Venereologist)
	Dr Nilantha Darmawardana (Acting Medical officer in charge)
<b>13</b>	<b>Kurunegala District</b>
	<b>19. STD clinic – Kurunegala</b>
Address	STD Clinic, Hospital, premises Kurunegala
Email:	<a href="mailto:stdclinic.kurunegala@gmail.com">stdclinic.kurunegala@gmail.com</a>
Telephone	037-2224339
Fax	037-2224339
Contact persons	Dr (Ms.) Chandrika Jayakody (Venereologist)
	Dr Nihal Edirisinghe (Medical officer in charge)
<b>14</b>	<b>Kilinochchi District</b>
	<b>20. STD clinic – Kilinochchi</b>
Address	STD Clinic, Base Hospital, Kilinochchi
Telephone	021-2283709
Contact person	Dr (Ms.) G.D.K.N. Karunaratna (Medical Officer)
<b>15</b>	<b>Mannar District</b>
	<b>21. STD clinic – Mannar</b>
Address	STD clinic, District General, Hospital Mannar
Email:	<a href="mailto:stdclinic.mannar@gmail.com">stdclinic.mannar@gmail.com</a>
Fax	023-2250573, 023-2250748
Contact person	Dr(Ms.) Rajani Anton Sisil (Medical officer in charge)
<b>16</b>	<b>Matale District</b>
	<b>22. STD clinic – Matale</b>
Address	STD clinic, District General Hospital, Matale
Email:	<a href="mailto:stdclinic.matale@gmail.com">stdclinic.matale@gmail.com</a>
Telephone	066-2053746
Contact persons	Dr Jagath Ranawaka ( Acting Venereologist)
	Dr (Ms) H.M.K. Wijerathna (Medical officer in charge)
<b>18</b>	<b>Monaragala District</b>
	<b>24. STD clinic – Monaragala</b>
Address	STD clinic, District General Hospital, Monaragala
Email:	<a href="mailto:stdclinic.monaragala@gmail.com">stdclinic.monaragala@gmail.com</a>
Telephone	055-2276261, 055-2276826
Fax	055-2276700
Contact person	Dr Pradeep Kumara (Medical officer in charge)
<b>19</b>	<b>Mullaitivu District</b>
	<b>25. STD clinic – Mullaitivu</b>
Address	STD clinic, General Hospital, Mullaitivu
Email:	<a href="mailto:Stdidscontrolprogramme.mtv@gmail.com">Stdidscontrolprogramme.mtv@gmail.com</a>
Telephone	021-2061414
Contact person	Dr.A.Dayalan (Medical officer in charge)

<b>20</b>	<b>Nuwara Eliya District</b> <b>26. STD clinic – Nuwara Eliya</b>
Address	STD clinic, General Hospital, Nuwara Eliya
Email:	<a href="mailto:stdclinic.nuwaraeliya@gmail.com">stdclinic.nuwaraeliya@gmail.com</a>
Telephone	052-2223210, 0522222261
Fax	052-2223476
Contact person	Dr Tissa Seneviratne (Medical officer in charge)
<b>21</b>	<b>Polonnaruwa District</b> <b>27. STD clinic – Polonnaruwa</b>
Address	STD clinic, General Hospital, Polonnaruwa
Email:	<a href="mailto:stclinic.polonnaruwa@gmail.com">stclinic.polonnaruwa@gmail.com</a>
Telephone	027-2225787
Fax	027-2225787
Contact Person:	Dr Indra Peris (Medical officer in charge)
<b>22</b>	<b>Puttalam District</b> <b>28. STD clinic – Chilaw</b>
Address	STD clinic, General Hospital, Chilaw
Email:	<a href="mailto:stdclinic.chilaw@gmail.com">stdclinic.chilaw@gmail.com</a>
Telephone	032-2220750
Fax	032-2220750
Contact person	Dr N. R. Amarajeewa (Medical officer in charge)
<b>23</b>	<b>Ratnapura District</b> <b>29. STD clinic – Ratnapura</b>
Address	STD clinic, Provincial General Hospital premises, Ratnapura
Email:	<a href="mailto:stdclinic.ratnapura@gmail.com">stdclinic.ratnapura@gmail.com</a>
Telephone	045-2226561
Fax	045-2226561
Contact persons	Dr Darshani Mallikarachchi (Venereologist), Dr K. Upasena (Medical officer in charge)
<b>24</b>	<b>Trincomalee District</b> <b>30. STD clinic – Trincomalee</b>
Address	STD clinic, General Hospital, Trincomalee
Email:	<a href="mailto:stdclinic.trincomalee@gmail.com">stdclinic.trincomalee@gmail.com</a>
Telephone	026-2222563 (Hospital 026-2222261)
Fax	026-2222563
Contact person	Dr V. Srigawriesvaran (Medical officer in charge)
<b>25</b>	<b>Vavuniya District</b> <b>31. STD clinic – Vavuniya</b>
Address	STD clinic, General Hospital, Vavuniya
Email:	<a href="mailto:stdclinic.vavuniya@gmail.com">stdclinic.vavuniya@gmail.com</a>
Telephone	024-2224575
Fax	024-2224575, 024-2222892
Contact person	Dr K. Chandrakumar (Medical officer in charge)