National STD/AIDS Control Programme Sri Lanka

Annual Report 2017

Ministry of Health Sri Lanka

National STD/AIDS Control Programme

National STD/AIDS Control Programme

ANNUAL REPORT 2017

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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.

The country launched the Road Map to end AIDS by 2025 on World AIDS Day 2016 and as the first step of ending AIDS the country needs to reach targets 90-90-90 by 2020. The main challenge lies in the first 90 in 90-90-90 as the country needs to identify >90% of estimated 3500 PLHIV in the community. While strengthening the STI and HIV services including antiretroviral treatment (ART) services, in the year 2017 more emphasis was placed on scaling up of HIV testing services. Introduction of new methods of testing such as community based and community led testing have made testing more accessible to population.

As the EMTCT of HIV and syphilis programme shows satisfactory results, NSACP intensified activities aiming at reaching validation targets by end of 2018. The process to apply for validation of EMTCT of syphilis and HIV programme was initiated in mid-2017. The much needed National communication strategy was developed and officially launched on the World AIDS Day 2017. This will help to address the main issue of increasing awareness on STI and HIV as well as social marketing of services making STD and HIV services more accessible to the community.

Prevention services have been strengthened including condom promotion and targeted interventions for key populations with the support of many stakeholders including NGOs and funding agencies mainly GFATM. Attempt has been made to reach vulnerable populations through prisons, tourist sector, migrants and youth. Provincial AIDS committees were established to obtain the support of several stakeholders in the provinces. Appointment of Venereologists to 22 STD clinics facilitated to improve STI and HIV prevention and care services including ART services in the provinces. The process for accreditation of National Reference Laboratory of NSACP has been initiated and this facilitated to improve the quality of laboratory services of NRL as well as peripheral STD clinic laboratories.

Surveillance services were further strengthened in the year with IBBS survey and Strategic Information Management unit supported development of several guidelines on M&E and improving data quality through several activities. Continued pre-service and in service training programmes for health care workers and undergraduate and postgraduate training on STI and HIV helped to expand services further. The equitable service provision was assured through regular monitoring of STI and HIV services in the North and East as well.

This volume of NSACP annual report summarizes the activities conducted by the NSACP during 2017 and presents 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. We humbly note that this document has been identified as one of the best annual reports on STI and HIV by world renowned experts.

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 team of the SIM unit led by Dr K.A.M. Ariyaratne, National coordinator for Strategic Information Management on STI and HIV 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.

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2nd of June 2018

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ABBREVIATIONS

ABC	abacavir
ABST	antibiotic susceptibility test
AEM	AIDS Epidemic Model
AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal clinic
ART	antiretroviral treatment
ARV	antiretroviral drugs
AZT	zidovudine
BB	Beach boys
BCC	Behaviour Change Communication
BH	Base Hospital
CD_4	Cluster of differentiation
CDC	Center for Disease Control
CIN	cervical intraepithelial neoplasia
CMV	Cytomegalovirus
CSHW	Castle Street Hospital for Women
DDG - PHS	Deputy Director General - Public Health Services
DFM	Diploma in Family Medicine
DGH	District General Hospital
DGHS	Director General of Health Services
DMH	De Soysa Maternity Hospital for Women
DQA	data quality assessment
DRV	darunavir
DTM	Diploma in Transfusion Medicine
DU	Drug user
ECS	early congenital syphilis
EFV	efavirenz
EIA	enzyme immunoassay
EID	early infant diagnosis
EIMS	Electronic Information Management System
ELISA	enzyme linked immunosorbent assay
EMTCT	elimination of mother to child transmission
EQA	external quality assessment
ETU	emergency treatment unit
FPA	Sri Lanka Family Planning Association
FSW	Female sex worker
FTC	emtricitabine
GFATM	Global Fund to fight AIDS, TB and Malaria
GH	General Hospital
GoSL	Government of Sri Lanka
HBsAg	Hepatitis B Surface Antigen
HCW	Health care worker
HDL	high density lipoprotein
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV	herpes simplex virus
HSS	health system strengthening
HTC	HIV testing and counselling

- HTS HIV testing services
- HCG human chorionic gonadotropin
- IBBS integrated biological and behavioural surveillance
- ICU intensive care unit
- ICTA information and communication technology agency
- IDU Injecting drug user
- IDV indinavir
- IEC information, education and communication
- KP Key population
- LFU lost to follow up
- LPV lopinavir
- LPV/r lopinavir and ritonavir
- LDL low density lipoprotein
- LoI letter of intent
- MAC mycobacterium avium complex
- MARP most at risk populations
- MCH maternal and child health
- MD Doctor of Medicine
- MDG Millennium Development Goals
- MLT Medical Laboratory Technologist
- MO Medical Officer
- MOH Ministry of Health
- MOIC Medical Officer in charge
- MS Medical student
- MSM Men who have sex with men
- MTCT mother to child transmission
- M&E monitoring and evaluation
- NAC National AIDS Committee
- NBTS National Blood Transfusion Service
- NDDCB National Dangerous Drug Control Board
- NCPA National Child Protection Authority
- NFM New funding model
- NGO nongovernmental organization
- NGU non-gonococcal urethritis
- NIID National Institute of Infectious Diseases *(IDH)*
- NNRTI non-nucleoside reverse transcriptase inhibitor
- NRL National Reference Laboratory
- NRTI nucleoside reverse transcriptase inhibitor
- NSACP National STD/AIDS Control Programme
- NS Nursing student
- NSP National strategic plan
- NVP nevirapine
- OI opportunistic infections
- OPD Outpatient Department
- PA particle agglutination
- PCR polymerase chain reaction
- PCU Primary Care Unit
- PDHS Provincial Director of Health Services
- PE peer educators
- PEP post exposure prophylaxis
- PEPFAR US President's Emergency Plan for AIDS Relief

- PGC presumptive gonococcal infection
- PHI Public Health Inspector
- PHLT Public Health Laboratory Technician
- PHNS Public Health Nursing Sister
- PLHIV People living with human immunodeficiency virus
- PMTCT prevention of mother to child transmission
- PI protease inhibitor
- PICT provider initiated counselling and testing
- PSE population size estimation
- PWID people who inject drugs
- RAL raltegravir
- RDHS Regional Director of Health Services
- SGOT serum glutamic oxaloacetic transaminase
- SGPT serum glutamic pyruvic transaminase
- SOP standard operational procedures
- SRH sexual and reproductive health
- STD sexually transmitted diseases
- STI sexually transmitted infections
- TA technical assistance
- TB tuberculosis
- TDF tenofovir
- TG transgender
- TOT Training of trainers
- TPPA Treponema pallidum particle agglutination assay
- TTI Transfusion transmissible infections
- UNAIDS Joint united nations programme on HIV/AIDS
- UNICEF United nations international children emergency fund
- UNFPA United Nations Population Fund
- USAID United States Agency for International Development
- VCT Voluntary Counselling and Testing
- VDRL venereal disease research laboratory test
- VOG Visiting Obstetrician and Gynecologist
- WAD World AIDS day
- WHO World Health Organization
- 3TC lamivudine

1 INTRODUCTION TO NSACP

The National STD/AIDS Control Programme (NSACP) of the Ministry of Health, is the main government organization responsible for planning and implementation of the national response to HIV/AIDS in Sri Lanka in collaboration with all stakeholders. NSACP is one of the special disease control programmes coming under the Deputy Director General (Public Health Services) of the Ministry of Health. NSACP involves in coordinating, planning and implementation of the HIV National Strategic Plan and the AIDS Policy of the country. The headquarters of the NSACP is situated at 29, De Saram Place, Colombo 10, Sri Lanka. As of end 2017, there are 33 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. The only non-NSACP ART facility is located in the National Institute of Infectious Diseases, Angoda. NSACP networks with all these clinics to deliver a coordinated national response against HIV and STIs.

Our Vision

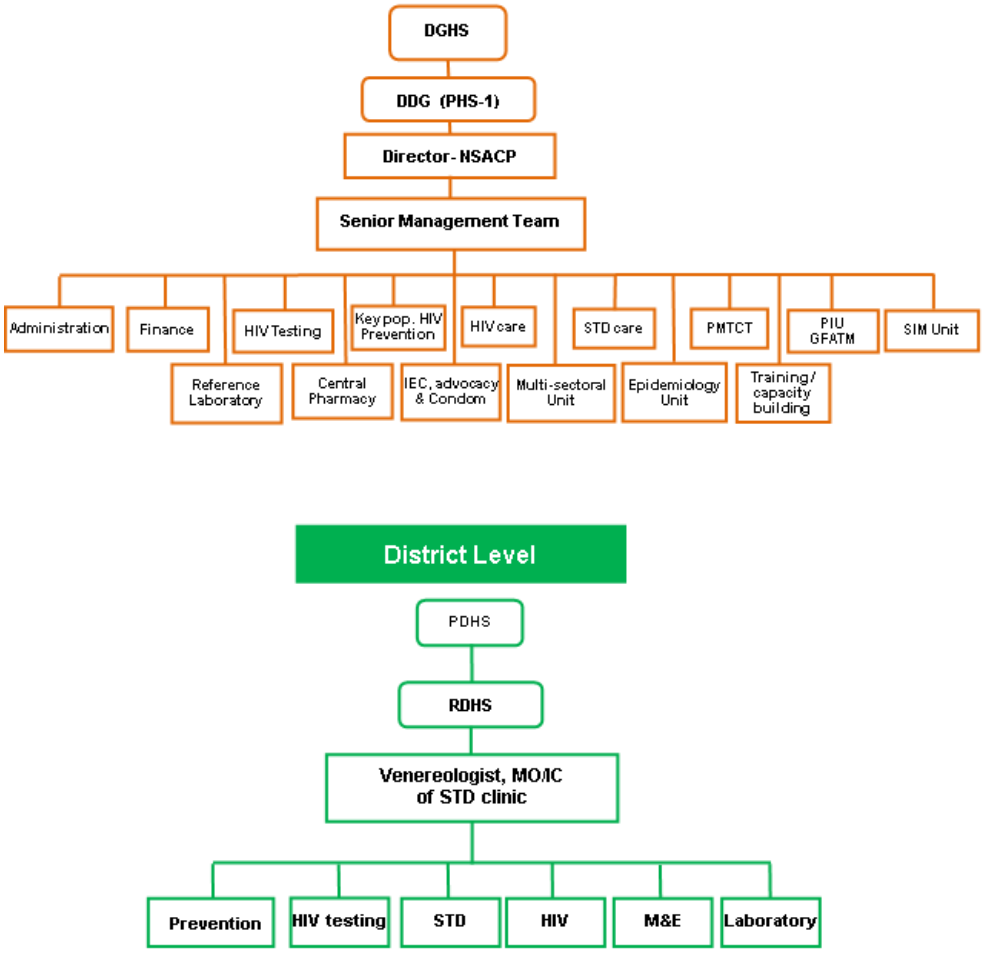
Quality sexual health services for a healthier nation.

Our Mission

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

Figure 1: Some of the events of NSACP during 2017

Figure 2: **Organogram of the National STD/AIDS Control Programme, Sri Lanka**

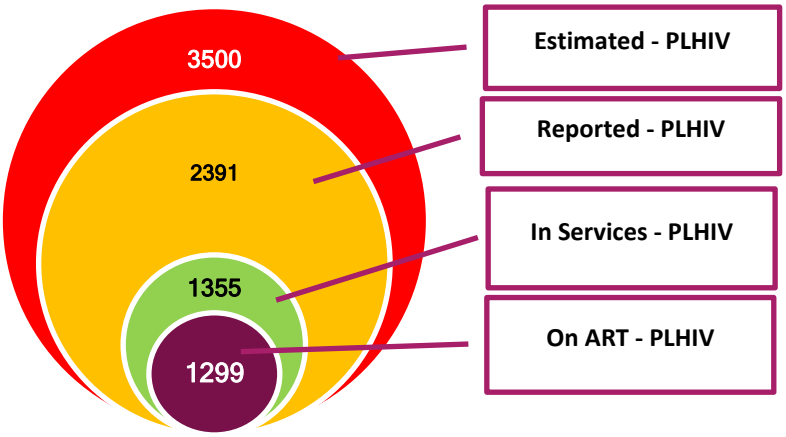


Abbreviations:
DGHS- *Director General of Health Service,* ***DDG (PHS-1)***- *Deputy Director General (Public Health Services-1),* ***PMTCT***- *Prevention of mother to child transmission,* ***GFATM***- *Global Fund to fight AIDS, tuberculosis and malaria,* ***PDHS***- *Provincial Director of Health Services,* ***RDHS***- *Regional Director of Health Services,* ***M&E***- *monitoring and evaluation ,* ***PIU***- *Project Implementation Unit*

2 SITUATION OF HIV EPIDEMIC

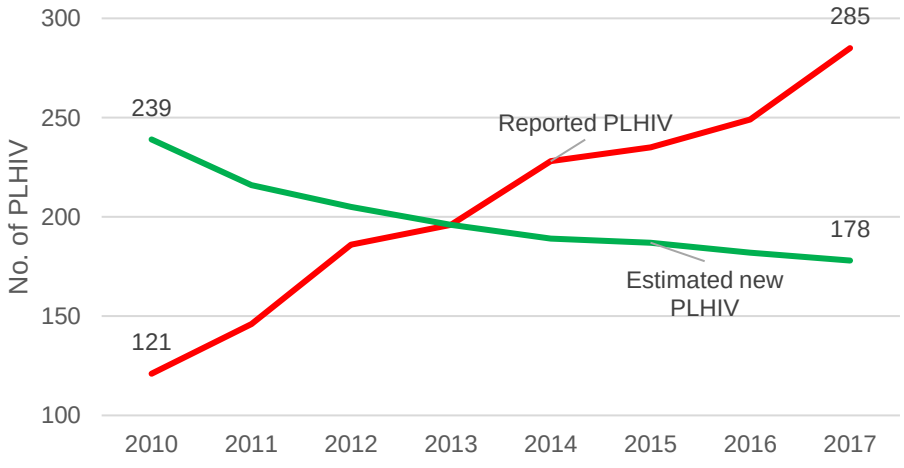
The estimated number of people living with HIV (PLHIV) as of end 2017 is 3500 (3000-4200). This is a slight reduction from the 2016 estimation figure of 4000. Total PLHIV diagnosed and alive are 2391. This figure was calculated by subtracting the total number of reported AIDS deaths (451) from the cumulative number of people reported with HIV (2842) up to end of 2017. However, it should be noted that these are cumulative figures since 1987 and there can be deaths that are not reported as AIDS deaths. Out of the total 1355 PLHIV who are currently linked with HIV treatment and care services, 1299 have been started on antiretroviral treatment (ART) as given in the figure below.

Figure 3: Summary of the status of PLHIV as of end 2017



The figure below shows the trends of newly diagnosed PLHIV and estimated new PLHIV for the period of 2010-2017. Even though newly diagnosed PLHIV seems to be increasing almost exponentially, estimated number of new PLHIV (incident HIV cases) is reducing during this period.

Figure 4: Trends of reported and estimated new PLHIV, 2010-2017



Below figure may explain these paradoxical trends. It indicates about 25% of newly diagnosed PLHIV are in very late stage with less than 200 CD4 count. Also 45-50% of PLHIV are in late stage cases with CD4 count less than 350 (AIDS stage). Therefore, it is reasonable to assume that around 50% of all newly diagnosed cases in a given year has been infected several years ago.

Figure 5: **CD4 counts of PLHIV newly enrolled in HIV care, 2015-2017**

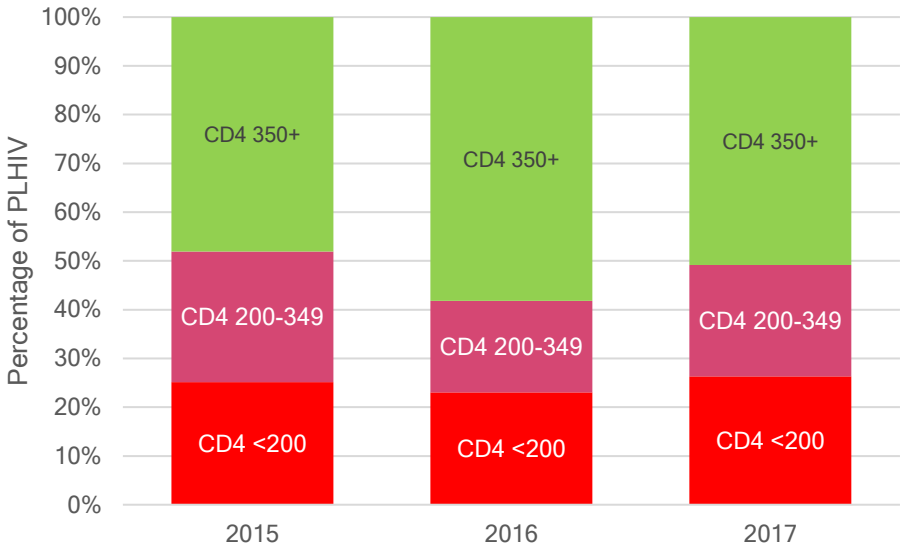
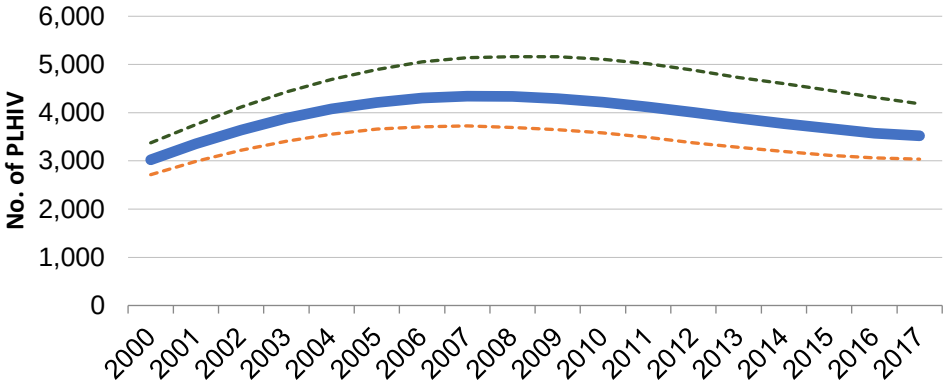


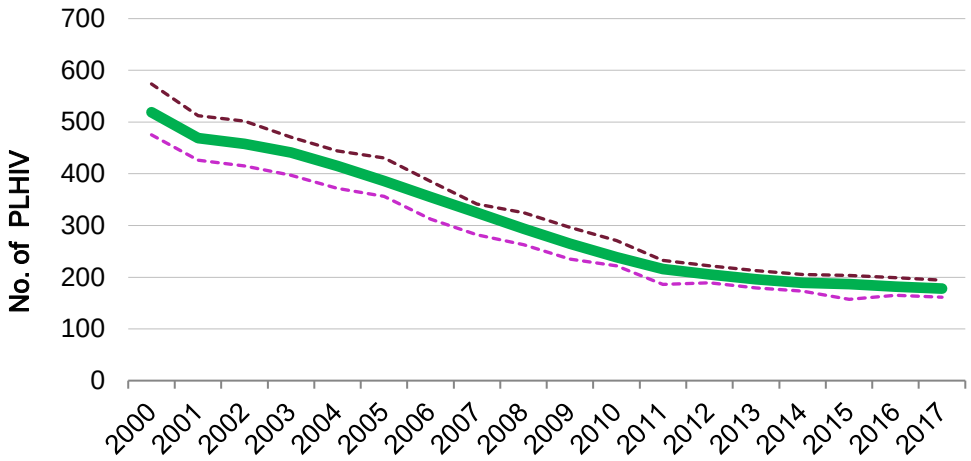
Figure 6: **Trend of estimated number of people living with HIV, 2000-2017**



(upper and lower bounds are given in dotted lines)

Above figure shows the trend of estimated number of PLHIV. Number of PLHIV had been peaked around 2008 and stabilizing around 2015. With the scaling up to ART programme, trend of PLHIV expected to be increasing depending on the number of new HIV infections adding to the number of PLHIV.

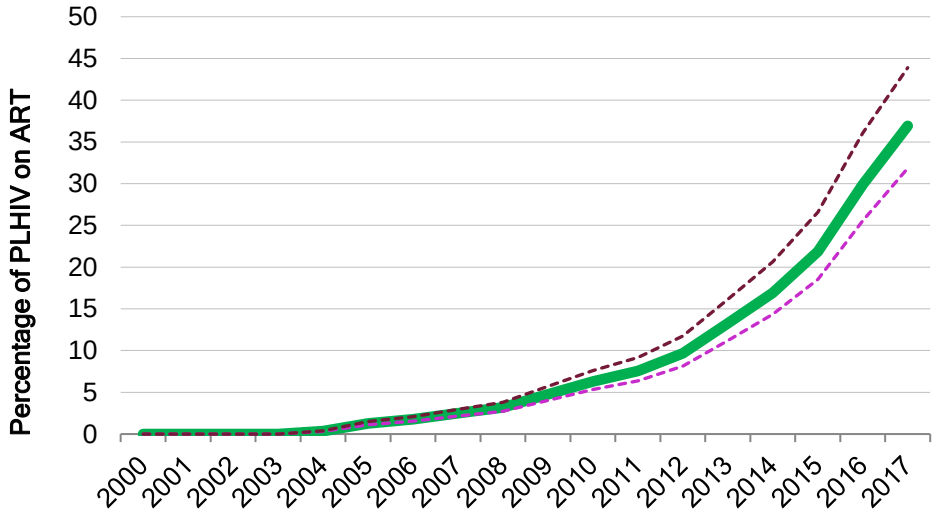
Figure 7: **Trend of estimated new HIV infections, 2000-2017**



(upper and lower bounds are given in dotted lines)

Trend of estimated new HIV infections shows rapid decline and stabilizing around 2016. Currently the estimated new HIV infections are less than 200 per year. NSACP is working towards reducing the number of new HIV infections in collaboration with all stakeholders.

Figure 8: **Estimated % of people living with HIV receiving ART, 2000-2017**



(upper and lower bounds are given in dotted lines)

Above graph shows the percentage of people on ART out of the estimated number of PLHIV. Since 2016, NSACP is following the “treat all” policy by treating all diagnosed PLHIV irrespective of their CD4 level. In addition since 2016, funding for ART programme is coming from the government of Sri Lanka. Currently the ART coverage is at 37%. To improve this figure, targeted HIV testing has to be scaled up

to diagnose rest of the estimated PLHIV. During 2017, NSACP has been looking for a cost effective model to diagnose PLHIV who are still not aware of their HIV status.

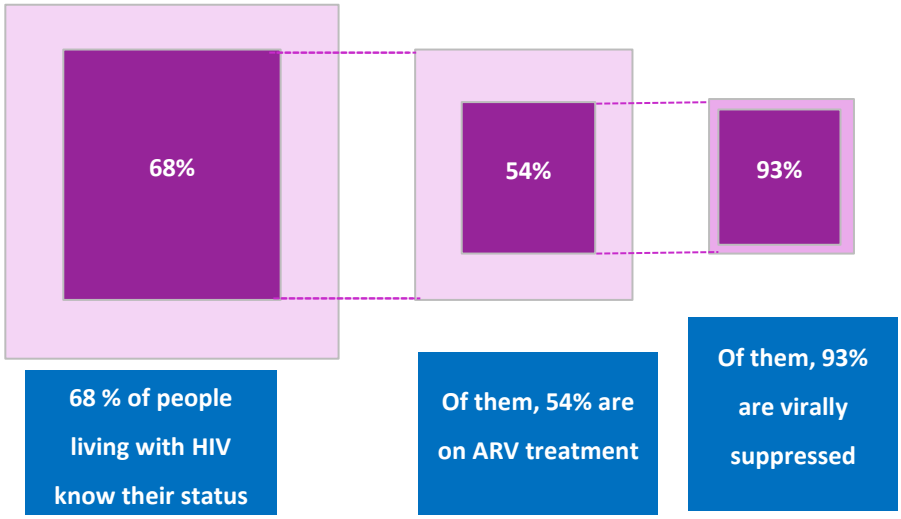
Ending AIDS epidemic by 2025

Sri Lanka has taken a proactive stance to end AIDS epidemic five years earlier compared to the global goal of ending AIDS epidemic by 2030. According to UNAIDS, 90-90-90 treatment targets need to be achieved to get the goal of "Ending AIDS epidemic". 90-90-90 treatment targets are given below.

I. 90% of all PLHIV know their HIV status
II. 90% of all PLHIV diagnosed receive ART
III. 90% of all people on ART have viral suppression

According to UNAIDS, ending AIDS epidemic is defined as declining number of new HIV infections and AIDS-related deaths by 90% compared to 2010.

Figure 9: Status of 90-90-90 treatment targets as of end 2017

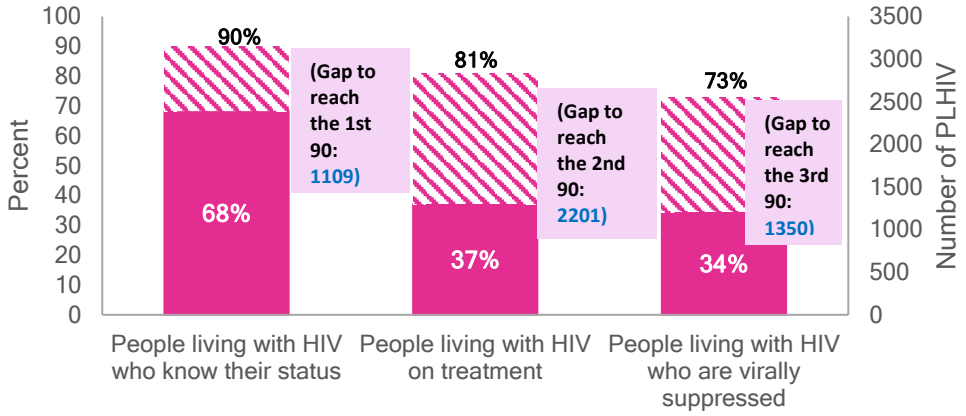


Above figure shows the status of treatment targets as of end 2017. Sri Lanka has shown above average performance on viral suppression of PLHIV who have initiated ART. First and second 90 targets need to be improved. First 90 treatment target can be improved by scaling up of HIV testing. Low percentage of second 90 is most probably due to underreporting of deaths in the cumulative diagnosed PLHIV. AIDS deaths could be deliberately unreported as 'AIDS deaths' due to stigma and insurance claiming related issues affecting surviving family members. It should be noted that all diagnosed PLHIV are offered free treatment and care services. Sri Lanka is one of the few countries in the entire world which provide HIV testing, ART and lab monitoring free of charge from the government health budget.

Cross sectional HIV treatment cascade as of end 2017

Below figure demonstrates the cross sectional HIV treatment cascade which illustrate the 90-90-90 target achievement in comparison to the estimated number of PLHIV. Since the 90% is calculated from the previous 90, targets in the cross sectional cascades are 90%, 81% and 73% from the total estimated number of PLHIV. Numbers to be achieved to reach above percentages are given in the cross sectional cascade.

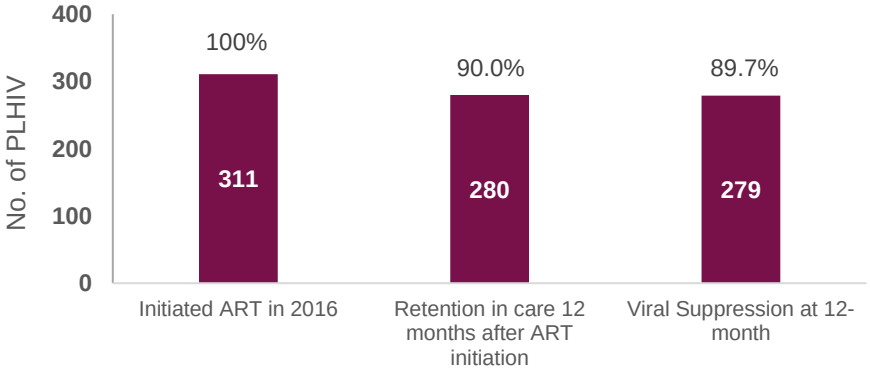
Figure 10: Cross sectional HIV treatment cascade as of end 2017



Since cross sectional HIV treatment cascade is dealing with cumulative numbers, there can be data related issues. However, longitudinal treatment cascades deals with PLHIV diagnosed in one year. Therefore, they are less likely to be affected by missing data.

Longitudinal treatment cascades

Figure 11: Longitudinal HIV cascade among PLHIV who initiated ART in 2016

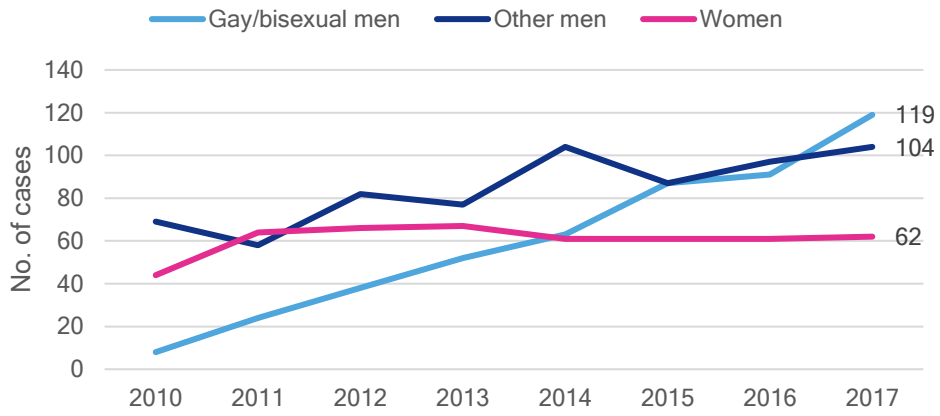


Longitudinal cascade graph of PLHIV who initiated ART in 2016, shows that 90% PLHIV were on ART after 12 months and all of them, except one PLHIV, have achieved viral suppression. This highlight the strength of ART programme in Sri Lanka.

Reported data on HIV

HIV infection is not a notifiable condition in Sri Lanka. However, because of the centralized HIV confirmatory system with Western blot at NSACP, all confirmatory HIV seropositive persons are getting reported and basic epidemiological information is collected by NSACP. There are strong recommendations from the international stakeholders to replace the Western blot with other less time consuming HIV confirmatory algorithms. However, data from NSACP shows minimal delays in linkage to care due to active follow up of diagnosed PLHIV while keeping the centralized HIV confirmatory system.

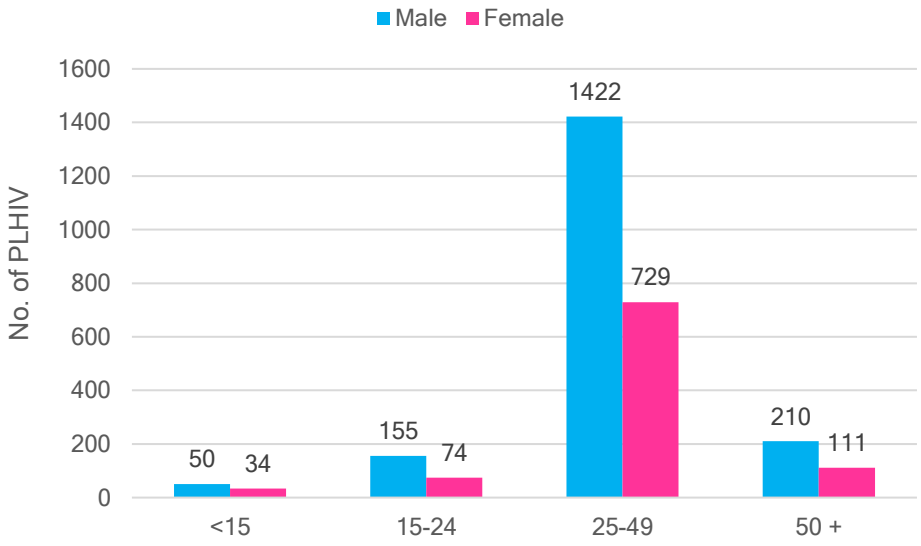
Figure 12: Trends of annually reported HIV diagnoses, 2010-2017



** Other men includes heterosexual, unknown mode etc.*

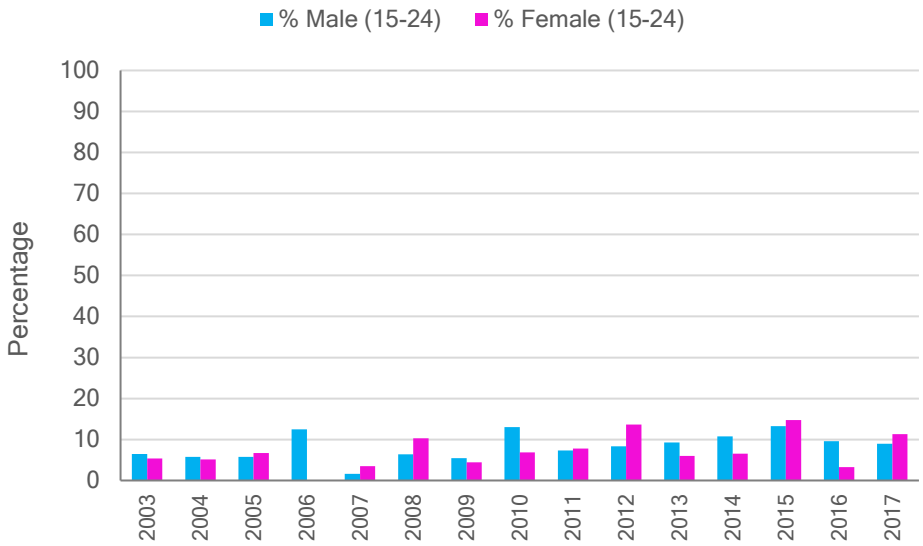
Above graph shows the annual trends of reported HIV diagnoses. Trend of reported HIV among women has stabilized over last five years while HIV among men is increasing over the years. The trend amongst gay/bisexual men is increasing exponentially. There are more HIV cases among this category than that of heterosexual/other men in 2017.

Figure 13: Age and sex of PLHIV reported, 1987-2017 (Total=2784)



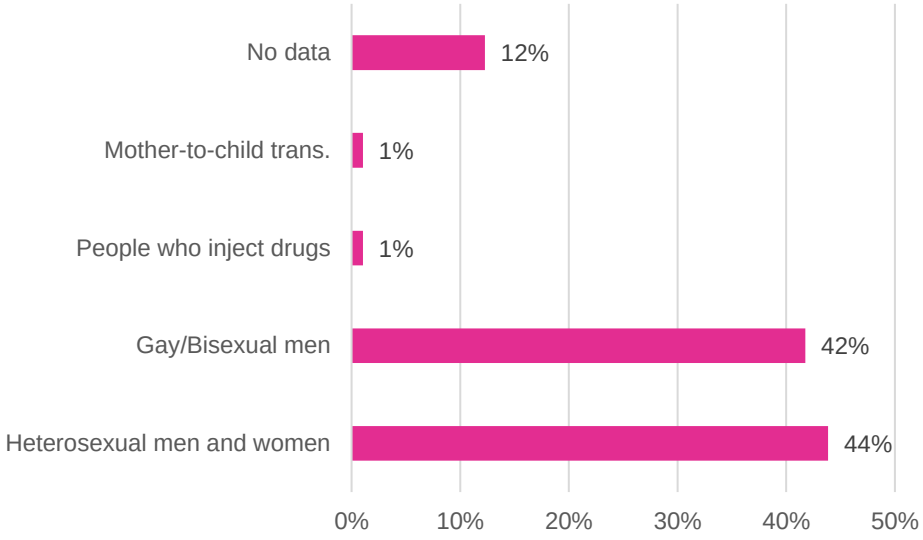
More men with HIV are seen in all age categories including pediatric age group. However, vast majority of HIV positives are in 25-49 age group.

Figure 14: Percent of young adults among all new HIV diagnoses 2003-2017



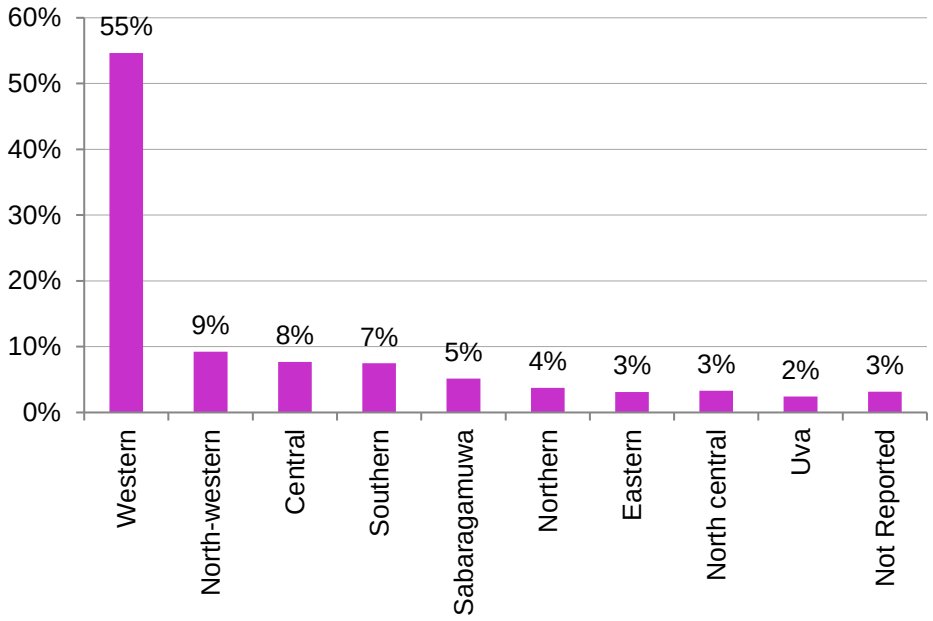
Above graph indicates the proportion of young adults among PLHIV diagnosed from 2003-2017. Around 10% of PLHIV are young adults who are in 15-24 age group. There is no clear trend seen over the years.

Figure 15: Probable mode of transmission of PLHIV reported in 2017 (n=285)



Above figure shows the probable mode of HIV transmission among PLHIV who were diagnosed during 2017 (N=285). Three cases reported following mother-to-child transmission that occurred in previous years. In addition, three (03) PLHIV also had a history of injecting drug use. Percentage among gay/bisexual men further increased in 2017.

Figure 16: **Cumulative PLHIV by province of residence, 1987-2017 (N= 2842)**



The figure given above indicates the province of residence among cumulative PLHIV who reported up to 2017. Majority of cases have been reported from the Western province while the percent reported from all other provinces were less than 10%.

3 SEXUALLY TRANSMITTED INFECTIONS

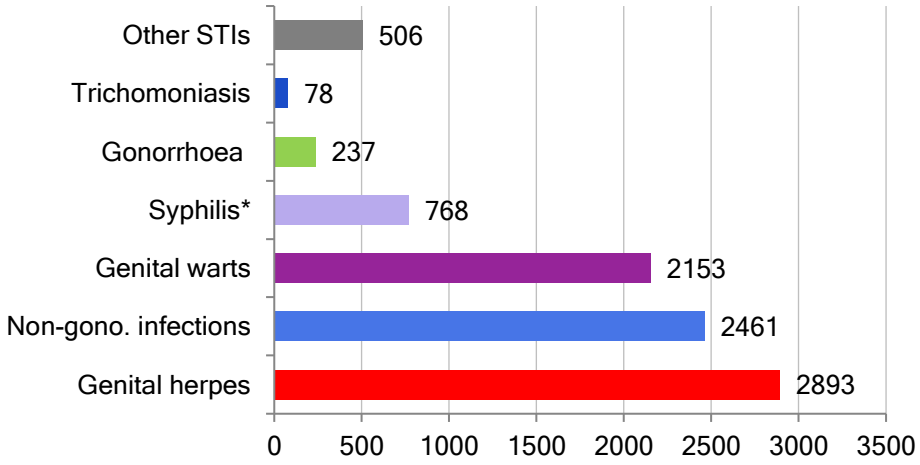
The National STD/AIDS Control Programme (NSACP) continued to prioritize STI prevention and care during 2017. Achieving the best possible control over Sexually Transmitted Infections (STIs) is one of the key areas in controlling the HIV epidemic in Sri Lanka.

Similar to previous years, genital herpes, non-gonococcal infections and genital warts consist of main STIs reported in 2017. Details of number of STIs reported and male to female distribution is described in the table below. More females have reported with genital herpes, non- gonococcal infections, and trichomoniasis, whereas more males reported for all the other STIs.

Table 1: STI diagnoses reported from STD clinics during 2017

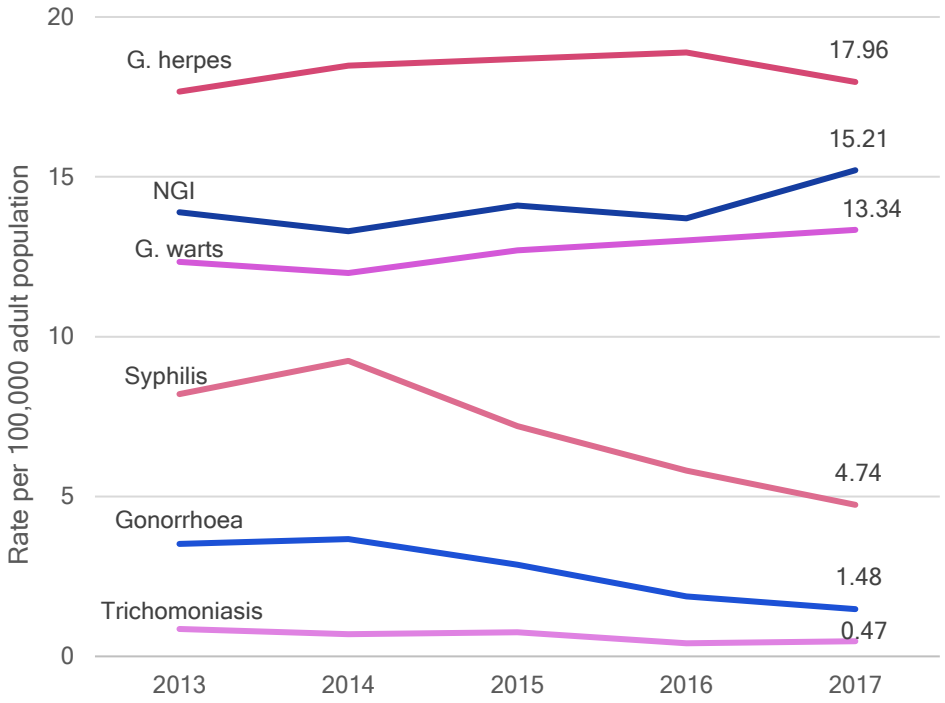
Diagnosis	Male		Female		Total	
	No.	%	No.	%	No.	%
Genital herpes	1149	28%	1744	35%	2893	32%
Non-gono. infections	669	16%	1792	36%	2461	27%
Genital warts	1221	30%	932	19%	2153	24%
Syphilis*	510	12%	258	5%	768	8%
Gonorrhoea	190	5%	47	1%	237	3%
Trichomoniasis	11	0%	67	1%	78	1%
Other STIs	347	8%	159	3%	506	6%
Total STIs	**4097**	**100%**	**4999**	**100%**	**9096**	**100%**

Figure 17: Number of STIs reported during 2017



Above graph shows the number of different STIs reported during 2017. Genital herpes, non-gonococcal infections and genital warts were the commonest STIs reported.

Figure 18: STI rates per 100,000 adult population (15+ years), 2013-2017



Above figure shows the STI rates per 100,000 adult population (15+ years). Trend of genital herpes and trichomoniasis rates were more static during last 5 years. Trends of genital warts and non-gonococcal infection rates were slightly increasing during this time period. However, there is a decrease in trends of syphilis and gonorrhoea rates during the period of 2013 to 2017. Caution should be taken when interpreting data as these rates represent only cases seen in the public STD clinics.

1. Genital herpes

Genital herpes remains the commonest STI reported during past years with a female predominance. This may be due to higher rates of symptomatic disease and recurrences among females than males. Two thousand eight hundred and ninety-three (2893) cases were reported in 2017 with a total of 1744 cases among females and 1149 cases among males. Number of cases reported among people above 25 years of age were markedly higher than that among people of less than 25 years of age. Overall trend of reported number of genital herpes cases shows only a slight increase over last five years as given in below graphs.

Figure 19: Genital herpes cases by sex, 2013 – 2017

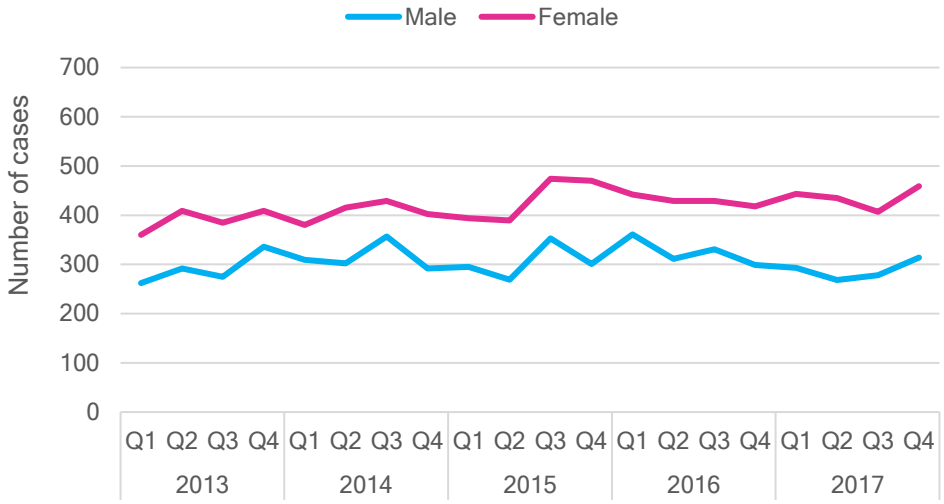
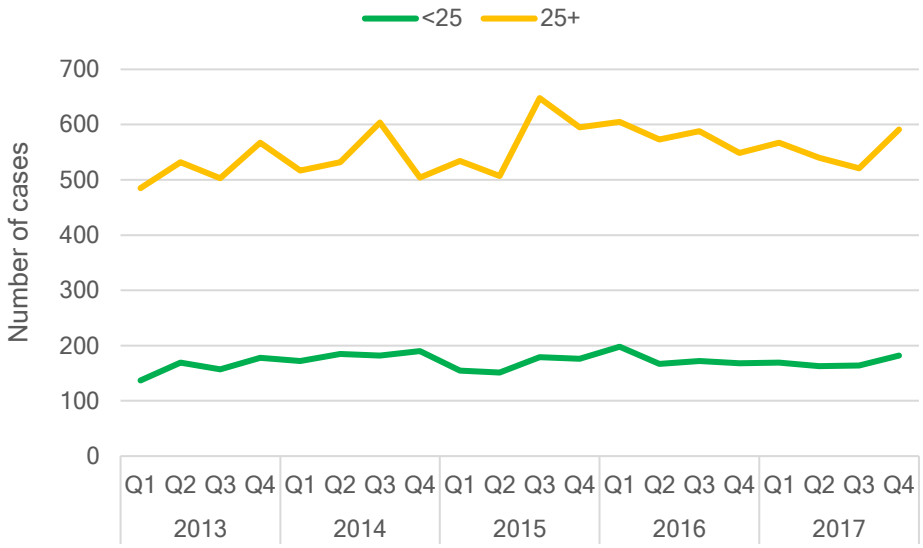


Figure 20: Genital herpes cases by age, 2013 – 2017



2. Non-gonococcal urethritis and cervicitis.

Two thousand five hundred and thirty-eight (2538) cases of non- gonococcal urethritis and cervicitis were reported in 2017. Chlamydia infections are included within this group, due to limited-availability of diagnostic facilities. Increasing trends are seen among females and those who are over 25 years old.

Figure 21: Non-gonococcal urethritis and cervicitis cases by sex, 2013 – 2017

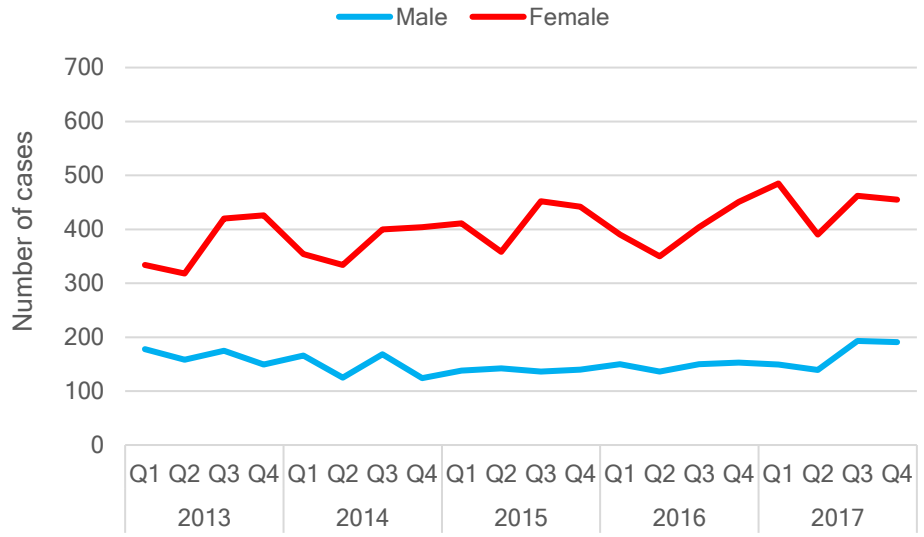
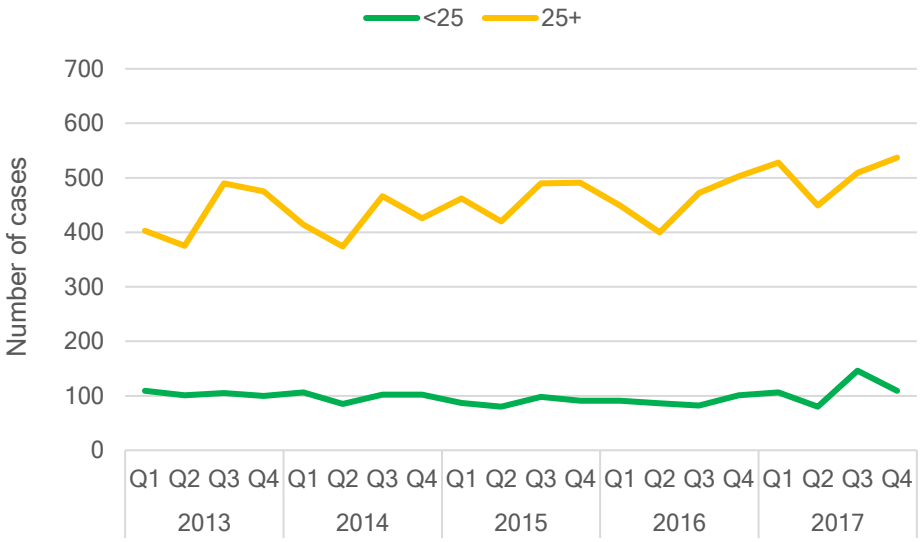


Figure 22: Non- gonococcal urethritis and cervicitis cases by age, 2013 – 2017



3. Chlamydia trachomatis

As mentioned above, specific diagnostic facilities were not available for diagnosis of *Chlamydia trachomatis* during the year of 2017, hence all those cases are included with non-gonococcal infections.

4. Syphilis

Figure 23: **Early syphilis and late syphilis cases by sex, 2013-2017**

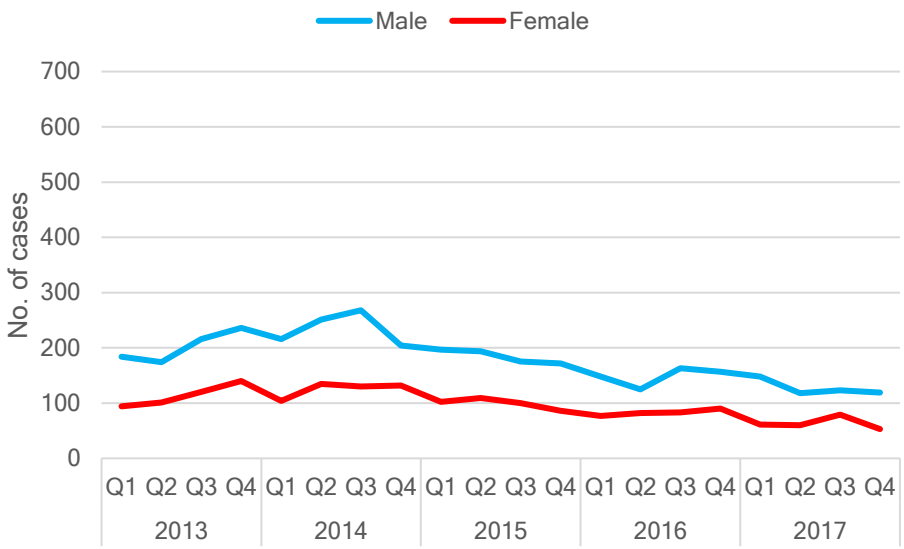
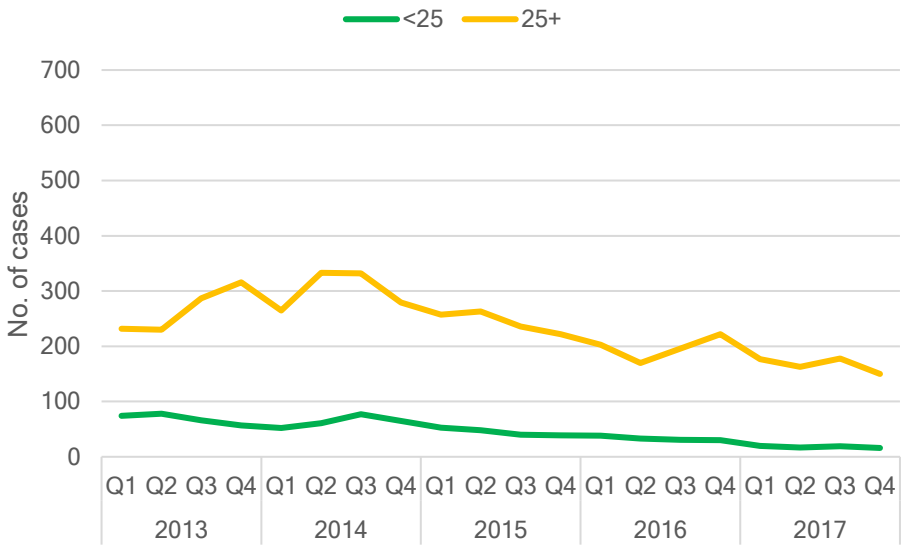


Figure 24: **Early syphilis & late syphilis cases by age, 2013-2017**



Above graphs show that early and late syphilis cases are more in males and among older age group (25 and over age group). A downward trend seen in all four categories (male, female, younger and older) since 2014.

5. Gonorrhoea

Below graphs show the trends of reported gonorrhoea cases during last five years. Similar to syphilis, gonorrhoea cases are more in males and among older age group (25 and over age group). A downward trend seen in all four categories (male, female, younger and older) since 2015.

Figure 25: Gonorrhoea cases by sex, 2013-2017

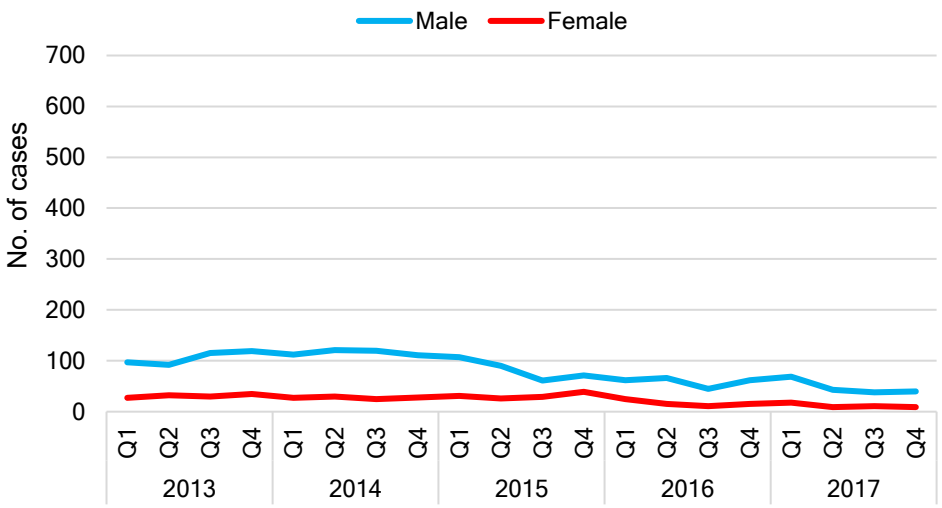
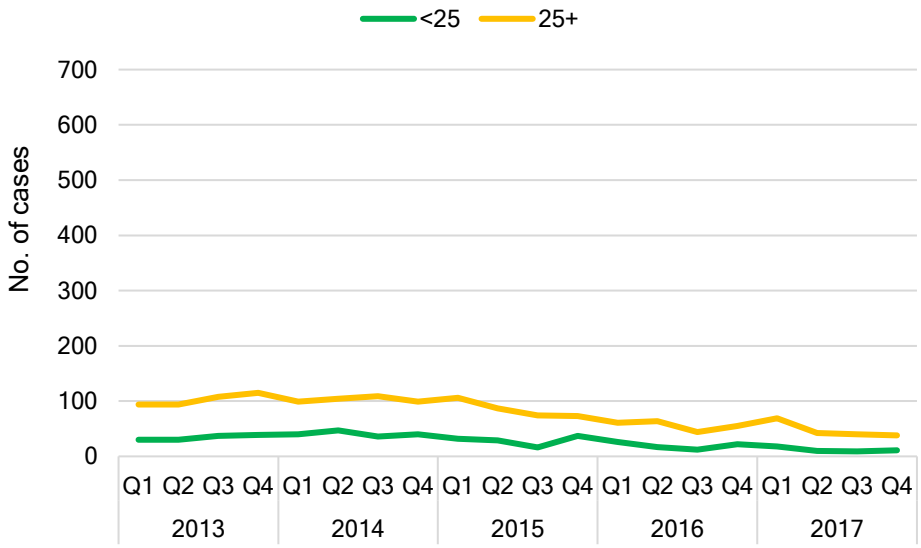


Figure 26: Gonorrhoea cases by age, 2013-2017



6. Genital warts

Higher number of genital warts cases have been reported among males and older age group. All four groups (males, females, younger and older) show a slight upward trend over past five years.

Figure 27*:* Genital wart cases by sex, 2013 – 2017

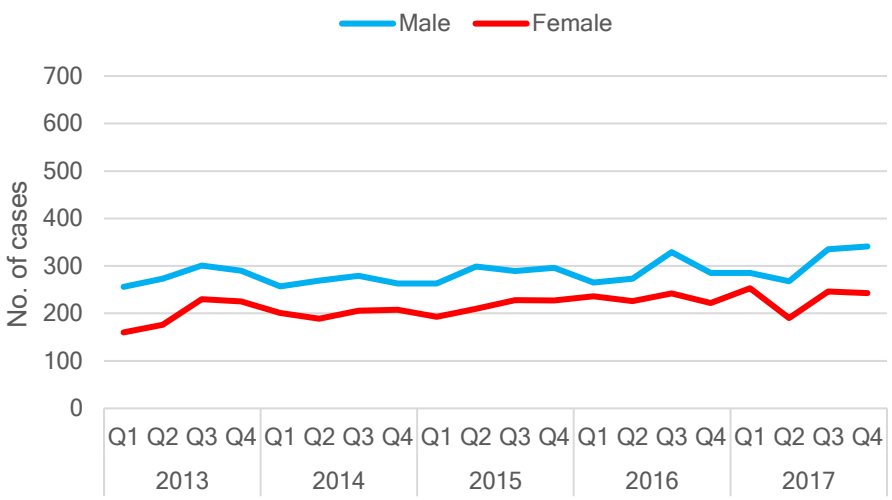
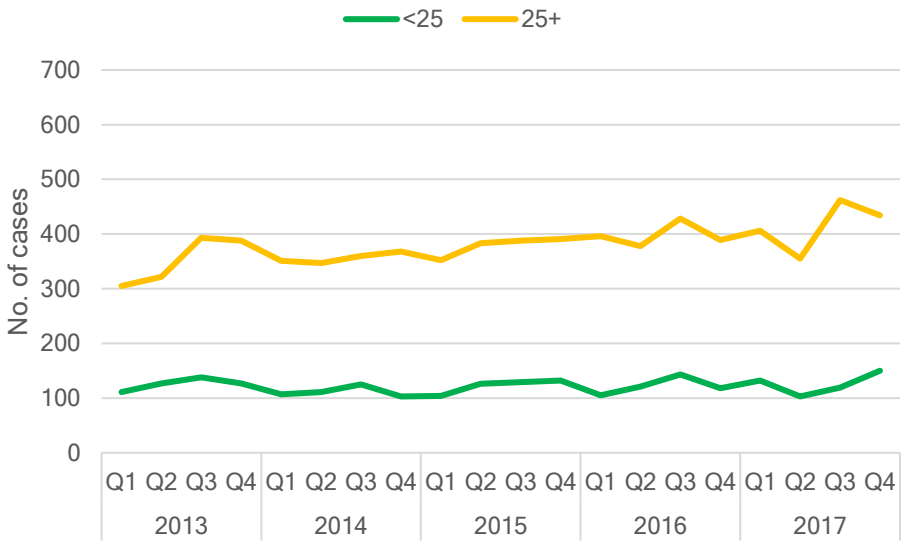


Figure 28*:* Genital wart cases by age, 2013 – 2017



7. Trichomoniasis

Number of reported cases of trichomoniasis is low compared to other STIs. Therefore, annually reported cases are depicted in above graphs. Number of cases are more among females and among older age group. A gradual decline in reported cases are seen since 2015 specially among females and among older age group.

Figure 29*:* **Trichomoniasis cases from all STD clinics by sex, 2009- 2017**

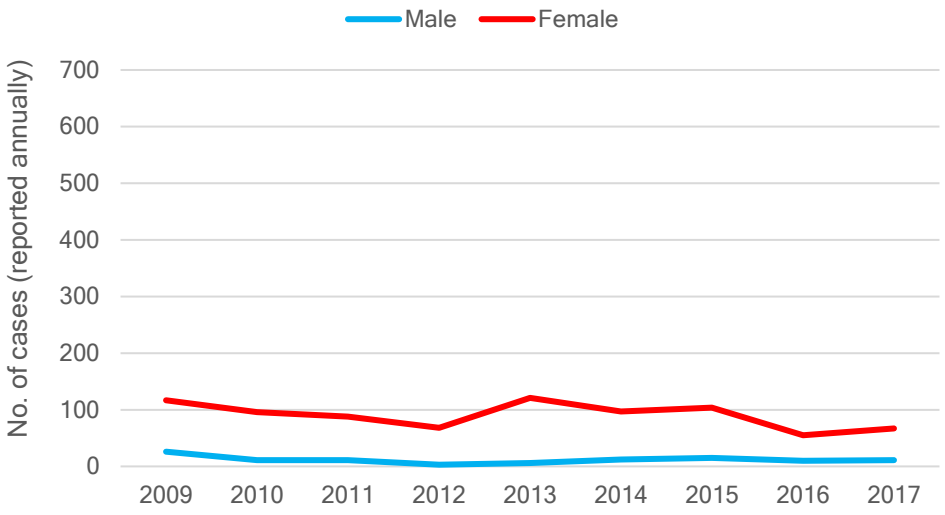
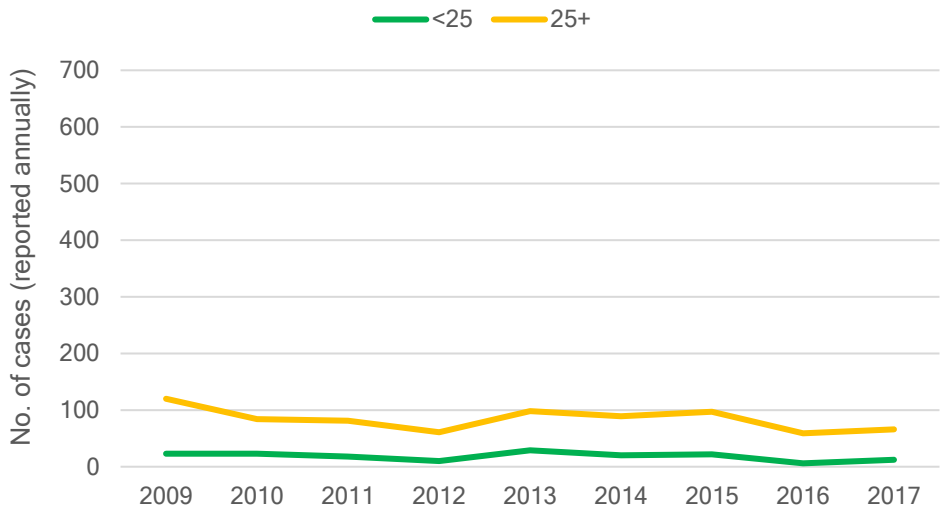


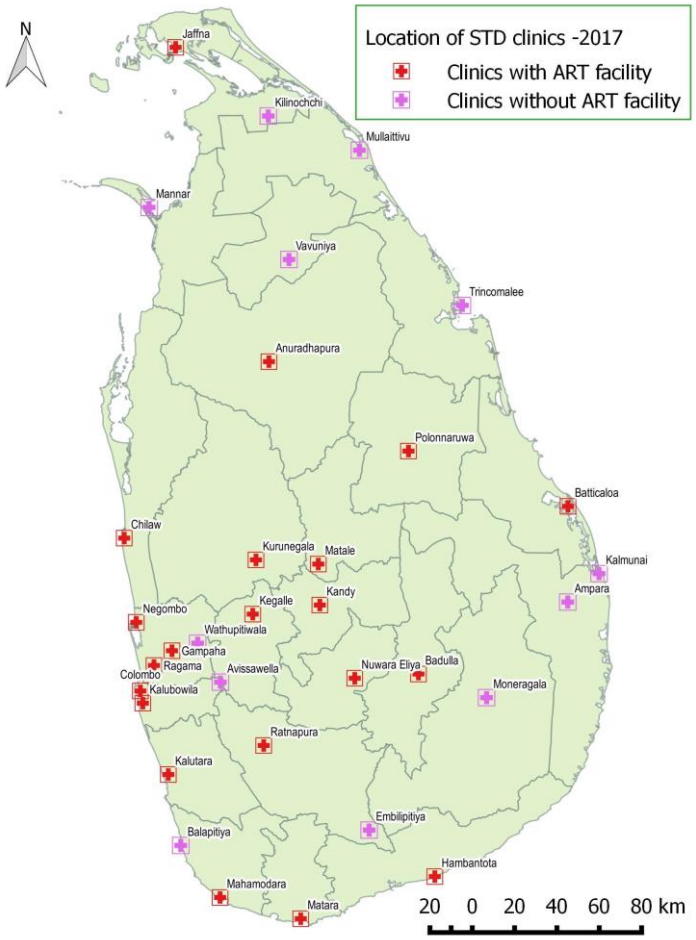
Figure 30: **Trichomoniasis cases from all STD clinics by age, 2009- 2017**



4 MONITORING OF STD SERVICES

Strategic Information Management (SIM) unit is carrying out monitoring and evaluation of services conducted by STD clinics. During 2017 a total of 33 STD clinics functioned island wide and of these, 21 had the capacity to prescribe ART for people living with HIV as indicated in the below figure. In addition, National Institute of Infectious Diseases (NIID) in Angoda also functions as an ART facility.

Figure 31: Full-time STD clinics in Sri Lanka, 2017



A range of population groups from general population to Key populations (female sex workers, men who have sex with men and drug users, beach boys, prisoners etc.) are receiving services from the network of STD and ART clinics. Currently monitoring and evaluation is carried out by systematic and timely maintenance of paper based records, registers and returns. During 2017, a special project initiated to develop an Electronic Information Management System (EIMS) with funding support from Global Fund. Once this system is in place, all paper based documents will be converted to electronic web based system.

Figure 32: Total clinic visits by STD clients during 2017

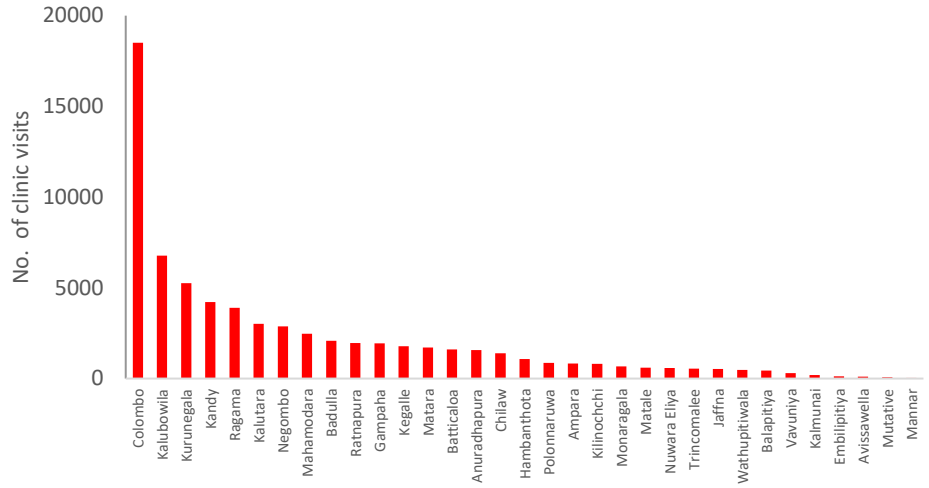
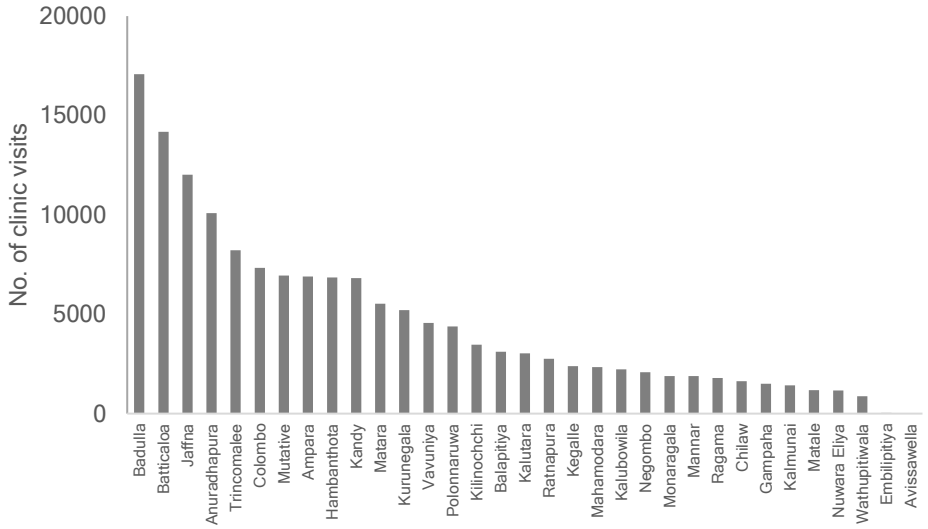


Figure 33: Total clinic visits by other clients* during 2017

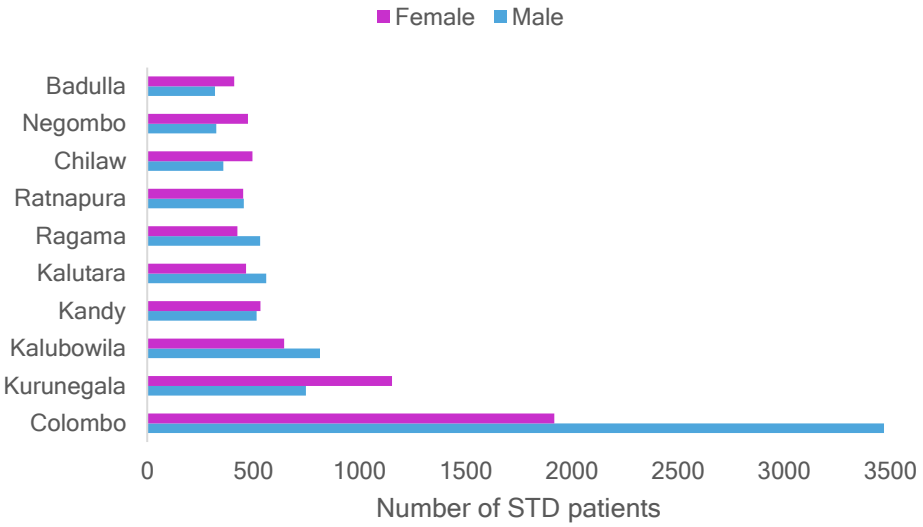


** Other clients include; ANC blood testing on OPD basis pre-employment and visa screening, etc.*

Above graphs illustrate the number of clinic visits by STD patients and other clients in all STI clinics during 2017. STI clinic, Colombo shows the highest number of clinic visits for STD patients followed by Kalubowila, Kurunegala, Kandy, and Ragama.

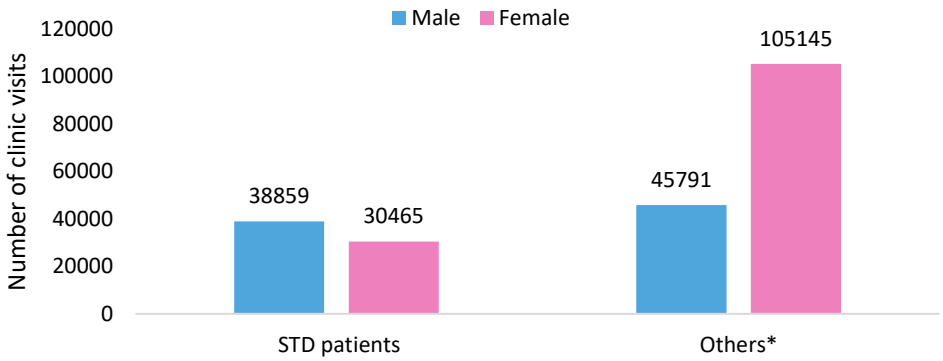
Clinic visits by other clients (ANC blood testing on OPD basis pre-employment and visa screening etc.) is highest in clinics with low STD patient loads such as Budulla, Batticaloa and Jaffna.

Figure 34: Number of new STD patients registered by sex during 2017



Above graph shows the number of top 10 STD clinics according to the number of new STD patients registered during 2017. As indicated in the graph, these clinics have provided services to over 700 newly registered STD patients during 2017. Of these Colombo, Kalubowila, Kalutara and Ragama clinics had more male clients than females.

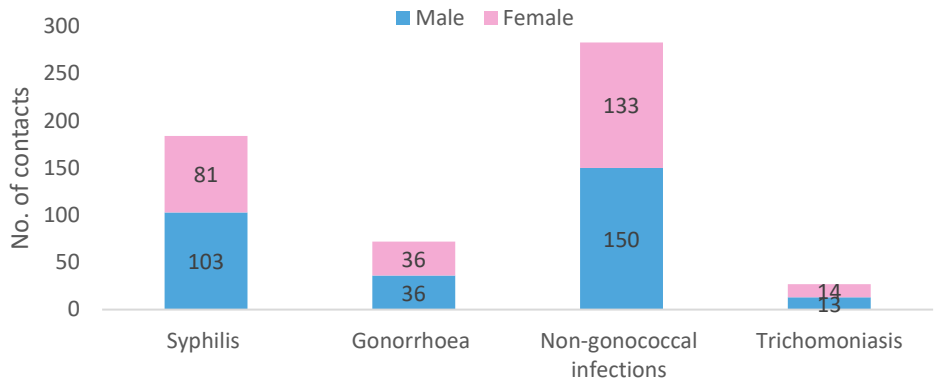
Figure 35: Number of STD clinic visits by sex – 2017



** Others: clinic visits for pre-employment screening, visa screening, ANC blood testing on OPD basis etc.*

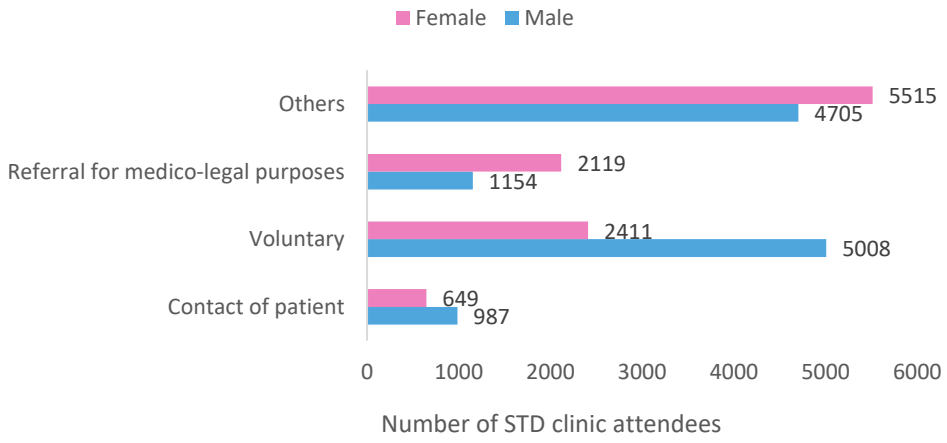
Above graph indicates number of STD clinic visits by STD patients and other clients by sex. A total of 220,260 of clinic visits generated by all STD clinics during 2017. Of these 31% is for STD patients while balance 69% is for 'others'.

Figure 36: Number of contacts treated during 2017



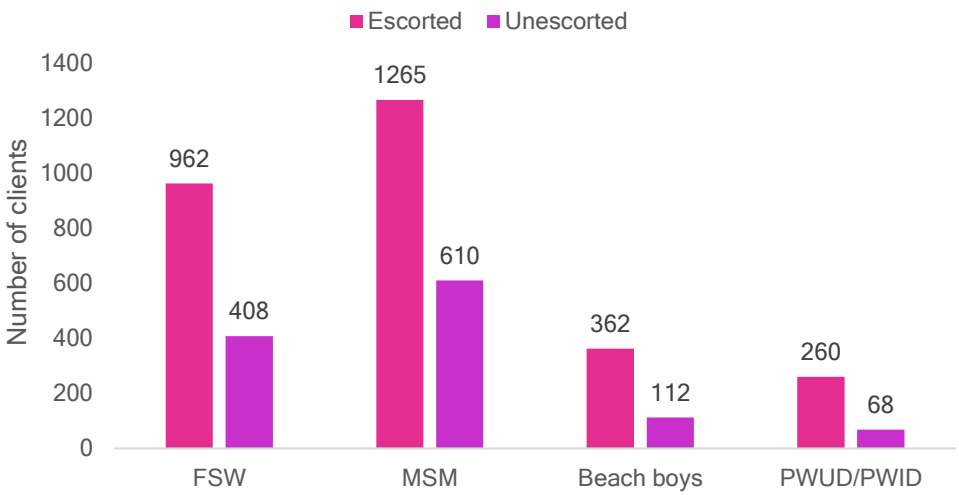
Contact tracing or partner notification is an integral part of STD case management. Above graph shows the number of contacts treated for selected sexually transmitted infections during 2017.

Figure 37: Reason for attendance of newly registered STD patients by sex



Above graph indicates the reasons for attendance of newly registered patients. Of the total 22,548 new STD patients, 7,419 (33%) attended voluntarily while 3273 (15%) had been referred for medico-legal purposes. Others include pre-employment screening, visa screening, ANC blood testing on OPD basis etc.

Figure 38: Key population STD clinic attendees according to escorted status



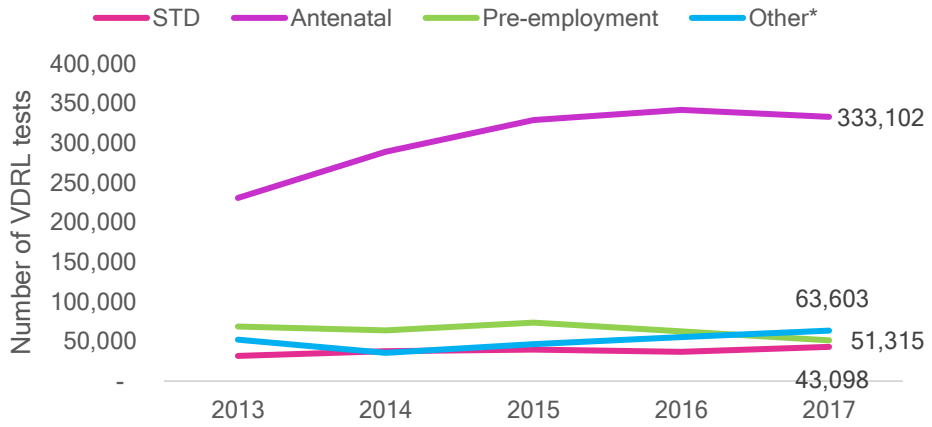
Above graph indicate the STD clinic attendees according to Key population type. NGO peer-leaders are escorting these clinic attendees under the peer-led outreach programme, funded by Global Fund HIV prevention programme. However, some Key population group members visit STD clinic voluntarily on their own.

Table 2: Number of STI diagnoses* among Key populations during 2017

STI	FSW (1370)	%	MSM (1875)	%	Beach boys (472)	%	Drug users (328)	%
NGU/NGC	302	37%	73	13%	0	0%	6	18%
Syphilis	147	18%	246	42%	17	100%	10	30%
Genital herpes	22	3%	66	11%	0	0%	2	6%
Genital warts	21	3%	116	20%	0	0%	6	18%
Trichomoniasis	13	2%	0	0%	0	0%	0	0%
Gonorrhoea	6	1%	24	4%	0	0%	2	6%
Other STDs	299	37%	56	10%	0	0%	7	21%
Total STIs	810	100%	581	100%	17	100%	33	100%

Above table shows the diagnoses of STIs among clinic attendees from Key populations during 2017. Non-gonococcal infections and syphilis (both early and late syphilis combined) appear to be the commonest STIs among all Key population groups while only few cases had gonorrhoea.

Figure 39: Number and type of samples screened for syphilis



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

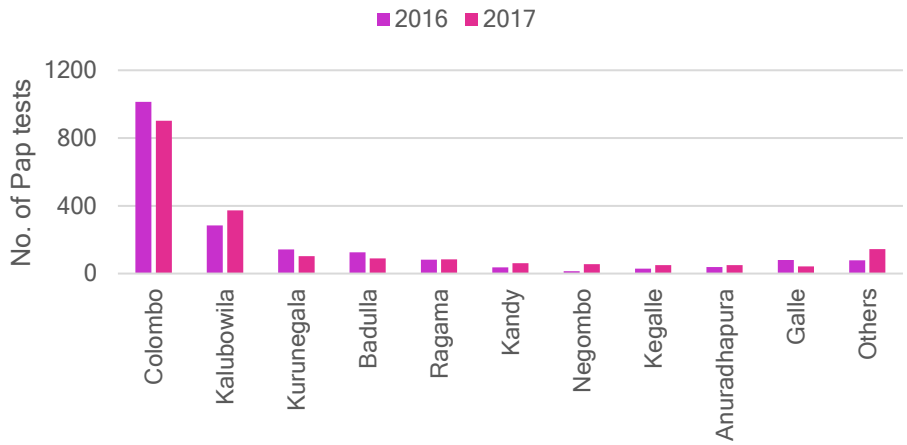
Apart from HIV, National STD/AIDS Control Programme carry out screening for syphilis. The above graph summarizes the total number of samples from each category tested for syphilis during the last five years. Scaling up of antenatal syphilis screening has significantly increased over the last 5 years.

Pap smear screening for STD clinic attendees

During 2017, four new peripheral STD clinics (Matale, Avissawella, Gampaha, Kalmunai) initiated Pap smear screening for female clinic attendees, increasing the number of facilities providing Pap smear screening to a total of 20 STD clinics.

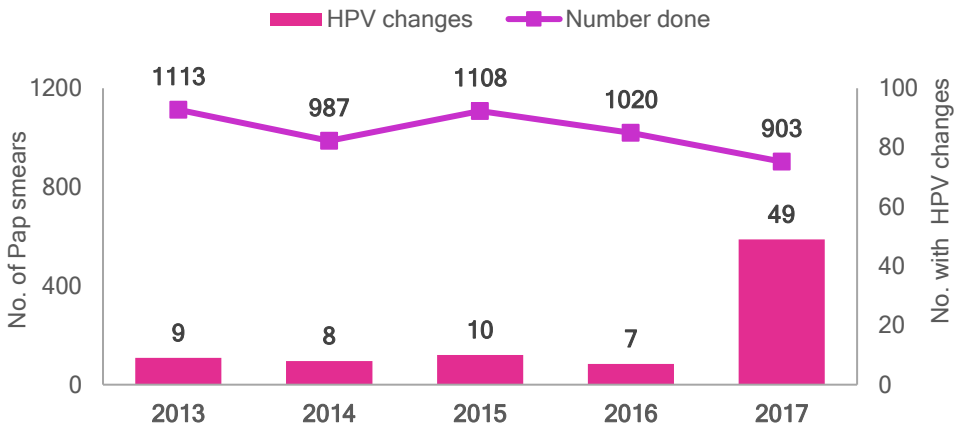
Of the 1,954 Pap smears examined at STD clinics, 46% were done in STD clinic Colombo. A total of 70 smears (4%) were reported as CIN I or above. Timely reporting of Pap smear results has been a challenge due to limited laboratory personnel assigned for this activity.

Figure 40: Pap smear tests done by STD clinics during 2016 and 2017



Above figure shows the top ten STD clinics according to the number of Pap smears conducted during 2016 and 2017. Only three clinics, i.e. Colombo, Kalubowila and Kurunegala had conducted more than 100 Pap tests per year during 2016 and 2017.

Figure 41: Results of Pap smear tests done at STD clinic, Colombo



Above figure shows the total Pap smear tests done at the Central STD clinic, Colombo with the diagnosis during past five years. No cervical cancers were detected during this period. However, 49 smears have been reported as having HPV changes such as CIN 1 or above during 2017.

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.

5 DATA QUALITY IMPROVEMENTS

Measures taken to Improve quality of data

This section deals with following steps taken by NSACP to improve data quality assurance during 2017.

A. Revision of reporting formats from STD and HIV clinics

B. Data quality assurance (DQA) visits

C. Development of an Electronic Information System (EIMS)

A. Revision of reporting formats from STD and HIV clinics

After number of consultations, NSACP updated the recording and reporting formats used for quarterly STD clinic and HIV clinic reports. Number of international consultants provided technical support for this activity.

Following forms, registers and documents were updated or developed during 2017.

1. Main register
2. OPD Blood Testing register
3. Microscopy daily register
4. Quarterly returns from STD clinics
5. Quarterly returns from HIV clinics
6. HIV confirmatory test request and strategic information form
7. HIV and STI surveillance strategy for NSACP
8. Guide for routine data analysis and triangulation related to HIV and STIs
9. National HIV M&E plan Sri Lanka, 2017-2022

Series of training workshops were held with the participation of district STD clinic staff to introduce these new recording and reporting formats.

B. Data quality assurance visits

During 2017, SIM unit prepared a data quality assurance check list for STD and HIV clinics. Staff of SIM unit started visiting district level STD and HIV clinics using this checklist to monitor and evaluate data quality of reported units. As given in the below figure, twenty district clinics were covered by DQA visits during 2017. These visits were useful to both SIM unit staff as well as to district clinic staff to understand data issues and take corrective measures.

Figure 42: District STD clinics visited for data quality assurance by SIM unit

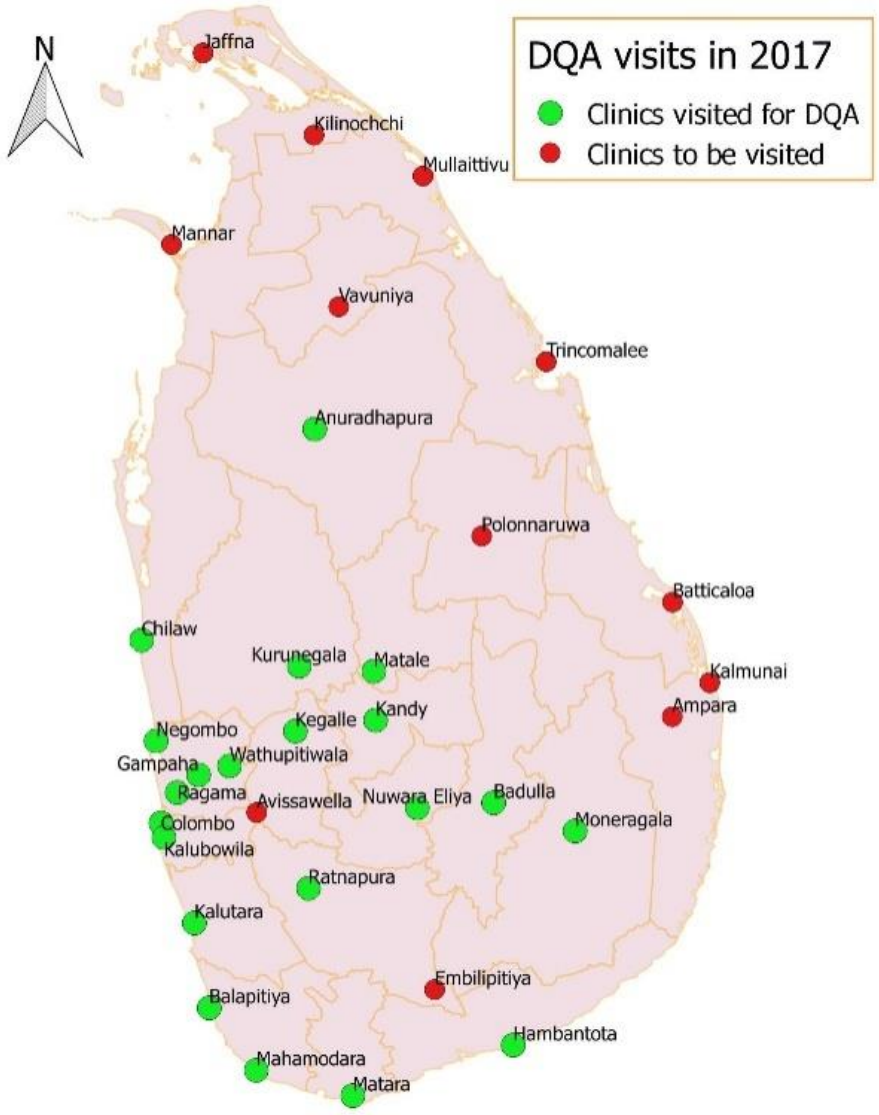


Figure 43: DQA visits to Kalutara, Kegalle, Kandy and N' Eliya STD clinics

Figure 44: DQA visits to Wathupitiwala and to Ragama STD clinics

C. Development of an Electronic Information System

National STD/AIDS Control programme initiated development of an Electronic Information Management System (EIMS) during 2017. This project is funded by GFATM through Ministry of Health, Nutrition & Indigenous Medicine.

Need for an Electronic Information System

The monitoring and evaluation of services of NSACP is currently carried out using a manual paper based system. As a result, there is no real-time monitoring. WHO paper based system is designed for following up of patients only for 24 months. However, due to improvements in HIV treatment, many patients need to follow up longer. Over the years, more and more new patients are getting into the HIV care and treatment system, and this further limits the paper based system for adequate M&E purposes. Therefore, it is necessary for an automated Electronic Information Management System (EIMS) for NSACP which gives timely information for efficient patient management and monitoring of HIV care and ART Programme.

After usual hassles in the government procurement process, NSACP has managed to select a company and handed over the development of EIMS during 2017. The main objective of the consultancy Assignment is to design, develop and implement of Electronic Information Management System (EIMS) which includes Sexually Transmitted Diseases (STD) care module, HIV care module, Pharmacy module, Laboratory module, NGO/Private sector information module, Queue management system and reporting module.

Figure 45: Signing of the EIMS contract and a EIMS development meeting

The current situation of EIMS development

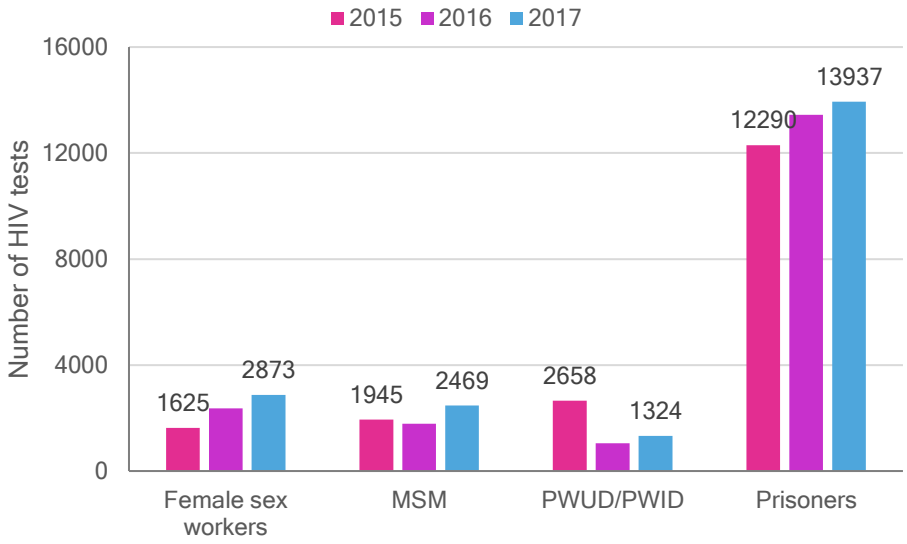
- The selection of consultancy firm was done through open national competitive bidding process in accordance with the procedures. The method for the selection of the consultant was based on the Quality and Cost Based Selection (QCBS). The closing date for the expression of interest was 19th of April, 2017.
- Technical Evaluation Committee evaluated the tender documents and recommended Maple Resource Lanka (Pvt) Ltd (Joint Ventured with Lunar Technologies) and Project Consultancy Procurement Committee awarded the contract on 28th August, 2017 to above firm.
- Signing of the contract agreement done (after approval from Legal department) on 27th November, 2017 between selected firm and Secretary, Ministry of Health.

Figure 46: Training session for NSACP staff prior to beta testing of EIMS

6 HIV TESTING SERVICES

HIV testing services are critically important in the national response to HIV epidemic. Over the years, the number of HIV tests carried out in the country has been increased. Although HIV tests done in private sector is underreported, all HIV positives are reported to NSACP as the confirmatory test (Western Blot) is available only at the National Reference Laboratory. Diversification of testing and service delivery methods were attempted during 2017.

Figure 47: HIV tests done for Key populations by NSACP 2015-2017



Above graph shows number of HIV tests carried out among key populations from STD clinics (both as clinic attendees as well as outreach testing). Most of tests have been carried out among prisoners as outreach. Except drug users, all other categories shows an improvement in testing numbers during past three years. Reduction of HIV testing among drug users is due to programmatic decisions to limit the escorting only to injecting drug users.

Table 3: HIV testing details in 2017

Types of blood samples screened for HIV	Number tested	Number HIV positive	Sero-positivity rate	Proportion of samples	Proportion of positives
Blood donor screening[1]	427,063	30	0.01%	36.5%	10.5%
Antenatal screening	338,363	15	0.004%	28.9%	5.3%
Private labs and SJGH[2]	191,984	52	0.03%	16.4%	18.2%
STD clinic samples[3]	127,897	170	0.13%	10.9%	59.6%
Tri-forces screening	63,018	3	0.01%	5.4%	1.1%
Survey samples	1440	1	0.07%	0.1%	0.4%
Prison HIV testing programme	13,088	5	0.04%	1.1%	1.8%
Screening among TB patients	7,996	9	0.11%	0.7%	3.2%
Community based testing[4]	747	0	0.0%	0.1%	0.0%
Total	1,171,596	285	0.02%	100%	100%

[1] Includes both government and private blood banks, [2]Sri Jayewardenepura General Hospital. [3]STD clinic samples include; clinic attendees, pre-employment screening, outreach samples and testing of contacts, [4]Done at drop-in-centers

A total of 1,171,596 HIV tests had been done in 2017. There is an increase of over 40,000 HIV tests compared to that of 2016. Antenatal samples, STD clinics testing and blood donor screening has been significantly higher compared to 2016. A slight increase of testing among TB patients also observed in the given year. Reduction of HIV testing in private hospitals were observed during 2017 and under reporting can be a significant factor for this observation. Total number of HIV positive persons detected during the year was 285.

HIV testing services through outreaching by STD clinics

Below given table shows the outreach HIV testing services provided by STD clinics in the country.

Providing HIV testing services through outreaching is an accepted good practice in many parts of the world. In Sri Lanka, STI/HIV/AIDS related services and HIV testing services are also increasingly being provided through outreaching. However, the total number of HIV tests provided through outreaching in 2017 shows a slight reduction compared to 2016.

Table 4: HIV screening through outreach activities by all STD clinics -2017

Type of outreach activities	No. tested for HIV	No. HIV positive	Sero-positivity rate
Prison blood survey	13,088	5	0.04%
Female sex workers	1248	0	0.00%
Men having sex with men	484	1	0.21%
Drug user survey	1188	0	0.00%
Beach boys	797	0	0.00%
Colombo municipal council	157	0	0.00%
World AIDS Day 2017, Colombo	2279	1	0.04%
Others	24,077	2	0.01%
Total	**43,318**	**9**	**0.02%**

Escorting of Key population to STD clinics

Peer-led targeted intervention programme provides a sexual health services package to Key population groups. Promoting care seeking behavior among service recipients is one of the components of the package. Within that component, the peer-leaders (peer-educators) are encouraged to escort their community members to STD clinics. These escorts are offered HIV tests and other HIV and STD services when they attend STD clinics.

Table 5: HIV testing among escorts by peer-educators*

Type of Key population	No. escorted*	No. HIV positive	Sero-positivity rate
Female Sex workers	796	1	0.1%
Men who have sex with men	1265	9	0.7%
Beach Boys	362	0	0.0%
Drug users	260	0	0.0%
Total	**2683**	**10**	**0.4%**

** source of data: STD clinic returns*

Community based HIV testing

NSACP and its partners have started community level HIV testing in 2017 for female sex workers, men having sex with men and drug users. In this service model, the HIV testing services are run by the communities and services are provided to fellow members of the communities. An increased service uptake is expected by above population groups in coming years. Below given table shows the community based HIV testing services provided in 2017 according to the National HIV testing guidelines.

Table 6: HIV testing through community based testing in drop-in centers

Type of Key population	No. of HIV tests	No. HIV positives	Sero-positivity rate
Female sex workers	312	0	0.00%
Men who have sex with men	114	0	0.00%
Drug users	321	0	0.00%
Total	**747**	**0**	**0.00%**

7 HIV TREATMENT AND CARE SERVICES

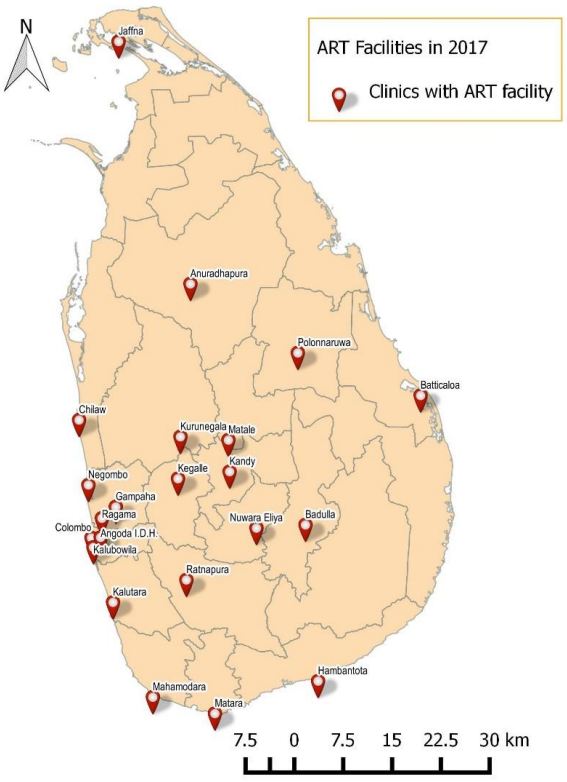
On the World AIDS Day 2016, Sri Lanka took a major step by launching the road map to End AIDS in 2025, five years ahead of the global target. Ending AIDS in 2025 can be achieved by reaching 90-90-90 targets by 2020.

90-90-90 targets are,

- 90% of people living with HIV diagnosed by 2020
- 90% of diagnosed PLHIV start on antiretroviral treatment by 2020
- 90% of PLHIV on treatment virally suppressed by 2020

In the year 2017 there were 285 new persons confirmed as having HIV infection. Of them, 277 (97%) have been linked to services. Most of them have been identified through STD clinics, blood banks and private sector. Comprehensive care services including ART were provided to all PLHIV attending for services at HIV clinics.

Figure 48: Clinics with ART facilities during 2017



Antiretroviral treatment

In Sri Lanka the ART services were initiated in 2004. Since then 1579 PLHIV were started on ART. The total number receiving HIV care services by the end of 2017 was 1351 and of them 1299 were on ART. This included 44 children of less than 15 years. Colombo HIV clinic had the highest number of PLHIV receiving ART followed

by Ragama and Kandy. While all STD clinics with specialist services provided ART services, Galle, Kalubowila and Kurunegala also had reasonable numbers.

Table 7: Age and sex of PLHIV on ART

Age category	Female	Male	Total	%
1-4	1	1	2	0%
5-9	11	15	26	2%
10-14	5	10	15	1%
15-19	6	9	15	1%
20-24	16	31	47	4%
25-49	256	595	851	66%
50+	133	210	343	26%
Total	**428**	**871**	**1299**	**100%**

In the year 2017, a total of 279 were started ART. This comprised 68 females and 211 males. The median CD4 count of those who started ART in 2017 was 383 cells/µl.

Table 8: Number of PLHIV in HIV care services as of end 2017

Name of Clinic	Pre-ART	ART	Total	%
Colombo	27	670	697	52%
Ragama	4	146	150	11%
IDH	1	74	75	6%
Kandy	3	65	68	5%
Galle	3	48	51	4%
Kalubowila	5	42	47	3%
Kurunegala	3	35	38	3%
Jaffna	0	29	29	2%
Kalutara	1	28	29	2%
Anuradhapura	2	26	28	2%
Negombo	0	20	20	1%
Ratnapura	0	20	20	1%
Gampaha	2	16	18	1%
Chilaw	0	17	17	1%
Polonnaruwa	0	15	15	1%
Badulla	0	12	12	1%
Kegalle	0	12	12	1%
Matara	0	9	9	1%
Matale	0	7	7	1%
Hambantota	1	3	4	0%
Batticaloa	0	3	3	0%
Nuwara Eliya	0	2	2	0%
Grand Total	**52**	**1299**	**1351**	**100%**

Since 2016 government has been procuring ART for all PLHIV in the country. The policy decision was taken in 2016 to treat all PLHIV with ART. By end of 2017 the cumulative number on ART was 1299. This included 1235 on first line ARV regimen and 62 on second line regimen. Two PLHIV were on third line regimen. All groups of ARV drugs including nucleoside reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI), protease inhibitors and integrase inhibitors were available. According to WHO guidelines the preferred first line ART regimen is TDF+FTC+EFV fixed dose combination. Most of the PLHIV (62%) were on this treatment. Those who are doing well on previous first line regimens with AZT+3TC backbones were continued in 2017 as well (22%). Tenofovir

related renal complications need to be further evaluated since Sri Lanka is facing an epidemic of chronic kidney disease of unknown etiology. Those who are on first line ARV regimen, AZT+3TC+EFV/NVP will be assessed in 2018 for suitability of change to fixed dose combination TDF+3TC+EFV in 2019.

According to WHO recommendations, atazanavir is preferred among protease inhibitors due to once daily dosage. However, due to cosmetic reasons this is not popular among patients as they are worried about the yellowish discoloration of the eyes.

Raltegravir and darunavir have been identified as third-line options. However, raltegravir had to be used for first-line regimens in special situations such as for pregnant women who were diagnosed in late stages of pregnancy and HIV and TB coinfections.

The procurement review committee which functions as the National quantification working group met regularly and decided on the ARV needs of the country. The long time taken for procurement process is a concern.

Table 9: Types of ART regimens

ART regimens	No. of PLHIV	%
TDF+FTC+EFV	804	61.9%
AZT+3TC+EFV	219	16.9%
AZT+3TC+NVP	56	4.3%
TDF+FTC+RAL	52	4.0%
TDF+FTC+LPV/r	48	3.7%
TDF+FTC+ATV/r	36	2.8%
AZT+3TC+LPV/r	26	2.0%
ABC+3TC+EFV	19	1.5%
Others	39	3.0%
Total	**1299**	**100.0%**

Multidisciplinary involvement in providing services

In management of PLHIV the Venereologist acts as the focal point and takes responsibility of overall management of PLHIV for life time. However, many other disciplines are involved in the management. Technical expert committee comprising of Physicians, Surgeons, Ophthalmologists, Microbiologists, Virologists, Obstetricians met to understand the issues in relation to the provision of comprehensive care services for PLHIV.

Venereologists participated in TB advisory committee to improve services with regard to TB and HIV management. INAH prophylaxis was arranged to be issued from the NSACP, considering the convenience to the patients in 2017. Further the discussion was initiated to provide TB screening services in the main HIV clinic, Colombo weekly from 2018.

HIV care subcommittee met quarterly of which members included administrators, NSACP coordinators, Venereologists, Physician from IDH, Microbiologists, NGO

and three PLHIV support groups. In addition, NDDCB, NCPA and Department of social services were invited to identify additional services.

Main HIV clinic, Colombo

As the main HIV care unit in the country, HIV clinic, Colombo had to strengthen the prevention measures through PLHIV. Appointment of PHNS and PHI to the unit helped to improve the public health team. More attention was paid to the defaulter tracing. However, contact tracing need to be improved further. Contact tracing will give opportunity to identify undiagnosed PLHIV in the community and would give a higher yield through testing. This aspect should be improved in the year 2018.

The HIV care services were further improved with addition of Psychiatrist service and Nutritionist service at the HIV clinic, Colombo.

Scaling up HIV care services

HIV care services were further scaled up to cover all provinces with specialist services. By end 2017, out of 30 district STD clinics, 22 clinics had specialist services provided by a consultant Venereologist. This helped in strengthening the HIV care services including ART services by increasing geographical accessibility throughout the country including Northern and Eastern provinces as well.

Differentiated care services were introduced and PLHIV who are stable with undetectable viral loads were issued ARV drugs for 3 months.

PLHIV groups

There are three positive support groups for PLHIV; Positive women's network, Positive hopes alliance and Lanka Plus. In addition the NGOs such as Family Planning Association and National AIDS Foundation also provide support to PLHIV regularly. Resource persons from NSACP conducted programmes on positive living for PLHIV with the help of PLHIV support groups and FPA.

Management of opportunistic infections

Among the newly diagnosed PLHIV in 2017, 51 were in the AIDS stage at the time of diagnosis. Common opportunistic infections were Candidiasis, TB and pneumocystis jiroveci pneumonia. Cytomegalovirus infection was seen among 13 PLHIV. Inward services were provided by specialists representing various disciplines at many hospitals including National Institute of Infectious Diseases (NIID) in Angoda. Late diagnosis is a concern as the cost of management is very high. There were 33 deaths in 2017 due to AIDS.

Opportunistic infections management guideline was developed with the participation of Venereologists and other specialists. The finalized document has been submitted for printing and will be distributed among HIV care providers in 2018.

Non communicable diseases (NCD) were not uncommon among PLHIV. Two were diagnosed with malignancies and 5 women had significant changes in the Pap smear. Renal diseases were identified in 19 PLHIV while one patient had significant bone changes.

Capacity building of Health care workers

In the year 2017 several activities were conducted for health care workers to introduce comprehensive care services for PLHIV and to address the issue of stigma and discrimination. Capacity building programmes for health care workers were continued under global fund project in 13 tertiary care hospitals in the country.

1. Diyatalawa base hospital
2. Kalmunai base hospital
3. Nuwara Eliya dis. gen. hospital
4. Elpitiya base hospital
5. Kilinochchi dis. gen. hospital
6. Mannar base hospital
7. Bibile base hospital
8. Cancer institute
9. Welisara Chest Hospital
10. Sri Jayawardenapura Hospital
11. Angoda base hospital
12. National Institute of Mental Health
13. Dental Institute

Teams comprising Consultants, Medical officers, nursing officers, MLT and pharmacists of respective hospitals were given awareness and training on the new advances in treatment and care services for HIV. The importance of zero discrimination was highlighted through group activities and lecture discussions.

Two workshops were organized to introduce new advances in ART services for Consultants, Medical Officers and Healthcare workers attached to STD clinics to improve quality of care services provided to PLHIV.

Comprehensive health care services for PLHIV was introduced to private sector healthcare workers through two workshops. Health care workers representing private sector institutions in the country participated in the programmes.

Challenges

During the year 2017 NSACP has taken steps to scale up HIV care services further. Contact tracing is an area which needs further strengthening. As the numbers of PLHIV are increasing gradually STD clinics need to be prepared to provide long term care services which requires more resources. Lack of space and lack of human resources are areas which needs attention of authorities. Estimating the ARV drug need is a challenge and the long procurement process further affects continuous supply of ARV drugs. However, it is encouraging to note that since 2016, under the treat all policy over 90% of diagnosed PLHIV are on treatment and of them over 90% have achieved viral suppression.

8 POST EXPOSURE PROPHYLAXIS

Post Exposure Prophylaxis (PEP) is provided to health care workers as well as non-health care workers after getting exposed to potentially hazardous material as a measure of preventing HIV infection. Following educational programs conducted by the National STD/AIDS Control Program in different health care settings, the number of healthcare workers seeking PEP services has been rising as compared to past years. The National STD/AIDS Control Program provides post exposure prophylaxis in clinic hours to the exposed as well as it serves as the central station to provide starter packs to other healthcare institutes to initiate PEP as soon as possible following an exposure. Starter packs of ART has been provided to identified, 24 hours functioning unit of each hospital.

Antiretroviral drugs are always issued following thorough counselling of the importance of taking PEP and the possible side effects. Post exposure prophylaxis should be continued for 28 days with good compliance to prevent HIV by the exposure.

Post exposure prophylaxis was given by 29 STD clinics and it was available at 45 hospitals in the country during 2017.

A total of 3,190 exposed people to potentially hazardous material came following exposure, and of them 3137 (98%) were occupational exposures and 53 (2%) were non-occupational exposures. Seventy nine occupational exposures were started on PEP throughout the country which is 2.4% from all occupational exposures reported. Out of the 79 occupational exposures started with PEP only 29 people (36.7%) have completed PEP for 28 days. Majority came to the Colombo, Anuradhapura and Kandy STD clinics and the numbers were 565, 341 and 323 respectively. In addition to occupational exposures, 3 people were started on post exposure prophylaxis following non occupational exposures at Negombo and Trincomalee STD clinics.

When considering the antiretroviral treatment, most clinics used TDF+FTC+EFV regimen for PEP (80 %). TDF+FTC+LPV/r was the other regimen used island wide for the remaining 20% of them.

Figure 49: Summary of PEP services in 2017

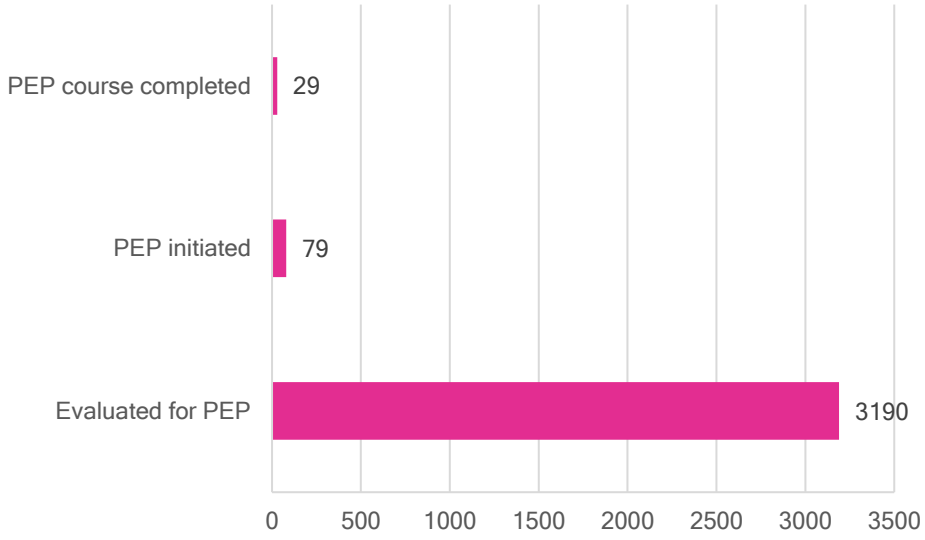
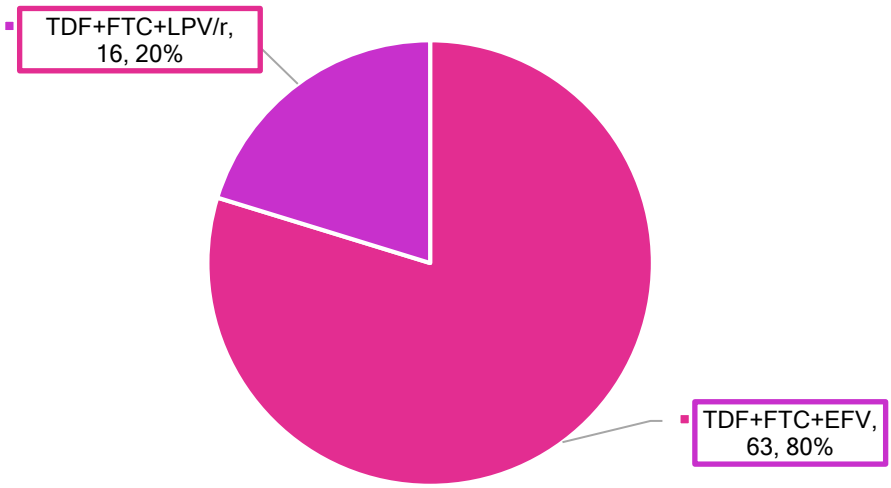


Figure 50: ART regimens used for PEP in 2017 (N = 79)



New Circular on PEP 2017 (General circular 1-19/2017)

National STD/AIDS control programme initiated action to issue a circular on PEP from the Ministry of Health during 2017. This circular will replace the existing circular on PEP issued in early 2000.

According to the general circular 1-19/2017 issued from Ministry of Health, the risk exposures that requires consideration of PEP are as follows.

- Percutaneous injury – Needle stick or cut injury with sharp object
- Contact of mucous membranes
- Non intact skin - chapped abraded or afflicted with dermatitis

Exposure to blood, semen, vaginal secretions, breast milk, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid are identified as risky, and PEP should be considered. Exposure to saliva, urine, nasal secretions, vomitus, tears, sweat and faces are identified as no risk of HIV infection.

The basic steps in the management of exposure to a hazardous material can be illustrated as follows.

1. Management of the exposed site

- Prick or cut injury – Wash with soap and water without irritation of skin
- Mucous membranes – Flush with water

2. Initiation of starter pack should be considered if,

- Needle pricks or cut injuries by sharp objects that is contaminated with blood or other potentially infectious material
- Bitten by a person with visible bleeding in the mouth that causes break in the skin and mucosa of the exposed person
- A non-intact skin exposure to blood or other potentially infectious material

3. Continuation of PEP should be considered if,

- Needle pricks or cut injuries by sharp objects that is contaminated with blood or other potentially infectious material
- Bitten by a person with visible bleeding in the mouth that causes break in the skin and mucosa of the exposed person
- A non-intact skin exposure to blood or other potentially infectious material

2. Evaluation of the source

   Prompt initiation of PEP is needed when exposed to blood or potentially infectious material from a HIV infected source.

   When the source is known but the source HIV status is unknown, HIV rapid and HIV ELISA both will be performed with the blood sample taken from the source with informed consent. PEP should be started promptly when the source HIV rapid test becomes positive.

   When the source is unknown, PEP will be considered in the exposed person only after case by case assessment of the exposure by a Consultant Venereologist.

3. PEP initiation

   Ideally PEP should be started within two hours of the exposure.

   In the exposures happened beyond 72 hours the PEP should be considered in a case by case analysis. The ART regimen of choice TDF + FTC + LPV/r or ATV/r.

   PEP regimen should be continued with good adherence for 28 days following counselling by a Consultant Venereologist.

4. Risk reduction counselling should be done to the exposed person for the 16 weeks of PEP follow up period.

- Use of condoms to prevent sexual transmission
- Avoid pregnancy and breastfeeding
- Avoid needle sharing
- Avoid from donating blood, plasma, tissue or semen

- Identifying symptoms of primary HIV infection and report

5. Follow up with HIV ELISA

- If PEP started follow up should be done with HIV ELISA at baseline, 10 weeks and 16 weeks
- If PEP not started follow up has to be done with HIV ELISA at baseline, 6 weeks and 3 months.

Table 10: Location information of ART for PEP in Sri Lanka during 2017

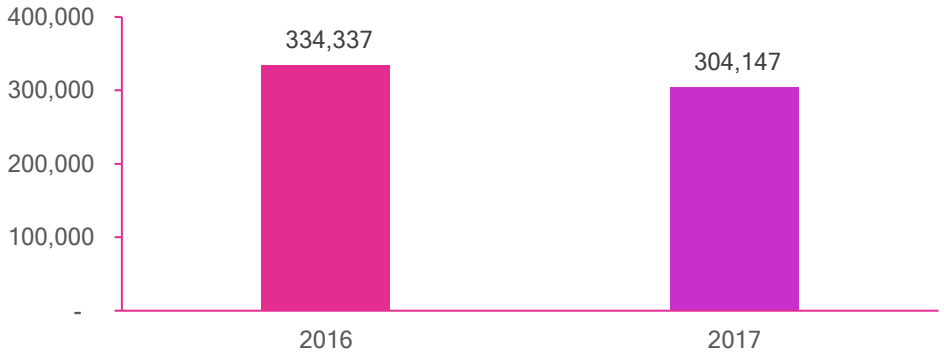
District	Institution	Unit of location	Contact Number
Ampara	DGH - Ampara	ETU	063 222 2262
Anuradhapura	TH - Anuradhapura	Medical ICU STD Clinic	025 2236461 Ext 700/701 0252236461
Badulla	PGH - Badulla	Ward 4 STD Clinic, Badulla	055 2222261 Ext.322 0552222578
Batticaloa	TH Batticaloa	STD clinic	065 2222261
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 4 A injection room	011 2693911-5 Ext.231
	TH- Sri Jayawardenapura	ETU	011 2802695-6 Ext.3018, 3019
	TH- Kalubowila	ETU STD Clinic, Kalubowila	011 2763261 Ext.277 0114891055
	National institute of mental health	Pharmacy	011 2578234-5 Ext.222
	BH- Angoda (NIID)	Infection control unit	011 2411284 Ext.264
Galle	TH - Karapitiya	ETU STD Clinic, Mahamodara	091 2232250 Ext.7813 091 2245998
Gampaha	TH - Ragama	Surgical ICU STD Clinic-Ragama	011 2959261 0112960224
	DGH - Gampaha	Primary care unit(PCU) Gampaha STD Clinic	033 2296897 Ext.112, 113 033-2234383
	DGH - Negombo	MICU	031 2222261, Ext.104
	National hospital for chest diseases-Welisara	OPD/ETU	011 2960509
	DBH - Wathupitiwala	ICU STD Clinic - Wathupitiwala	033-2280261 033-2280261
Hambantota	DGH - Hambantota	PCU STD Clinic-Hambantota	047 2222247 047-2222247
Jaffna	Teaching hospital Jaffna	ETU STD Clinic	021 2222261 021-2217756
Kalutara	GH - Kalutara	Accident and emergency unit STD Clinic - Kalutara	034 2222261, Ext.250 034-2236937
	BH - Panadura	ETU	038 2222261, Ext.243
	BH- Horana	Theatre	034 2261261, Ext.319
Kandy	TH- Kandy	ETU STD Clinic	081 2233338, 0812234208 081-2203622
	BH - Gampola	ETU	081 2352261

District	Institution	Unit of location	Contact Number
	DBH- Teldeniya	ETU	081-2374055
	BH - Nawalapitiya	ETU	054 2222261
Kegalle	TH- Kegalle	ETU STD Clinic	035 2222261 035-2231222
	BH - Mawanella	ETU	035 2247835
	BH - Karawanella	ETU	036 2267374
	BH - Warakapola	ETU	035 2267261
Kilinochchi	BH -Kilinochchi	ETU STD clinic	021 2285329 021-2283709
Kurunegala	TH - Kurunegala	STD Clinic	033-2224339
Matale	STD clinic - Matale	STD clinic	066 2053746
Matara	DGH - Matara	ETU STD Clinic	041 2222261, Ext.161 041-2232302
Monaragala	DGH Monaragala	Primary care unit STD Clinic, Monaragala	055 2276261, Ext.215, 213 055-2276826
Mullaitivu	DGH hospital	STD clinic	021 2061412
Nuwara Eliya	GH Nuwara Eliya	OPD STD Clinic, Nuwara Eliya	052 2234393 052-2223210
	DBH Dickoya	OPD	051-2222261
	BH Rikillagaskada	OPD	081-2365261
Polonnaruwa	GH- Polonnaruwa	ETU STD Clinic	027 2222384 027-2225787
Puttalam	DGH Chilaw	PCU STD clinic, Chilaw	032-2223261 032 2220750
Ratnapura	PGH - Ratnapura	ICU STD Clinic, Ratnapura	045 2225396, Ext.225, 337 045-2226561
	BH - Embilipitiya	OPD STD Clinic	047 2230261 No contact number
Trincomalee	GH Trincomalee	ICU STD Clinic	026 2222261 0262222563
Vavuniya	DGH, Vavuniya	ETU STD Clinic	024 2224575 024-2224575

9 CONDOM PROMOTION

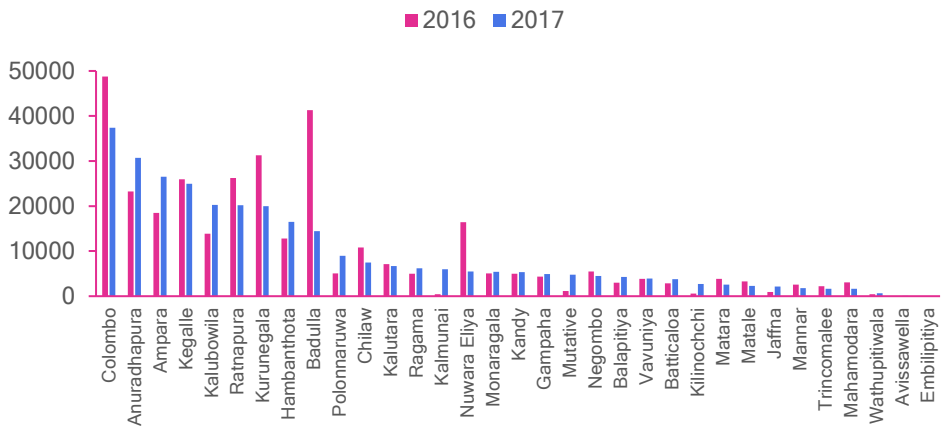
There are many players who promote condoms in the country for different purposes. The main objective of NSACP to promote condoms is to prevent STIs including HIV. Family Health Bureau (FHB) promotes condoms as a family planning method. Private sector players promote condoms on commercial basis, nevertheless, contribute to above stated both sexual and family planning objectives. NSACP promotes condoms through its network of STD clinics and peer-led targeted intervention programmes among Key populations.

Figure 51: **Number of condoms distributed by STD clinics, 2016 & 2017**



Above graph shows the number of condoms distributed by STD clinics during 2016 and 2017. During 2017, a total of 304,147condoms had been distributed by STD clinics. Colombo, Anuradhapura, Ampara, Kegalle, Kalubowila, Ratnapura and Kurunegala clinics had distributed over 20,000 condoms during 2017. There is a 9% less condom distribution during 2017 compared to 2016. However, STD clinics in Ampara, Anuradhapura, Kalubowila, Kalmunai, Polonnaruwa, Hambanthota, Mutative and Kilinochchi had distributed more condoms during 2017 compared to the previous year.

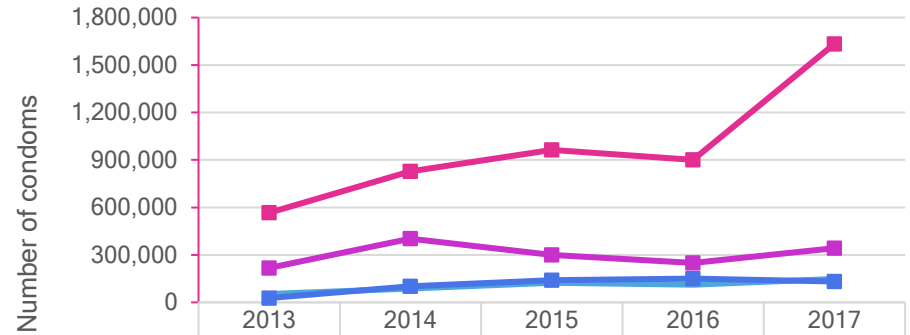
Figure 52: Number of condoms distributed by all STD clinics 2012-2017



Condom promotion through peer-led targeted interventions

Following graph shows the number of condoms distributed to Key population through peer-led targeted intervention programmes supported by Global Fund. A significant increase of condom distribution is seen among female sex workers. Condom distribution for men who have sex with men (MSM) and other Key populations remains rather static during last 5 years

Figure 53: Number of condoms distributed to key populations 2013 – 2017



	2013	2014	2015	2016	2017
FSW	566,439	828,460	964,244	900,306	1,633,514
MSM	217,738	402,509	299,127	250,128	343,457
Beach boys	52,972	87,845	123,673	111,939	148,121
Drug users	27,411	102,142	140,400	150,330	131,831

10 EMTCT OF SYPHILIS & HIV

During the year 2017 the elimination of mother to child transmission (EMTCT) of syphilis and HIV programme was further strengthened. By end 2016, universal screening of pregnant mothers for syphilis and HIV was in place covering all 25 districts in the country. EMTCT services were provided through partnership of STD and MCH services.

Figure 54: Antenatal screening for HIV and syphilis

The path to submission of the request for validation of EMTCT programme was identified as follows.

1. Setting up a national validation committee
2. Formation of the advisory committee
3. Formation of four working groups for four main domains
4. Review of the programme by external consultants
5. EMTCT report preparation
6. Request to regional office and submission

It was decided to work on these steps during the years 2017 and 2018.

The National Steering Committee members were identified as the members of the national validation committee as well. Advisory Committee was formed under the chairmanship of Hon. Minister of Health, Nutrition and Indigenous Medicine Dr Rajitha Senaratne on 28.8.2017. The main task of the advisory committee is to guide, support and facilitate the validation process.

Four Working groups were established for four main domains that is treatment and care services, Laboratory, Data management and Human rights. The following coordinators were identified to lead the working groups.

- Treatment and care services: Dr Lilani Rajapaksa, Dr Irosha Nilaweera
- Laboratory Dr Jayanthi Elwitigala, Dr Loshan Munasinghe
- Data management : Dr K.A.M. Ariyaratne, Dr Kaushalya Kasturiarachchi
- Human rights : Dr G. Weerasinghe, Ms. K. Thalaisingham

The working groups met regularly and improved respective domain areas while working on developing the main chapters for the country report. A two-day residential workshop was organized at Citrus Hotel, Waskaduwa on 11th and 12th of November, 2017 to finalize the chapters done by four main domains. All consultants attached to NSACP and provinces and two local WHO consultants participated at the meeting.

Figure 55: Members of the working groups of EMTCT validation programme

Technical Support

On request of NSACP, WHO facilitated the visit of two Thai experts to review the EMTCT programme on data management and laboratory aspects. The two consultants reviewed the EMTCT programme from 22nd to 24th of May 2017. The recommendations were to request for elimination of congenital syphilis by 2018 as there is satisfactory data. As the island wide coverage of EMTCT services for HIV were reached only in 2016, it is important to look at data in 2017 and 2018 to apply for validation of EMTCT of HIV programme.

WHO supported the EMTCT programme by identifying senior Consultant Venereologist, former WHO regional advisor to HIV programme/*SEARO* region, Dr Iyanathi Abeyewickreme to review the EMTCT programme to understand the readiness for validation process.

Prof A. Pathmeswaran was identified by the WHO to write the country report. Finalized documents were used by the two consultants to develop the reports.

Validation process

In the initial stages of EMTCT programme more emphasis was placed on increasing coverage of HIV testing among pregnant women. By the end of 2016 country wide coverage was achieved. In the year 2017 the validation process was introduced to MCH and STD staff. Validation process was formally launched on 27.6.2017 in the presence of a large gathering including health care workers of maternal and child health and STD services, ministry officials, provincial health staff, UN agencies and PLHIV and other key populations.

District monitoring teams were formed under the leadership of the regional authorities, Venereologists and MO-MCH of the district. The district teams met regularly to review the progress of the EMTCT programme in the districts. Provincial reviews under the chairmanship of PDHS of the province were held in all nine provinces during the months October and November 2017. These meetings gave opportunity to understand the progress of the EMTCT programme and also identify the challenges and steps forward. The support extended by the provincial and district authorities and MO MCH has to be appreciated.

Guidelines

Guidelines and circulars were distributed among RDHS, PDHS, MO/MCH and VOG to make them aware of the EMTCT programme.

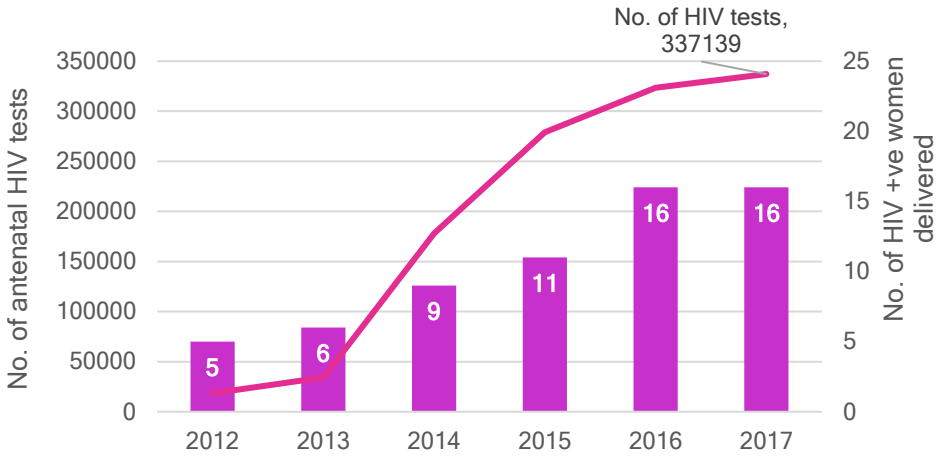
MCH guide was printed in English to train MCH and STD staff to provide the services in a uniform manner. This includes the check list for supervisory visits as well. Sinhala and Tamil translations are being printed.

The leaflets and posters were reprinted to be made available to 365 MOH offices island wide.

A rapid assessment survey was done in the post-natal units of major tertiary care units to understand the coverage, quality and accessibility to EMTCT services.

A. Mother to child transmission of HIV

Figure 56: ANC HIV tests and no. of HIV seropositive women delivered



Sixteen (16) HIV positive women delivered during 2017. Of these 6 were known HIV positive women on ART. Ten were newly diagnosed during antenatal screening. All 16 infants were started on nevirapine prophylaxis and early diagnostic tests were arranged including RNA PCR at birth and DNA PCR at 8 and 16 weeks. All babies born to mothers who received EMTCT services for HIV, reported negative results.

Children living with HIV: In the year 2017, three children were identified including a 5 month old infant from the district of Matale. This baby was born in 2016. Matale started EMTCT of HIV services in late 2016 and was the last district to start these services in the country. The infant and the mother were started on ART immediately. Other two were from Matale (4years) and Anuradhapura (two and half years).

Early infant diagnosis: The services for early infant diagnosis were continued with RNA PCR testing at birth done at reference laboratory NSACP and DNA PCR done at 2 and 4 months after delivery. Up to end 2017, DNA PCR testing facilities were provided by NARI, India. Establishing DNA PCR testing at the reference laboratory NSACP is another step forward in the march to reach elimination status.

Training of health care workers

Health care workers of STD clinics, MCH staff and institutional staff were trained to improve capacity to provide EMTCT services. Health care workers providing antenatal, natal and postnatal services of main hospitals in Kurunegala, Hambantota, Matale, Nuwara Eliya, Kegalle, Kalmunai, Colombo, Gampaha, Monaragala, Kalutara, Puttalam, DMH, Polonnaruwa and Chilaw were given training to improve services and to introduce the validation process. In addition the field MCH staff were given training opportunities in Monaragala, Matara, Colombo CMC, Gampaha, Kalutara, Galle, Kandy, Puttalam, Kurunegala, Avissawella, Badulla, Matale, Nuwara Eliya, Jaffna and Kilinochchi districts.

UNICEF provided funds of Rs. 2,245,185 in 2017. UNICEF funds were used for capacity building, advocacy, provincial reviews and mass media campaign in radio

and TV. MCH guide was printed and safety kits were purchased. A symposium was organized by the Sri Lanka College of Sexual health and HIV medicine in collaboration with Colleges of Obstetricians and Pediatricians. UNICEF supported the media campaign in October and November through TV and radio commercials by spending Rs. 3.1 million for media campaign for 2 months. The media campaign was started in October to coincide with the World Children's day activities.

TV commercials (10 seconds) were aired during prime times in ITN and Vasantham channels while through SLBC, radio commercial (30 second) was broadcasted in ten channels including provincial channels giving a wide coverage to the EMTCT programme.

WHO supported the programme throughout by providing technical experts. Two external consultants were invited to review the programme in May 2017. External review of ART and EMTCT programmes were reviewed by the experts provided by WHO. Further, WHO identified two local consultants to facilitate validation process.

Media campaigns

In response to the request of the NSACP to media organizations many media institutions came forward to take the message to the general public on EMTCT of HIV and syphilis in Sri Lanka. In addition prime time in television channels Rupvahini, ITN, Derana and Radio SLBC were given free to make people aware on elimination of mother to child transmission of HIV and syphilis programme.

Newspaper articles in The Nation, Rivira, Tharuni, Sunday Observer and Sunday Times provided awareness on the EMTCT programme. Media campaigns organized for the World AIDS Day programmes in December too highlighted the EMTCT services and the validation process.

Private hospital survey

EMTCT of HIV and syphilis in the private sector had to be strengthened. This issue was raised in Private Sector Regulatory Council in September. According to the DHS survey MCH services in the country was satisfactory with >99% receiving ANC services and delivering in an institution. According to the DHS survey only 5.4% of deliveries take place in the private sector and most of the private sector deliveries were reported from Colombo, Gampaha and Kalutara. As most of these deliveries occur in 10 major private hospitals in Colombo, a survey was carried out by the epidemiology unit/NSACP to understand the coverage of HIV and syphilis testing among women receiving ANC services in these hospitals. Many areas which needs strengthening were identified. This survey created interest in EMTCT programme and private sector staff were trained through many programmes organized by NSACP and private hospitals. The circulars and relevant material were sent to private sector hospitals and Obstetricians.

Introduction of the validation process to key populations and PLHIV groups

In collaboration with Sri Lanka Family Planning Association, several meetings were organized to make key population groups and PLHIV aware of EMTCT services available in Sri Lanka. This opportunity was used to introduce the validation process of EMTCT programme as well.

To improve the awareness of EMTCT programme among STD clinic staff, a poster competition was held. Epidemiology unit of NSACP won the first place while STD clinic, Colombo and Hambantota won second and third places respectively.

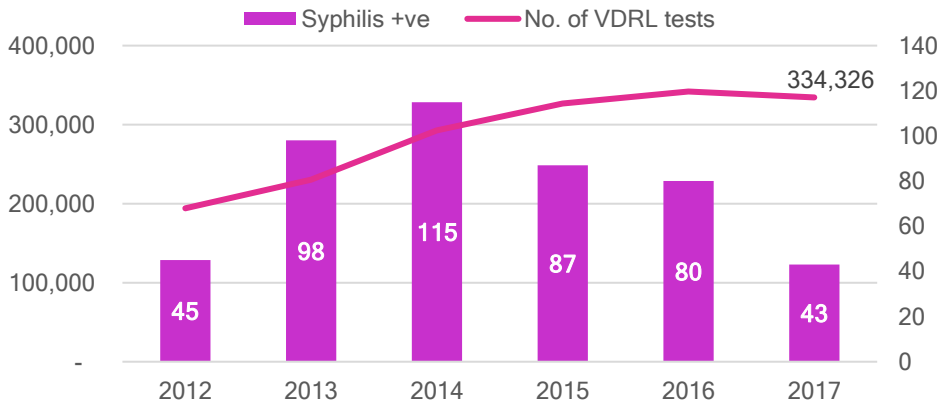
Multi-disciplinary approach

Throughout the year the support extended by all relevant parties starting from the MOH, FHB, Provincial authorities, Tertiary care hospitals as well as NRL and STD clinics has to be commended. Ministry of Health was the main sponsor of the programme and UN funding agencies such as UNICEF and WHO supported to further strengthen the programme in 2017.

B. Mother to child transmission of syphilis

In 2017 there was a marked decline of pregnant mothers identified with syphilis. Only 43 pregnant women were identified which is half of the number identified in 2016. All these mothers received appropriate services and their partners and babies were managed as well.

Figure 57: VDRL tests and syphilis positives among antenatal women



EMTCT programme aimed to reach identified targets by the end of 2017 and all these targets could be achieved. End of 2017 signifies reaching elimination targets. Sustained efforts through 2018 will qualify Sri Lanka to request for validation of EMTCT of HIV and syphilis status. The need of the hour is further strengthening the programme in the year 2018 aiming at the validation process.

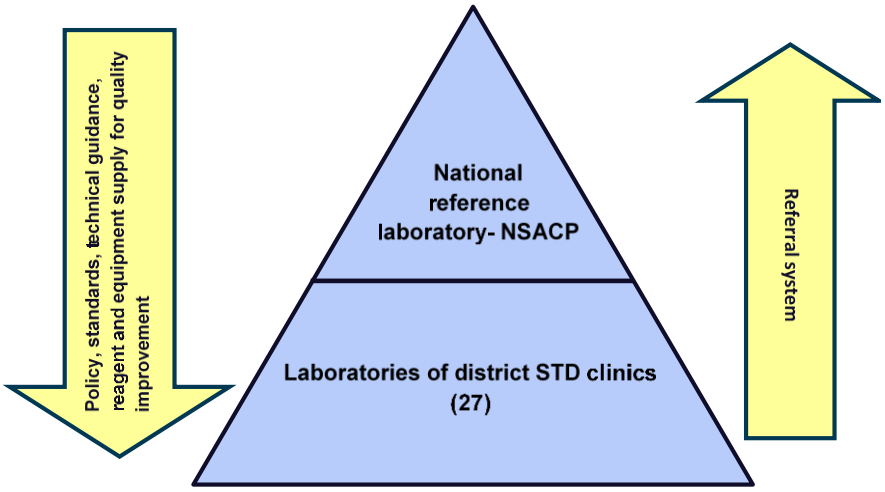
11 LABORATORY SERVICES

The laboratory services of National STD/AIDS Control Programme are provided by the National Reference Laboratory (NRL) of NSACP and by 27 laboratories of the peripheral STD clinics. These laboratories work in a network fashion and NRL is the focal point. The NRL provides technical guidance to these laboratories in diagnostic and monitoring services for sexually transmitted infections and HIV.

The range of laboratory services extend from the detection of sexually transmitted infections and HIV to monitoring and evaluation of the clinical management of patients. In addition, biochemical and hematological tests are also provided by the NRL for People living with HIV (PLHIV).

The laboratory is expected to work towards the accreditation with the intention of maintaining its standards especially for EMTCT validation procedure. Infrastructure and human resources are big challenges in improving the quality management system of laboratories. These restrictions are big hindrances to the journey towards accreditation.

Figure 58: Laboratory network of NSACP and district STD clinics



There are 27 STD clinic laboratories in the country distributed with one or more laboratory per district. All the laboratories are located in the STD clinics of the relevant districts.

Distribution of Testing Facilities for Diagnosis and Monitoring of STI and HIV.

- Tests in use for screening of HIV (ELISA, Particle agglutination and rapid strip tests) are performed by the laboratory on routine basis. The ELISA technique was introduced to ten (10) new STD laboratories in year 2017 (Ampara, Balapitiya, Batticaloa, Kalmunai, Matara, Galle, Monaragala, Kilinochchi,

Kurunegala and Hambanthota). By the end of 2017, all the STD clinics laboratories were capable of performing screening tests for Syphilis and HIV.

- The confirmatory test for HIV is performed only in the National Reference Laboratory of NSACP (NRL). In order to improve the case detection and diagnosis of HIV in the country, NRL provides HIV confirmation services to National blood transfusion service and to private sector laboratories, free of charge.
- The decentralization of HIV viral load testing and CD4 testing to three STD clinics was done in 2017 with the view of facilitating management of people living with HIV at peripheral STD clinics other than the NSACP. This facilitates the easy access to the patients. CD4 testing facilities were established in STD clinics, Galle and Kandy. Viral load testing facility was established with two Gene Expert machines in STD clinic Galle and Anuradhapura.
- 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 Central STD clinic and few other district STD clinics where adequate facilities are not available to diagnose STDs.

Figure 59: HIV screening and Western blot tests done at NRL, 2013-2017

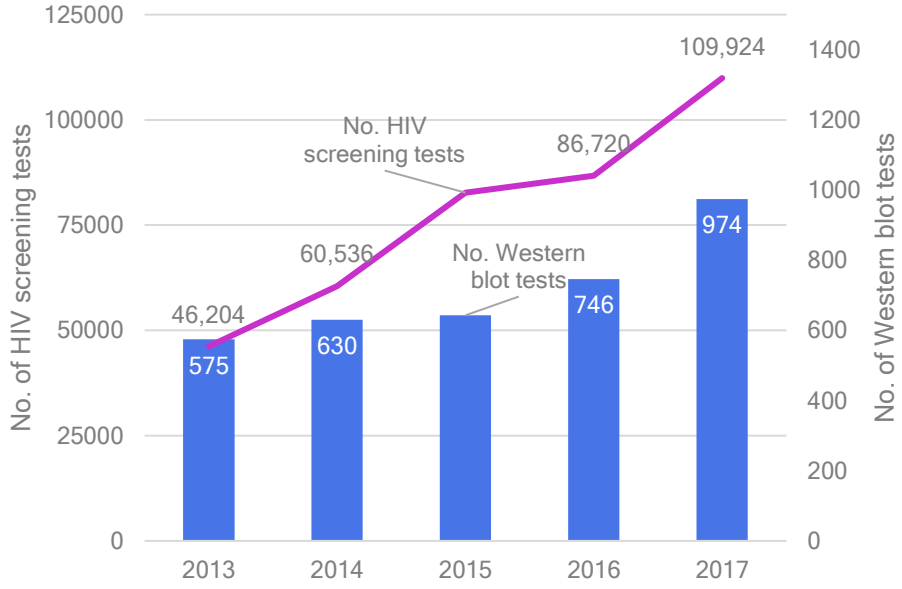


Figure 60: Distribution of testing facilities for STI and HIV as of end 2017

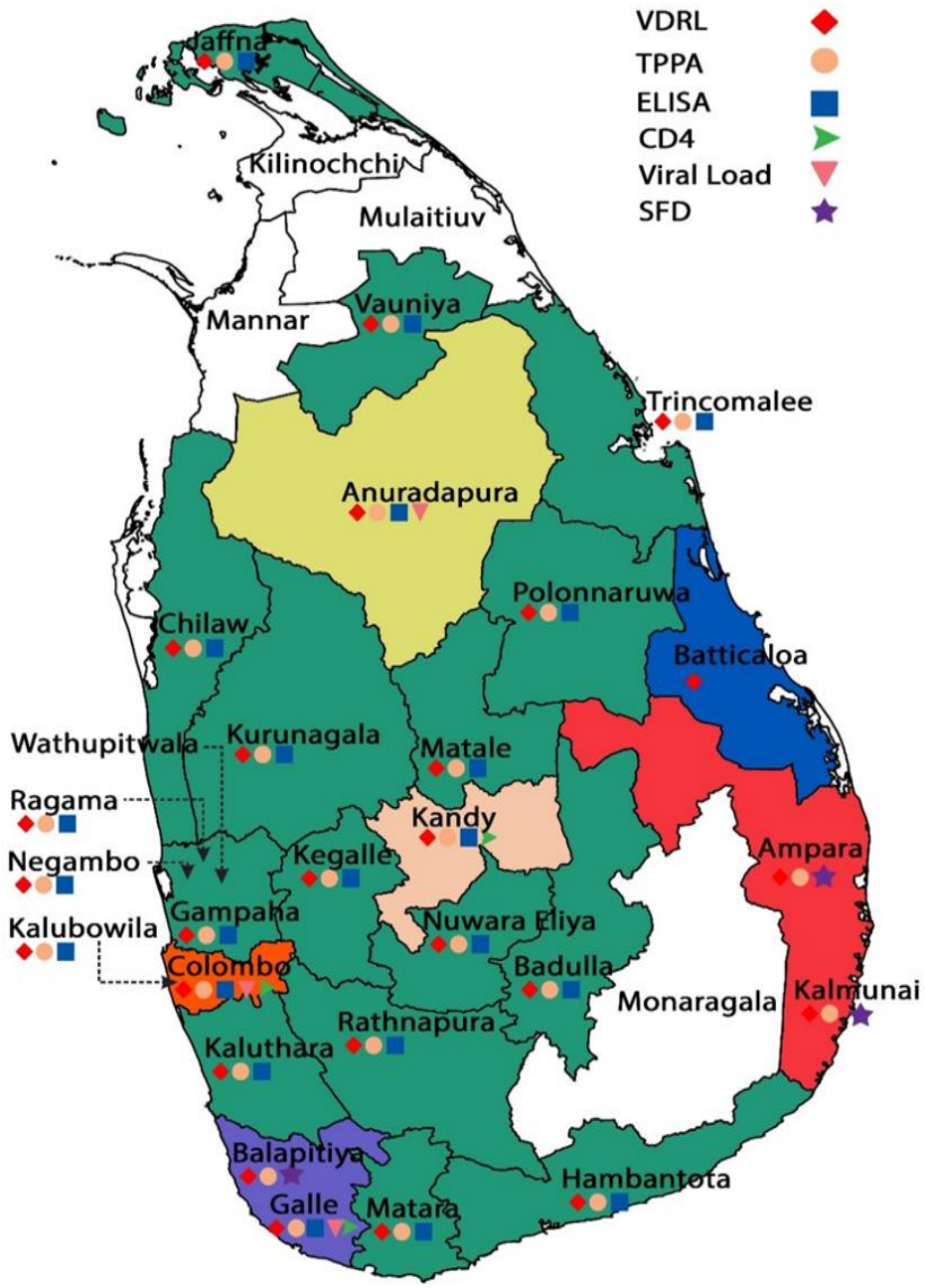
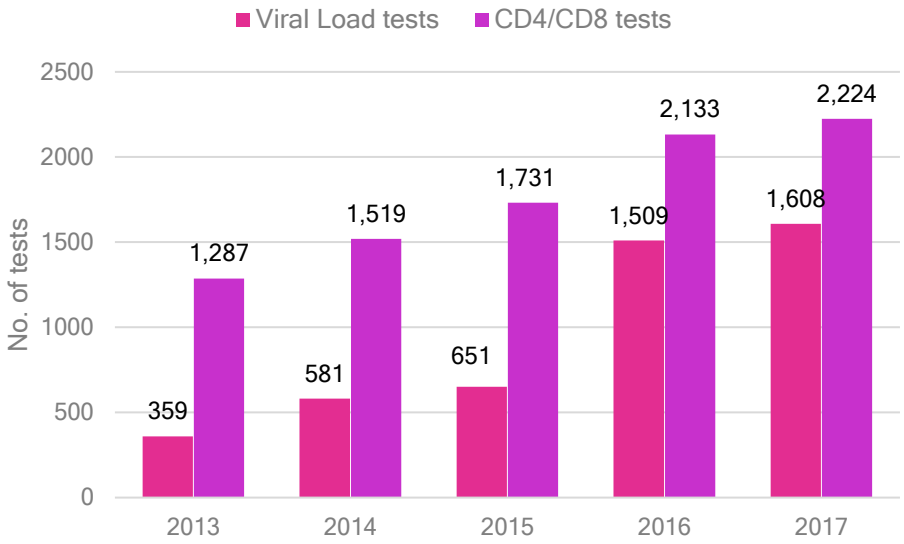


Figure 61: Viral load and CD4 assays in 2014-2017



New developments in testing

- Establishment of HIV DNA PCR testing at NRL:

  In 2017, NRL established the facility to provide HIV DNA PCR testing to diagnose HIV infection in infants younger than 18 months. This facility was not available in the country earlier.
- Establishment of HSV and chlamydia PCR testing:
- HIV drug resistance testing:

  In 2017, 51 samples were tested for drug resistance. Since year 2015, services for HIV drug resistance testing are provided in collaboration with National AIDS Research Institute of India.

Laboratory validation for elimination of mother to child transmission of HIV and syphilis (EMTCT)

Scaling up EMTCT programme for syphilis and HIV require testing of antenatal mothers country wide. Improved testing is the corner stone of detecting the mothers in early pregnancy leading to prevention of mother to child transmission of HIV. The infected mothers can correctly be identified only by improving the quality of testing. To improve the quality of testing it is very important to improve the quality management system of the laboratories. Therefore, the NRL and the peripheral STD laboratory network are working towards the Validation of EMTCT of HIV and syphilis. In this journey, NRL has to work hard to overcome the major obstacles like changing attitudes, infrastructure development and system establishment.

Existing situation and major challenges faced

Inadequacy of human resource has been identified as a main barrier to improve the quality management system of the laboratories. Therefore, NRL is working in collaboration with Ministry of Health to complete the cadre of technical staff of NRL and peripheral STD clinics. Until the entire cadre positions are filled, NRL mops up the testing of STD clinics where MLT staff is not available. Certain other STD clinics are also providing support for the neighboring districts. e.g. Badulla

Equipment for laboratories necessary for STI and HIV screening

It is necessary to equip the laboratories with essential equipment for screening of Syphilis and HIV. A situational analysis of equipment was performed in year 2016 and 2017 with a view to fulfill the gaps.

In year 2017 equipment procurement through the GOSL funds and GFATM funds was carried out in this regard. Ten ELISA machines were given with many other accessories to ten STD laboratories in year 2017 i.e. Ampara, Balapitiya, Batticaloa, Kalmunai, Matara, Galle, Monaragala, Kilinochchi, Kurunegala and Hambanthota.

Laboratory quality management

Reinforcement of laboratory quality management system is in process and all laboratory staff were trained for maintenance of a good quality management system in their relevant laboratories. A series of workshops were conducted to train the STD laboratory staff on requirements of EMTCT laboratory validation process. The consultant/MOIC of the STD clinics together with the MLT and the PHLT were invited for these workshops with regard to improvement of laboratory quality. Two workshops were conducted in collaboration with the external consultants from India as well.

On site evaluation of peripheral STD laboratory

The aim for the onsite supervision of peripheral STD laboratories is to assess lab components critical for EMTCT of HIV and Syphilis prior to external validation.

The objective is to verify the existence of good quality systems, an adequate lab network to provide the services needed to achieve and maintain a programme for EMTCT of HIV and Syphilis. This activity will ensure that the results generated by the lab network are accurate and reliable.

Therefore, onsite evaluation of peripheral STD Clinics was started by a team of NRL including the Consultant Microbiologist, Medical staff and technical staff. Supervision of STD laboratory of Ragama, Gampaha, Balapitiya and Matara is already completed. The laboratory staff were informed of the strengths and weaknesses. Support was given on site to overcome the certain difficulties and also highlighted

the correct practices observed at the lab. Feedback from peripheral STD clinic for this activity was positive and they all were very supportive.

Outreach HIV testing

- In the path for ending AIDS by 2025, NRL successfully managed to introduce HIV antigen /antibody rapid test (combo test) for the first time in Sri Lanka.
- The Staff of the NRL gave their contribution to the entire outreach programme of NSACP to enhance the HIV testing services for outreach testing at community level.

HIV and STI 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 surveillance.
- The surveillance programme of prison and drug resistance is totally supported by the NRL and the district STD laboratories in routine basis.

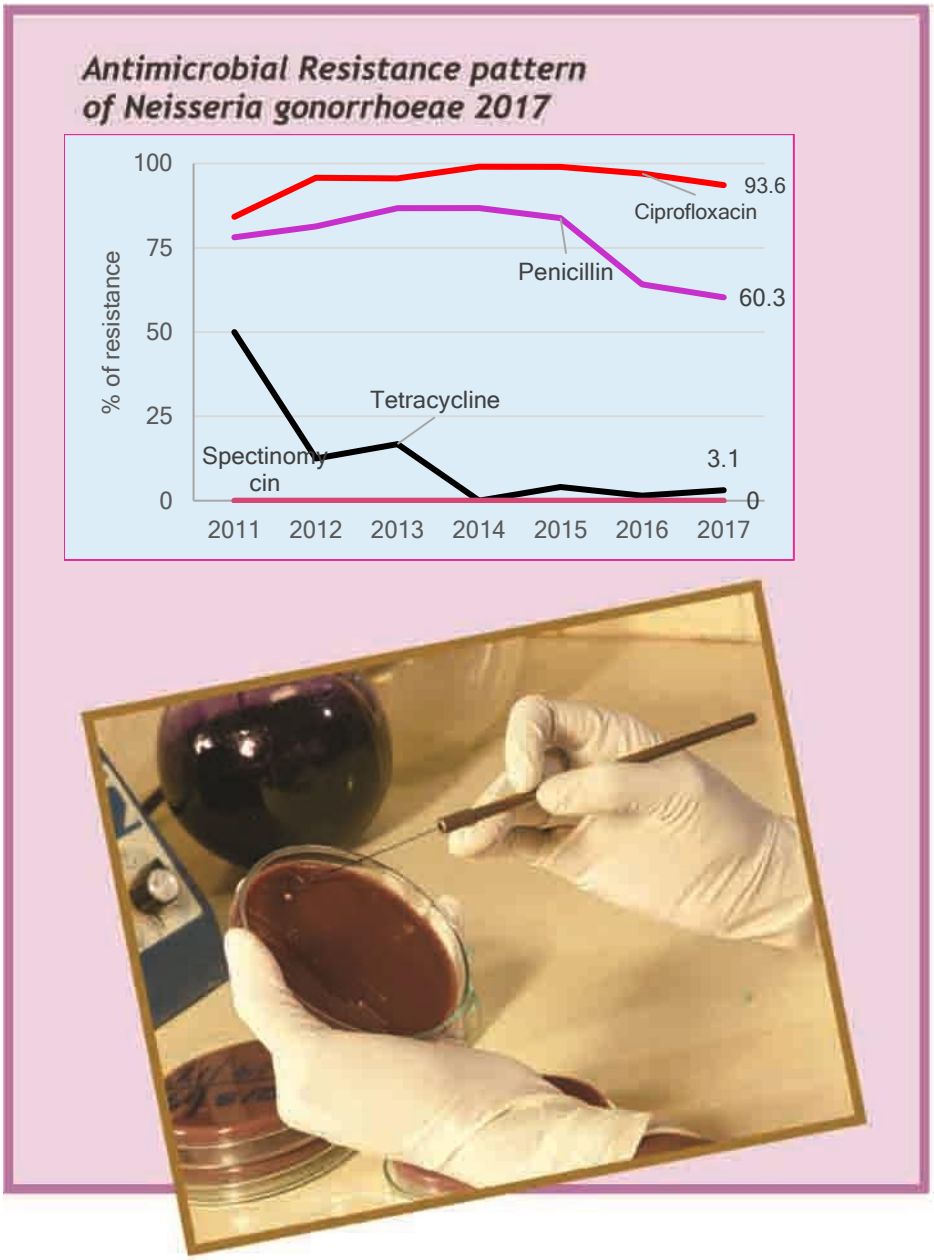
Strengthening of the external quality assurance (EQA) programme of HIV and Syphilis

- The National Reference Laboratory participates in the EQA twice every year for HIV screening and confirmatory testing conducted by the NRL for HIV of Australia to maintain the high quality of testing.
- Proficiency testing for syphilis serology is with Center for Disease Control Atlanta, USA and is performed once in every two months.
- The EQA for Gonococcal Antimicrobial 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.
- The EQA for microscopy services are provided by the NRL on a monthly basis to the peripheral STD laboratories.

Towards the accreditation

- Quality improvement and scaling up of the laboratory system towards the accreditation is the main challenge. NRL is working towards the accreditation with technical assistance of CDC/ CMIA India with PEPFAR support. In May 2017, 2 external consultants from WHO visited the lab to assess the lab system for EMTCT preparation. In August 2017 a Laboratory assessment was done in NRL by CDC/PEPFAR team and report dissemination on situational analysis was done on November 2017.A team of laboratory staff from NSACP and peripheral STD clinic laboratories were trained at CMC Vellore, India for laboratory quality improvement in September 2017. A laboratory quality manager and laboratory safety officer was identified from NRL technical staff and Laboratory development committee was established.

- A team of laboratory personal who engage in EQA programme underwent training on ISO 17043 at New Delhi, India. According to that External Quality assessment programme conducted by NRL on HIV serology, syphilis serology twice a year for all STD clinics laboratories will be strengthened and improved.
- Regular management meetings for accreditation has been arranged and carried out.
- Quality manual, sample collection manual, quality standard procedures and standard operating procedures (SOP) are currently under development.
- Calibration of equipment is achieved at NRL. This will be extended to the peripheral clinics as well.



12 CDC SUPPORT TO NSACP

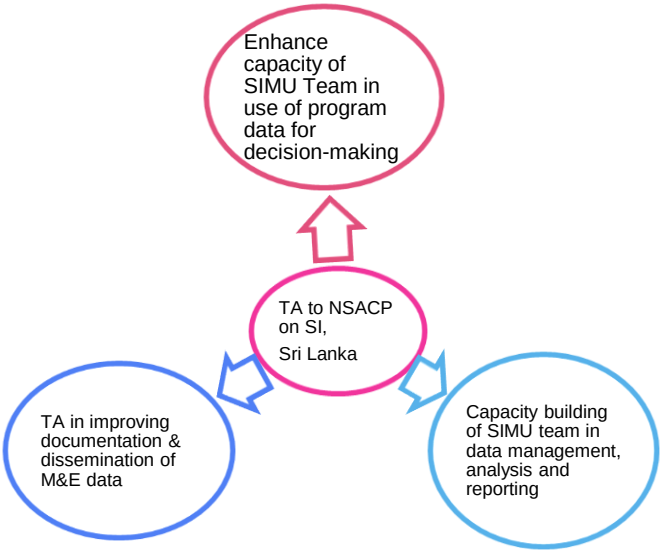
The President's Emergency Plan for AIDS Relief (PEPFAR) is a United States governmental initiative to address the global HIV/AIDS epidemic. PEPFAR and Centers for Disease Control and Prevention (CDC) have been working with Ministries of Health to accelerate countries' efforts to optimize the quality, coverage, and impact of the national HIV/AIDS, towards achieving the goal of ending AIDS by 2030. PEPFAR and CDC, not only support collaboration within countries, but also support inter-country collaboration between neighboring countries to facilitate mutual learning, knowledge sharing and co-creation of innovative approaches, so that the partnering countries are benefitted. CDC brings with the power of best practices gleaned from PEPFAR's engagement with 50 host countries over the past 14 years.

A. Technical assistance for Strategic Information Management

Figure 62: Meeting between CDC teams and DGHS, MoH Sri Lanka

CDC/India through its cooperative implementing partner, the Voluntary Health Services (VHS), Chennai is extending Technical Assistance (TA) to strategic Information management of NSACP. The overall goal of the project is to strengthen the National HIV/AIDS response in Sri Lanka by facilitating technical cooperation in the areas of laboratory, strategic information and prevention.

Figure 63: Key component of the TA on SIM



Through a situational assessment, CDC, VHS-CDC project and NSACP jointly identified the following specific areas of technical assistance for Strategic Information Management.

I. To enhance the capacities of in-country Strategic Information Management (SIM) unit team in use of program data for decision making and dissemination.

II. To further improve the capacity of the SIM unit in data management, analysis and reporting.

III. Strengthen capacity of SIM unit team in data use, documentation and dissemination at national, regional and global levels.

This strategic technical assistance will primarily adopt key approaches like trainings, mentoring, exchange visits, knowledge exchange, consultations, expert guidance, documentation, dissemination etc.

NSACP facilitated for signing of a letter of intent (LoI) between Ministry of Health, Govt. of Sri Lanka and CDC/DGHT (Division of Global HIV & TB) - India for undertaking technical collaboration initiatives for strengthening SI systems.

The VHS-CDC project in collaboration with SIM unit – NSACP has undertaken strategic TA related activities such as,

- Development of concept note on PEPFAR supported HIV/AIDS TA to NSACP highlighting the overall TA plan, execution plan, coordination plan, etc.
- Development of situation assessment of SIMS under NSACP, strategies and approaches of TA to SI under NSACP.
- Development of a comprehensive dashboard indicators on STD/HIV/AIDS.
- Sharing India experiences on Inventory Management System (IMS) and demonstrated the PLHIV-ART Linkage System (PALS) with SIM unit and EIMS development team for integrating in the software development.

- Sharing the resource materials to SIM unit for reference and incorporating needful methods in the planned activities such as: IBBA study, Mapping of MARPs and HSS.
- Supporting participation, presentation in the Australasian sexual health and HIV/AIDS conference.
- Facilitating an exposure visit to the Clinic 275 of South Australia.
- Developing plan for facilitating GEV to observe Regional Best Practices on SI.
- Continuous interactions and coordination with SIM unit team.

For facilitating capacity building, knowledge transfer and system strengthening, VHS-CDC project in collaboration with SIM unit-NSACP is in the process of undertaking Training Need Assessment, documenting best practices on M&E system in NSACP for dissemination at national and international level, updating M&E manual to align with national strategic plan, updating the website with special features on dashboard, infographics and interactive. VHS-CDC project is also working closely with SIM unit team in NSACP for building the capacities of SIM unit team, developing M&E operational plan, facilitating exposure visits, TA on improving documentation and dissemination of M&E data, further enhancing the capacities of NSACP on EIMS, use of social media for data dissemination, etc.

NSACP has also developed a plan for conducting quarterly review meetings for ensuring coordination between CDC, VHS and NSACP. VHS is closely working with the Coordinator-SIM, SIM unit team and senior management team of NSACP. VHS-CDC appreciates the support extended by SIM unit and NSACP in the process of technical collaboration initiatives. In the initial phase, VHS-CDC project has extended TA on LSS (laboratory systems strengthening) and initiated efforts in development of checklist for conducting a situational assessment to review the functioning of National reference laboratory and district STD clinic laboratories & branch STD clinic laboratories. VHS-CDC transitioned the activities related to TA on LSS to CMAI (Christian Medical Association of India), supported by CDC.

Figure 64: **Signing of the LoI between Secretary Health and CDC/India**

B. CDC Technical Assistance for Laboratory Systems

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) provides technical assistance to countries to maximize the quality, coverage, and impact of the national HIV/AIDS response. To facilitate mutual learning, knowledge sharing, and co-creation of innovative approaches, PEPFAR/CDC, India signed a Letter of Intent (LOI) with the Ministry of Health Sri Lanka, to provide technical assistance to the National STD/AIDS Control Programme (NSACP) on laboratory system strengthening. The implementing partner is Christian Medical Association of India (CMAI). The specific objectives are to provide technical assistance to strengthen the capacity of the National Reference Laboratory (NRL) and STI clinic laboratories under NSACP with a specific focus on Lab QMS as per ISO 15189 towards achieving accreditation for NRL, capacity building for molecular testing, EQAS provision to peripheral labs in compliance with ISO 17043 and strengthen lab data management and reporting.

Following milestones were achieved by this collaboration.

A. **Baseline review and gap analysis development of Strategic Action Plan**

The baseline review and gap analysis was conducted in July 2017 with the specific objective of establishing a baseline data, review the implementing structure and diagnostic services provided by the NRL and STD clinics, identify specific gaps, issues, challenges, and opportunities which are essential for formulating strategies and activities for technical assistance. The assessment was carried out using specific lab assessment tools for NRL and STD Clinic Laboratories by independent external assessors. Based on the findings, a strategic action plan was developed for implementation.

Figure 65: Dissemination of baseline assessment at NSACP

B. **Dissemination of baseline review and gap analysis**

The project team in collaboration with NSACP disseminated the baseline assessment findings on 13th of November, 2017. CMAI programme officials from NSACP and project staff attended the meeting. The key findings and the proposed areas of assistance were presented during the meeting. The panel discussion highlighted the need for improvement in infrastructure, human resources, capacity building, development of SOPs (standard operating procedures), equipment, Lab Management Information System (LIMS) and monitoring and supervision of laboratories.

C. **Training of Trainers (TOT) at Christian Medical College, Vellore, India**

Based on the identified training needs following the baseline review, Training was provided to selected NRL technical staff from NSACP which included hands-on training at Christian Medical College (CMC), Vellore on Quality Management Systems. The training was conducted from 18th to 22nd of September, 2017 jointly by Departments of Clinical Virology and Clinical Microbiology, CMC, Vellore with a focus on documentation, equipment calibration and maintenance, internal and external quality control procedures and basics of molecular biology.

D. **On-site training on QMS at NRL, Colombo, Sri Lanka**

A two-day training was conducted from 14th to 17th of November, 2017 for the NRL and 26 peripheral STI clinics staff. Following the training, an advanced level training on External Quality Assessment (EQA) was organized exclusively for NRL staff on 18th of November, 2017. In total, 21 medical officers, 38 MLTs, and 29 PHLTs were trained. The technical areas covered were document control, development of standard operating procedures, biosafety, equipment preventive maintenance, calibration, inventory management etc.

Figure 66: Launching of the situation assessment of lab systems

E. ISO training

A four-day training on management and technical requirements was conducted in New Delhi. The objective of the training was to enhance the knowledge and skills on designing and operation of EQA schemes, statistical methods, reporting and interpretation. Seven members from NRL and one Technical officer participated in the training which covered the key technical areas on requirements of ISO/IEC 17043.

F. Onsite mentoring support

The technical staff of the project provided mentoring and handholding support to NRL to address the specific gaps in documentation, preparation of Quality manual, Quality System Procedures and SOPs during 2018. Technical assistance was also provided to comply with QMS requirements.

G. E-learning through webinars

The project proposed to conduct six webinars on molecular techniques with the technical support of NIMHANS (National Institute of Mental Health and Neuro-Sciences), Bangalore and CMC, Vellore. Two webinars have been conducted on “Basics of molecular techniques” which provided a platform for the participants to interact and clarify their queries online.

13 MULTI-SECTORAL RESPONSE

Multisectoral response to HIV epidemic during 2017

Multi-sectoral unit coordinates and works in partnership with public, private, civil society organizations, and development partners. Multi-sectoral unit provides technical support for advocacy, capacity building, awareness and internalization of STI and HIV prevention activities for these institutions. It has its focus mainly on the activities conducted aiming the vulnerable groups which have been identified in the National HIV Strategic Plan. Multi-sectoral sub-committee meeting is conducted with the participation of stakeholders from relevant sectors.

Prison sector - HIV prevention programme

Prisoners are considered as a Key population. Prisoners are more likely to be living with HIV than adults in the general population. Life skill based education and health promotional activities are used in the prison sector programme to prevent HIV/AIDS and other sexually transmitted infections among the prison community in Sri Lanka.

New funding model of Global Fund supported the prison programme 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. On an average, 19,108 prisoners were occupying the prisons in Sri Lanka in a given day. Of these, 10,144 were convicted prisoners and the remaining 8,964 were remand prisoners. 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 four times during 2017. During year 2017 the NSACP has conducted several advocacy meetings for prison authorities.

Rehabilitation officers in all prisons were given one day refresher training on sexual health promotion for prisoners. Prison peer educators were trained by rehabilitation officers. A total of 3600 prisoners were trained in 30 prisons island wide.

HIV testing promotion in the prison setup

HIV testing was done according to the HIV testing guidelines for the prison setup. This guideline was circulated among both STD clinic staff and relevant prison staff prior to testing. Prison inmates volunteered for HIV testing after the formal and informal discussions carried out by peer educators. During 2017, thirty mobile HIV testing clinics were held every month by 20 STD clinics. The confirmed positive

cases were referred for treatment and care services at 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 2017, a total of 13,937prison inmates underwent voluntary HIV testing in the prisons. Of them, five (5) were HIV positive.

Prison health staff were trained on HIV rapid testing. From the central laboratory of National STD/AIDS Control Programme, 15500 rapid diagnostic test kits (HIV/ Syphilis duo) were distributed among STD clinics with the objective of increasing the number of prisoners being tested.

Prison HIV prevention, treatment and care policy

Fulfilling a long awaited requirement, National STD/AIDS Control Programme developed a policy on prison HIV prevention, treatment and care. This was done after several consultative meetings with stake holders and opinions were taken from international experts. The Global Fund supported this activity. The approval for prison policy has been given from both Health Ministry and the Prison Ministry. However, the policy has been forwarded to the Cabinet and still awaiting for approval. Meanwhile dissemination of the contents of prison HIV prevention, treatment and care policy was carried out for superintendents of prisons.

The main objectives of the Prison HIV prevention, treatment and care policy are as follows.

Prevent HIV among all prisoners and prison staff to ensure no new HIV transmissions occur in prison settings.

1. Enable prisoners to know their HIV status by promoting voluntary, confidential HIV counseling and testing and follow up
2. Provide access to treatment, care and support for HIV, hepatitis, tuberculosis and STI.
3. Preserve and protect the rights of people living with and affected by HIV.
4. Ensure the prison environment is conducive to promote and preserve the health of the prisoners and prison staff.
5. Conduct regular assessments to ensure the policy and programmes are effective.

HIV prevention via entertainment in prisons

Two hundred checker boards and 100 carom boards were purchased to distribute among all prisons in the county. In addition, stickers containing HIV testing promotion and stigma reduction messages were printed and to be distributed among all prisons. The objective was to promote HIV prevention through entertainment activities.

Armed forces - HIV prevention programme

Interventions for three Armed forces have been identified in the National HIV Strategic plan. The main objective of the Armed forces training was to promote HIV

testing, while promoting behaviour 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 2017, 153 armed force personnel were trained as trainers through these programmes. A sensitization programme for Army personnel who are in athletic care was conducted and there were a participation of 58 personnel.

All three armed forces carried out activities to commemorate the World AIDS Day 2017. The NSACP facilitated these initiatives by providing communication material (posters, banners and leaflets).

Police sector - HIV prevention programme

Police officers very often deal with most of the Key population groups. Even though implementing the existing law is part of their profession, it was emphasized the need of avoiding unnecessary harassments in order to protect the human rights of Key population groups. This will lead to a conducive environment and better access for healthcare services.

Three day programmes of training of trainers were conducted for police officers and 97 officers participated in two such programmes held during 2017. Both workshops were conducted by the participation of resource persons from NSACP and high ranking officers from police sector. During 2017, a training programme on HIV prevention among Key population was conducted for police officers in Hambantota district.

Figure 67: Police training sessions and launching of IEC material for migrant workers

Youth sector - HIV prevention programmes

The Youth Steering Committee for HIV prevention has recognized the need to take early action to prevent an HIV epidemic among youth. Three training of trainers programmes were conducted for island wide Youth Corps officers. A total of 109 Youth Corps trainees were trained during 2017.

Officers from the Youth Corps were given a three-day training and all necessary communication material were provided to carry out programmes by them 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 48 Youth Corps centers island-wide. A total of 12,000 youth are trained each year for career guidance by Youth Ministry. The selected officers were trained as trainers by the staff of Multi sectoral unit, using a training module. Sexual health has been incorporated into their regular training curriculum. In addition, the Multi sectoral unit facilitated special awareness programmes in all Youth Corp centers with the support of the respective medical officers. All these youths were given communication material on HIV prevention and leaflets regarding condoms.

Education sector - HIV prevention programme

National Institute of Education has taken initiatives for incorporating sexual health, within the subject of 'Health and wellbeing' for students who follow the vocational training stream (also called 13 years' compulsory education stream) since 2017. The subject area is covered under the topics of sexuality, overcoming sexual challenges, prevention of sexually transmitted diseases and HIV/AIDS. National Institute of Education arranged a training programme for capacity building among the school teachers to implement this curriculum.

The Women and Gender subcommittee of the parliament has recognized the need for age appropriate comprehensive sexual education for school children. As a result, Ministry of Education has developed a training module together with the other stake holders. Multisectoral Unit contributed to the module and had conducted training of trainers programme for teachers. A pilot project has been carried out in different educational zones in Colombo district at present.

Multisectoral unit involved the training of trainers programme of Health and Physical Education teachers in Ampara district, and fifty teachers were trained through this programme during 2017.

Migrant sector - HIV prevention programme

According HIV case reporting system of NSACP, a significant proportion of people living with HIV give a history of external migration during past few years. Therefore, carrying out HIV prevention activities among migrant worker population was

identified as a priority area. Sri Lanka Foreign Employment Bureau (SLFEB) is working in collaboration with NSACP in HIV prevention services.

The training module which was developed to promote sexual health among female migrant workers was translated into both Sinhala and Tamil languages, and printed during 2017. Development and printing of IEC materials (HIV testing leaflets and small folders on HIV/AIDS) for migrant men and women were done. USB Pen drives and display folders with messages for migrant men were developed. Those IEC materials were handed over to training of trainers of SLFEB.

Tourism sector - HIV prevention programme

Sri Lanka has been identified as one of the most popular tourist destinations in the world and more than two million tourists have arrived here during 2017. According to World Health Organization, travel and tourism may enhance the probability of having sex with casual partners and increase the risk of contracting sexually transmitted infections including HIV/AIDS. Country's popularity for sex tourism also has been identified as a risk factor which could potentially increase the rate of HIV transmission within the country. Hence, 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.

Two consultative workshops for training of trainers among tourist professionals on HIV prevention were conducted for 36 participants, who provide training to young professionals entering tourism industry in collaboration with Sri Lanka Institute of Tourism and Hotel Management (SLITHM).

A HIV/STD risk assessment among officially registered tourist guides was started and a part of it was completed, using a qualitative study. Meetings with guide associations on HIV prevention in tourism sector were held with funding from tourism sector.

Several IEC materials, including 100 USB Pen drives and 500 copies of handbooks titled 'Prevention of HIV and AIDS for lecturers in the Sri Lanka Institute of Tourism and Hotel Management 2017', large folders, posters, HIV testing stickers, condom promotion stickers in Sinhala, English, German and Russian languages were distributed within the tourist sector.

HIV programmes for Child Protection Officers

Training of trainers programme on sexual health promotion for behavioural change communication among district coordinators of Child Protection Authority was conducted for 50 participants. A two-day consultative workshop on prevention of HIV for training of trainers among 44 child protection officers was also conducted in 2017.

14 USAID SUPPORT

The Government of Sri Lanka (GoSL) and the United States Agency for International Development (USAID) launched a two-year, HIV/AIDS Technical Assistance Partnership to support the goal of Ending AIDS by 2025. During the launching, a Letter of Intent (LoI) was signed by Mr. Janaka Sugathadasa, Secretary, Ministry of Health, Sri Lanka, Mr. Andrew Sisson, Mission Director, USAID/Sri Lanka and Mr. Mark Anthony White, Mission Director, USAID/India to formalize this partnership.

Figure 68: Launching event of USAID Technical Assistance Partnership

The two-year Technical Assistance Partnership with the GoSL, works in close collaboration with key stakeholders in the country namely, National STD/ AIDS Control Programme (NSACP), Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and Civil Society Organizations (CSO).

The Technical Assistance activities are implemented by FHI 360, a US-based, not-for-profit, international public health, development and research organization, that builds technical capacity within government and NGOs in a wide range of public health and development areas. In Sri Lanka, FHI 360 will bring experiences from the Global LINKAGES project to strengthen key population program response.

The LINKAGES project in Sri Lanka is working closely with existing civil society organizations working with key population i.e. Female Sex Workers, Men who have Sex with Men, People who Use/Inject Drugs, funded by GFATM.

Figure 69: USAID and FHI360 representatives with NSACP staff

Summary of the key achievements of LINKAGES in Sri Lanka in 2017:

- Several meetings were held between USAID and FHI 360 and key stakeholders to finalize the areas of technical assistance to be supported in Sri Lanka.
- The official launch of LINKAGES was held on 8th of December, 2017 at Colombo. On this occasion, the Letter of Intent was signed between USAID and Ministry of Health (MoH), Government of Sri Lanka (GoSL).
- A partnership advisory committee has been set-up to ensure smooth implementation of the LINKAGES activities in Sri Lanka. This committee is chaired by the Secretary, Ministry of Health and secretary post is from the FHI 360.
- Global Fund sub-recipients - Community Strength Development Foundation (CSDF), Saviya Development Foundation (SDF) and Alcohol and Drug Information Center (ADIC) were identified to be developed as learning sites for FSW, MSM and PWU/ID interventions respectively.

15 DISTRICT STD CLINICS

Eighteen district STD clinics have sent photos of events conducted during 2017 as given in alphabetical order below.

Badulla	Kalutara
Batticaloa	Kandy
Chilaw	Kilinochchi
Embilipitiya	Mahamodara
Gampaha	Nuwara Eliya
Hambantota	Polonnaruwa
Jaffna	Ragama
Kalmunai	Ratnapura
Kalubowila	Vavuniya

District STD clinic, STD clinic, Badulla

Figure 70: Events from STD clinic Badulla

Badulla STD clinic had 600 new patients and a total of 2084 clinic visits. The number of HIV patients followed up in the clinic had also risen to 12. The laboratory provided serological testing facility for Badulla and Monaragala districts and a total of 29,481 HIV tests had been performed and EMTCT coverage for this year through the clinic was 95.6% for the Uva province. A total of 108 awareness programmes were carried out reaching 12,482 individuals of various target populations. Given above are some of the highlights of the World AIDS Day 2017; a street walk and a seminar held in Badulla town on the theme “Getting to Zero”.

District STD clinic, Batticaloa

Figure 71: Events from STD clinic Batticaloa

A street drama had been organised to raise public awareness to commemorate the World AIDS day 2017. Awareness programme for garment factory workers and outreach testing conducted by Dr Anusha Srisankar and Batticaloa STD clinic staff is also depicted in these photos.

District STD clinic, Chilaw

Figure 72: Events from STD clinic Chilaw

Above pictures show the public walk organised by the staff of Chilaw STD clinic to commemorate the World AIDS Day, 2017.

District STD clinic, Embilipitiya

Figure 73: Events from STD clinic Embilipitiya

A public walk had been organized to commemorate the World AIDS Day by the staff of Embilipitiya STD clinic.

District STD clinic, Gampaha

Figure 74: Events from STD clinic Gampaha

Above photos show different event organized by Gampaha STD clinic during 2017.

District STD clinic, Hambantota

Figure 75: Events from STD clinic Hambantota

An open kite competition was held in Hambantota on 21st of December 2017 at the Hambantota beach park, with the participation of a huge public gathering including school children. Around 150 people competed in the kite competition bearing HIV prevention messages. Winners of the kite competition were awarded with cash and prizes.

District STD clinic, Jaffna

A walk, with the participation of over 300 participants from health sector as well as non-health sector related institutions and NGOs, was successfully held on 30th November 2017 to raise the public awareness on HIV/AIDS in Jaffna.

Figure 76: World AIDS Day events from STD clinic Jaffna

District STD clinic, Kalmunai

Figure 77: Events from STD clinic Kalmunai

Kalmunai STD clinic have organized a signature campaign, awareness programme and a public walk to commemorate the World AIDS Day 2017.

District STD clinic, Kalubowila

Figure 78: Events from STD clinic Kalubowila

A street drama has been conducted for world AIDS Day 2017 to raise public awareness. Staff members of STD clinic Kalubowila performed in the drama.

District STD clinic, Kalutara

Figure 79: Events from STD clinic Kalutara

Hon. Minister of Health, Dr Rajitha Senaratne participated in the World AIDS Day event organized by staff of STD clinic Kalutara.

District STD clinic, Kandy

Figure 80: Events from STD clinic Kandy

Awareness programmes organized by the staff of Kandy STD clinic are depicted in above photos.

District STD clinic, Kilinochchi

Figure 81: Events from STD clinic Kilinochchi

Above photos show few STD awareness and screening programmes organized in Kilinochchi district.

District STD clinic, Nuwara Eliya

Figure 82: Events from STD clinic Nuwara Eliya

Above photos show events organized by the staff of Nuwara Eliya STD clinic for the World AIDS Day 2017.

District STD clinic, Polonnaruwa

Figure 83: Events from STD clinic Polonnaruwa

Above photos indicate HIV testing programme organized by Polonnaruwa STD clinic staff to commemorate the World AIDS Day 2017.

District STD clinic, Ragama

Figure 84: Events from STD clinic Ragama

A street drama was organized by the staff of STD clinic Ragama on behalf of the World AIDS Day 2017.

District STD clinic, Ratnapura

Figure 85: Events from STD clinic Ratnapura

STD clinic Rathnapura conducted several programmes in parallel, to commemorate World AIDS Day 2017. A poster campaign was conducted for four weeks in public places in Rathnapura district for which a new poster had also been designed and displayed. An exhibition stall had been conducted for 2 days in Rathnapura and approximately 100 individuals got their blood tested for HIV and syphilis using rapid tests from this stall.

District STD clinic, Vavuniya

Figure 86: Events from STD clinic Vavuniya

Staff of Vavuniya STD clinic organized several awareness programmes and testing programmes to mark the World AIDS Day 2017.

16 PROVINCIAL REVIEWS

Evaluation of scaling up of STD services in Northern and Eastern Provinces

Sexual health services to Northern province are provide by Jaffna, Kilinochchi, Mannar, Mullaitivu and Vavuniya STD clinics, whereas these services in Eastern province are provided by Ampara, Batticaloa, Kalmunai and Trincomalee STD clinics. These services are significantly scaled up in the Northern and Eastern Provinces during 2017.

Sexual health services are improved at institutional level and have penetrated into the communities including key populations as a result of proper guidance by NSACP and provincial health administrators. This has resulted in increased awareness and testing among people in Northern and Eastern Provinces.

Below table explain the scaling up of services in Northern and Eastern Provinces since 2016. Following colour code is used in these tables.

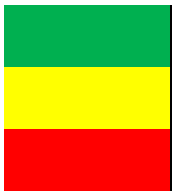


Table 11: Progress of key STD clinic service improvement milestones in 2017

STD Clinic	Provincial Review 2017	Provincial AIDS Committee	NSACP Clinic supervision visits	Office equipment procurement	Lab services establishment	Staff appointment	Staff Training	Building renovation
Jaffna								
Kilinochchi								
Mannar								
Mullaitivu								
Vavuniya								
Ampara								
Batticaloa								
Kalmunai								
Trincomalee								

The Global Fund has supported major service improvements including renovation of the STD clinic, Mannar.

Laboratory facilities were lack in the STD clinics in Kilinochchi, Mannar and Mullaitivu in the Northern province and Batticaloa in Eastern province. Steps to establish laboratory facilities for the above clinics are in progress.

Lack of appropriate staff and non-availability of vehicles have created difficulties in routine clinic activities of most clinics. In addition, Mannar and Kalmunai clinics were functioning without a permanent medical officer during 2017. None of these clinics were having a permanent Consultant Venereologist during 2017.

Table 12: STD clinic performance in clinic activities in 2017

STD Clinic	Prevention programs	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								
Kilinochchi								
Mannar								
Mullaitivu								
Vavuniya								
Ampara								
Batticaloa								
Kalmunai								
Trincomalee								

HIV testing day 2017

The community and health administrators of the Northern province were in a view that having a specific day for HIV testing would improve HIV testing in post war transitioning period that prevails in the province. The Provincial AIDS Committee decided to conduct the HIV testing day in Mullaitivu on 27th June 2017.

The day was a great opportunity to create public awareness on HIV and HIV testing. Health as well as non-health sector individuals were trained on HIV rapid testing, strengthening evidence for feasibility of rapid testing in the community to enhance HIV testing.

HIV testing was carried out without any stigma and those who got tested considered this as a life time opportunity.

The media conference organized a week prior to HIV testing day had created an opportunity for advocating administrators of the district. Smooth conduct of testing centers throughout Mullaitivu district was possible with the participation of variety of media personnel and health authorities.

Media conference was held at RDHS office and there were about 100 participants all together from media and healthcare workers from MOH, Mullaitivu.

Public Health Midwives, Public Health Inspectors, Nursing Officers and people from tri-forces were trained on organizing the testing day and performing HIV rapid testing in two-day training program conducted at the RDHS office Mullaitivu by a Public

Health Specialist from NSACP. The Hatton National Bank and the Ministry of Health provided financial support.

Mass media campaign was done almost for a week from the day of media conference to 'HIV testing day programme' and it was advertised through local and national newspapers, radio as well as TV channels. This huge publicity attracted target population from each corner of the Mullaitivu district and 3750 people got themselves tested for HIV.

Table 13: Progress of 2017 North and East Province STD clinic Activity plan

Strategic area	Activities	Target Population/area	Quarter			
			1	2	3	4
STD clinic System Strengthening	ToT	Public Health Staff in each district	X			
	Setting of information unit within STD clinic	Each district STD clinic	X	X		
Prevention	Awareness/ IEC/BCC	Key population Vulnerable population General population	X	X	X	X
	Condom Distribution					
	HIV testing					
Treatment, care and support	Establishing PLHIV supportive organization	Jaffna District	X	X		
Meetings and reviews	Monthly RDHS level review	District level	X	X	X	X
	District AIDS Committee	District level				
	Provincial AIDS Committee	N and E Provinces	X			
	Provincial Reviews	N and E Provinces	X			
	National Annual Review	National level	X			
Surveys	HIV Sentinel Surveillance among returning migrants	District level	X	X		
Special Activities	HIV testing Day June 27	Mullaitivu District		X		
	December 1 (AIDS Day)	All districts				X
Clinic Supervision	By the NSACP	All districts			X	X

STD clinics in both provinces have achieved considerable progress in activity plan in 2017.

Table 14: Annual action plan for 2018

Strategic area	Activities	Target Population/area	Quarter			
			1	2	3	4
STD clinic, System Strengthening	Training of trainers	Public Health Staff in each district	X			
	Setting of information unit within STD clinic	Each district STD clinic	X	X		
Prevention	Awareness/ IEC/BCC	Key population Vulnerable population General population	X	X	X	X
	Condom Distribution					
	HIV testing					
Treatment, care and support	Establishing TG and PLHIV support groups	Jaffna District	X	X	X	X
Meetings and reviews	Monthly RDHS level review	District level	X	X	X	X
	District AIDS Committee	District level	X	X	X	X
	Provincial AIDS Committee	N and E Provinces	X			
	Provincial Reviews	N and E Provinces	X			
	National Annual Review	National level	X			
Surveys	HIV Sentinel Surveillance among returning migrants	District level	X	X		
Special Activities	HIV testing Day June 26	Mannar District		X		
	December 1 (AIDS Day)	All districts				X
Clinic Supervision	By the NSACP	All districts			X	X

Do Northern and Eastern clinics need special focus?

Currently there are 33 STD clinics in the country and most district level STD clinics are functioning with deficiencies in human resources and infrastructure. However the problem is even worse in Northern and Eastern provinces due to poor geographical accessibility. Thus Provincial AIDS Committee of these two provinces stated the necessity of special focus at least up to end 2019 until adequate infrastructure and laboratory services are established to those clinics.

17 GLOBAL FUND SUPPORT

By the end of 2017, NSACP achieved considerable physical and financial progress in the New Funding Model Grant 2016-2018. Of the 2017 approved budget of USD 1,898,343, a total of USD 1,324,445 was spent resulting 70% absorption rate. However, with the 2016 brought forward budget, the total available budget for 2017 was USD 2,516,963.

Table 15: Total budget available in 2017 by cost category

	Cost Category	Budget brought forward from 2016 & 2017 Budget, USD
1	Human Resources (HR)	179,161
2	Travel related costs (TRC)	229,202
3	External Professional services (EPS)	820,788
4	Health Products - Pharmaceutical Products (HPPP)	-
5	Health Products - Non-Pharmaceuticals (HPNP)	704,203
6	Health Products - Equipment (HPE)	-
7	Procurement and Supply-Chain Management costs (PSM)	136,222
8	Infrastructure (INF)	4,511
9	Non-health equipment (NHE)	400,849
10	Communication Material and Publications (CMP)	3,383
11	Indirect and Overhead Costs	38,644
12	Living support to client/ target population (LSCTP)	-
13	Results Based Financing	-
	Total	2,516,963

Financial and physical progress as of 1st of January, 2017 to 31st of December, 2017 are described below. All grant requirements and management actions pending for the year were successfully achieved in 2017 and reported to the Global Fund country team on time. Moreover, the grant activities were audited by the external audit, the office of the Inspector General's and the government auditors. There were no major challenges identified during these auditing processes. The Program Implementation unit submitted the Progress Update 2017 and the Disbursement Request 2018 (PUDR) on time.

Physical progress is monitored by set of coverage indicators and progress in the Work Plan Tracking Measures (WPTM).

Over all annual expenditure is described in the below table against cost category.

Table 16: Cost category wise expenditure in year 2017

	Cost Category	In Country (Vote 13)	PPM*	Total Expendit. (USD)
1.	Human Resources	120,923.27	-	120,923.27
2.	Travel related costs	77,270.28	-	77,270.28
3.	External Professional services	389,306.16	25,130.00	414,436.16
4.	Health Products - Pharmaceutical Products	-	-	-
5.	Health Products - Non-Pharmaceuticals	32,421.00	290,883.70	323,304.70
6.	Health Products - Equipment	23,063.20	-	23,063.20
7.	Procurement and Supply-Chain Management	187,626.91	44,644.20	232,271.11
8.	Infrastructure	28,906.93	-	28,906.93
9.	Non-health equipment	54,423.88	-	54,423.88
10.	Communication Material and Publications	29,861.32	-	29,861.32
11.	Programme Administration costs	19,984.30	-	19,984.30
	Total	**963,787.25**	**360,657.90**	**1,324,445.15**

** Pooled Procurement Mechanism*

Table 17: Key populations coverage indicators achieved in 2017

Indicator Description	Target			Result			Achievement Ratio
	N*	D*	%	N*	D*	%	
KP-1a: Percentage of MSM reached with HIV prevention programs - defined package of services	4,914	7,551	56%	7,085	7,551	93%	120%
KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services	8,036	14,132	57%	10,800	14,132	76%	120%
KP-1d: Percentage of PWID reached with HIV prevention programs - defined package of services	10,750	17,459	62%	11,051	17,459	63%	103%
KP-1e: Percentage of other vulnerable populations reached with HIV prevention programs - defined package of services	2,117			3,403			120%

** D- denominator, N- numerator*

Table 18: Treatment & Care indicators by coverage indicators in 2017

Indicator Description	Baseline (if applicable)				Target			Result			Achievement Ratio
	N	D	%	Year	N	D	%	N	D	%	
TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	644	3340	19%	2014	1617	4200	39%	1,300	3864	34%	87%
TCS-2: Percentage of people living with HIV that initiated ART with CD4 count of <200 cells/mm³	29	83	35%	2014	-	-	22%	45	168	27%	-
TCS-3: Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)	40	44	91%	2013	-	-	92%	239	264	91%	97%

** D- denominator, N- numerator*

18 IBBS AND PSE SURVEYS

National STD/AIDS control programme initiated another round of Population Size Estimation (PSE) and Integrated Biological and Behavioural Surveillance Survey (IBBS) during 2017. Female Sex Workers (FSW), People Who Inject Drugs, (PWID) Men Who have Sex with Men (MSM), Transgender women (TGW) and Beach boys (BB) will be covered in these surveys.

The objectives of the IBBS survey

- To estimate the prevalence of HIV, syphilis, hepatitis B, hepatitis C, herpes and associated risk behaviours among FSW, MSM, TGW, PWID and BB in Sri Lanka
- To assess the use of and access to health and social welfare programs among FSW, MSM, TGW, PWID and BB in Sri Lanka.

Figure 87: Steering committee and training events on IBBS and PSE

The objectives of the PSE

1. Implement the size estimation study of MSM, FSW, PWID, TG, and BB in the selected cities in Sri Lanka, using the service multiplier method
2. Implement the size estimation study of MSM, FSW, PWID, TG and BB in the selected cities in Sri Lanka, using the unique object multiplier method
3. Implement the size estimation study of MSM, FSW, PWID, TG, and BB in the selected cities in Sri Lanka, using Mapping and Enumeration methods
4. Analyze and synthesize the estimates of MSM, FSW, PWID, TG and BB based on different methods and calculation of national estimates after a consensus meeting with stakeholders.

Locations and Key populations covered by the IBBS Survey

1. FSW, PWID, MSM and TGW in Colombo
2. MSM in Anuradhapura
3. TGW in Jaffna
4. FSW in Kandy
5. BB, FSW and MSM in Galle

Total number of respondents expected to be covered by the IBBS Survey is 3,350 and the overall survey is designed based on the Respondent Driven Sampling (RDS) method. The data will be analyzed and prevalence levels will be estimated using RDS-A software.

The population size estimation (PSE) is conducted to assess the sizes of above Key populations. There are 49 divisional secretariats included in the PSE survey that have been selected randomly.

Following activities have been completed as of end 2017.

- Training of staff on conduct of formative research
- Conduct of formative research.
- Finalization of survey methodology, tools, selection of survey locations and work plans.
- Training of survey staff for conducting the IBBS survey.
- Training of survey staff for biological component.
- Training of survey staff for conducting PSE survey.

  In addition to the training of staff for IBBS survey, the staff was also trained by the international consultants on conducting the population size estimation in October and November 2017.
- Training of health staff on conducting IBBS and PSE.

  The MoH staff, particularly the medical staff attached to STD clinics in the country were trained on conducting IBBS Surveys and PSE Surveys in October and November 2017. These trainings were also conducted by the international consultants.

19 TARGETED INTERVENTIONS

The report on AIDS in Asia by AIDS commission highlighted the importance of peer-led targeted interventions for prevention of HIV. In this approach, leaders of Key population groups are used to educate and provide sexual health services to their fellow 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 who are potential drivers of the 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 play a key role in these intervention programmes in collaboration with National STD/AIDS Control Programme to provide 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.

Figure 88: Peer-led targeted interventions

Table 19: Achievements of the peer-led targeted interventions by end 2017

Key population	Prevention interventions								
	1. Reaching with services			2. Escorting to STD clinics			3. Distribution of condoms in 2017		
	Target	Results achieved		Target	Results achieved		Target	Results achieved	
		Number	%		Number	%		Number	%
FSW	8036	7927	99%	3214	3208	100%	4,512,840	1,633,299	36%
MSM	4914	4616	94%	1966	2304	117%	1,670,389	343,362	21%
BB	2117	2198	104%	847	909	107%	456,260	159,526	35%
PWUD/ID	10750	9744	91%	-	35	-	1,159,764	130,548	11%

Peer-educators (peer-leader) and field supervisors (outreach workers) are responsible for the delivery of the service at the community level for their peers. During 2017, a total of 832 peer-educators and 190 field supervisors were engaged in peer-led targeted intervention programmes in following districts in Sri Lanka.

Table 20:The field level staff and geographic coverage of peer-led programmes

		Target to enroll	Number in position	Districts of coverage
FSW	Peer - educators	389	337	Polonnaruwa, Anuradhapura, Colombo, Gampaha, Galle Kurunegala, Matara, Hambantota, Kandy, Ratnapura
	Field supervisors	78	67	
MSM	Peer - educators	235	181	Colombo, Galle, Gampaha, Kalutara, Kandy, Matale, Anuradhapura
	Field supervisors	43	41	
BB	Peer - educators	101	87	Hambantota, Matara, Galle, Kalutara, Colombo, Gampaha, Puttalam
	Field supervisors	20	17	
DU	Peer - educators	263	227	Colombo, Gampaha, Puttalam, Kurunegala, Kandy, Matale, Ratnapura, Galle, Matara, Hambanthota
	Field supervisors	66	63	

Figure 89: Peer-led targeted interventions

20 DRUG USER SURVEY

Rapid assessment of drug use pattern in Sri Lanka

During 2017, National STD/AIDS Control Programme in collaboration with National Dangerous Drug Control Board (NDDCB) conducted a rapid assessment of drug use pattern in Sri Lanka. The Alliance Regional Technical Support Hub South Asia provided technical support while the survey was funded by the Global Fund.

Figure 90: A meeting with technical partners, NSACP and NDDCB

Objectives of the survey

- Understanding drug use pattern
- Recommending programmes related to drug use

Methods

Quantitative component:

- Non-institutionalized people who use drugs (PWUD) (n=283) and people who inject drugs (PWID) (n=174) were recruited through a snow-ball sampling technique, from six high drug user prevalent districts, Colombo, Gampaha, Kalutara, Galle, Kandy and Rathnapura. These respondents were interviewed in one-to-one setting in the field by 16 trained interviewers from NDDCB.

Qualitative component:

- A total of 36 key Informant interviews were conducted.
- Ethical clearance was obtained from faculty of medicine, University of Colombo

Results

- Over 95% of the study sample was males in their late 30s.
- Over 90% of the sample was educated and employed.
- About two-third in both the groups (PWUD and PWID) used cannabis, while 93% of PWUD used heroin with the 'Chinese' method.
- Over 90% PWID used heroin for injecting.
- While heroin smoking starts around 19-20 years of age, heroin injecting starts around 28 years of age.
- 'Peer pressure' and 'curiosity' were the most common reasons behind onset of drug use.
- About 83% of PWID injected daily, and of them about 64% injecting 2-3 times per day.
- As many as 85% had shared their injecting equipment 'ever', while 64% shared in the last one month.
- Among those who reported sex with commercial sex partners (i.e. with female sex workers), 52% of PWID and 38% of PWUD reported unprotected sex.
- Only 41-42% have reported receiving any medical treatment.
- Over 90% had been apprehended by police and large majority (84% PWID and 78% PWUD) had been to jail.

The key informant interviews indicated following

- Deep-seated prejudices against drug use are prevalent.
- Widespread stigma and discrimination is faced by PWUD / PWID.
- There are misconceptions regarding harm reduction approaches.

Conclusions

- Large number of men, mostly in the productive age are suffering from heroin dependence.
- Inhalational drug users are at risk of transition to injecting drug users.
- Risky sexual practices are prevalent among drug users.
- The response to drug users is appeared to be heavily skewed toward the criminal justice system.
- There is poor access to effective, evidence-based treatment for opioid dependence.
- There is virtual non-existence of specific harm reduction interventions.
- A conducive environment should be created for provision of evidence-informed services.

Recommendations

- A conducive environment should be created for provision of evidence-informed services.
- Strong advocacy programmes are recommended for policy makers.
- Programmes are necessary to prevent young people get into drug use.
- Measures should be taken to prevent blood born viruses like HIV, HCV and HBV among drug users.
- Specific interventions should be implemented for treating current drug users.

21 EXTERNAL REVIEW

External Review of the National Response to HIV 2017

An external Review (ER) of the National Response to HIV/AIDS epidemic and STIs in Sri Lanka was conducted during 2017. This activity was planned with the purpose of reviewing whether the implementation of the national response to HIV/AIDS epidemic and STIs, is going in the right direction and producing the desired results to meet the targets defined in the national strategic plan (2013-2017).

The main objective of the ER was to assess the overall performance against the NSP (2013-2017) goals and targets and to identify areas which need more attention during the development of the NSP for the next five years.

Figure 91: A stakeholder meeting of the external review

In preparation for the ER, a steering committee comprising of 21 members who represented all stakeholder groups of the national programme including the Ministry of Health, NSACP, Country Coordinating Mechanism of the GFATM, NGOs, WHO, PLHIV, civil society members and key populations was appointed. Then five working groups were formed under the focal point for each thematic area. The main responsibility of the working groups was to facilitate the desk review and the field reviews which were used as the two main methods of collecting relevant information for the review.

The review team consisted of five international reviewers (Dr Tasnim Azim, Dr Bharat Rewari, Professor Priya Abraham, Mr Gary Reid and Dr Yujwal Raj) and two local reviewers (Dr Thalatha Liyanage and Dr Dulani Samaranayake) assisted by three members representing key populations (Mr S P I Niroshan, Mr Palitha Vijaya Bandara and Ms Bhoomi Harendran).

Figure 92: Dissemination of the external review findings

Summary of the main conclusions and recommendations of the external review is given below.

Epidemic Focus

- Sri Lanka, during these last five years, has successfully maintained its low HIV prevalence status although numbers of HIV diagnoses have been slowly rising over the years.
- The main population groups with a rising number of HIV positive cases have been males having sex with males (MSM) and returnee external migrant workers.
- Based on existing data, the country has identified KPs to be MSM, transgender (TG) persons, female sex workers (FSW), people who use drugs (PWUD) /people who inject drugs (PWID), Beach Boys (BBs) and prisoners.
- Armed forces and police personnel, returnee migrants and tourist industry workers are considered as vulnerable population groups.

Prevention

- The implementation of the peer educator (PE) model in the last five years has been an achievement for Sri Lanka's response to HIV/STI prevention as it has led to greater access to KPs. But need strengthening the PE model, expanding Drop-in centres (DIC), enhancing capacity of CBOs and KP networks.
- It is also important to incorporate novel methods of reaching hidden people, increase testing among KPs by making available a range of testing options.
- Need to create an enabling environment for KPs by enhancing efforts at reducing stigma and discrimination.
- Need to consider making available post exposure prophylaxis (PEP) for all KPs and pre exposure prophylaxis (PreP) for MSM and TGs.

Diagnosis, Treatment and Care

- Need to shorten the turnaround time and reducing the chances of loss to follow up (LFU) before providing HIV results by decentralizing HIV testing services (HTS) and using Rapid test kits at all sites following the WHO algorithm.
- Need to develop a systematic mechanism for tracking LFU.

- ARV procurement processes needs to be strengthened to avoid drug stock outs.
- Training of personnel at STD clinics and ART sites needs regularized and strengthen with innovative methods.

Strategic Information Management

- Standardize implementation, training and supervision protocols for HSS and improve the documentation and presentation of surveillance reports with wider dissemination.
- The analysis of data from HIV case reporting is limited and more regular and robust epidemiological analysis is required for which capacity needs to be built across the data collection system from central to peripheral facilities
- To use other models based on transmission dynamics such as the AIDS Epidemic Model to study and project the epidemic and estimate key burden indicators
- To create a knowledge management strategy for NSACP will strengthen evidence based programming.

Health System Strengthening

- Most of service delivery sites are constrained in terms of space and other facilities which needs attention.
- Need to improve the procurement process, and need to carefully forecast needs to prevent shortage of kits/reagents.
- Need training of staff at referral sites to raise awareness regarding the sensitivities related to PLHIV and KPs. Training needs to be decentralized to the district level.
- Storage facilities for drugs at the central STD clinic pharmacy and in many peripheral clinics are inadequate and it is recommended to address these inadequacies.
- It is recommended to revive the National AIDS Council, regularize meetings of NAC and activate its subcommittees, strengthen District AIDS committees considering the target of Ending AIDS by 2015.

Supportive Environment

- Training of health care providers should include law and Human Rights, ethical professional practice, special issues of KPs including sexual orientation and gender identity and expression.
- The media needs training and sensitization on HIV related issues.
- It is necessary to advocate with policy makers to update the curriculum on SRH including HIV/STI so that it is in keeping with the needs of young people.
- It is recommended to revisit laws such as Penal code 365 and 365A, that criminalizes same sex relations and create a barrier to MSM and TG accessing HIV/STI services as well as the Brothel and Vagrancy ordinances which affect FSW.

22 NATIONAL STRATEGIC PLAN

Developing National Strategic Plan 2018-2022

The National Strategic Plan (NSP) is the guiding document for Sri Lankan response to HIV/AIDS and STIs for next five years. During 2017, National STD/AIDS Control Programme (NSACP) completed developing the NSP for HIV/STI response, 2018-2022. Global fund financially supported this activity. Dr Tasnim Azim provided technical assistance to complete this activity in consultation with all stakeholders.

The NSP has considered global and national contextual changes, and emergence of new evidence and strategies. In addition, it has taken into account the findings and recommendations provided by the external review conducted in September 2017. This activity was financially supported by the Global Fund.

During the process of development, inputs were taken from relevant stakeholders such as Health ministry officials, officials from district STD clinics, community-based organizations (CBOs), non-government organizations (NGOs), networks of people living with HIV (PLHIV) and representatives of Key populations through various meetings and discussions.

Figure 93: From the dissemination of NSP 2018-2022

The NSP has defined its vision, mission, goal and objectives for the next five years. The vision is to see a “Country free of new HIV infections, discrimination and AIDS related deaths”. The mission is to “Prevent new HIV and STIs and provide comprehensive care and treatment services” and the goal is “Ending AIDS by 2025”.

Five objectives are identified for achieving this goal:

I. To prevent new infections of HIV/STI among key populations, vulnerable populations and the general population.

II. To provide universal access to HIV/STI diagnosis and treatment, care and support services for those infected and affected by HIV/STI.

III. To strengthen strategic information systems and knowledge management for an evidence-based response.

IV. To strengthen health systems at different levels and to ensure an effective multi-sector HIV/AIDS/STI response.

V. To provide a supportive environment for easy access and delivery of HIV prevention, diagnosis, treatment and care services for all.

The objectives are addressed through five strategic directions (SD) that are similar to the current NSP 2013-2017, and each SD has its own sub-strategies. Based on the achievements and gaps/barriers identified for each SD over the five years of the last NSP, priority actions to be undertaken have been outlined.

Strategic Direction 1: Prevention

This has four sub-strategies which are prevention of transmission of HIV/STI among KPs, prevention of transmission of HIV/STI among vulnerable groups, prevention of transmission of HIV/STI among the general population including young people (15-29 years) and prevention of transmission through infected blood. This NSP has included prisoners as a KP in order to align with international norms.

Strategic Direction 2: Diagnosis, Treatment and Care

This has five sub-strategies which are HIV testing and counselling (including laboratory aspects of testing), Antiretroviral Therapy (ART) services, Quality and Coverage of STI services, Elimination of mother to child transmission of HIV (EMTCT) and congenital syphilis and HIV TB services.

Strategic Direction 3: Strategic Information Management System

This has four sub-strategies which are HIV and STI surveillance, programme monitoring and routine reporting, HIV/AIDS/STI research and knowledge management.

Strategic Direction 4: Health System Strengthening

Under this SD several actions have been outlined related to improving infrastructure, human resource deployment and training for delivering services, activating high level committees and improving procurement supply chain mechanisms.

Strategic Direction 5: Supportive environment

Under this SD, the actions required are to ensure all training modules address issues on human rights, stigma and discrimination, issue a specific guideline to the education sector for protection of human rights of children affected by and infected with HIV and enhance awareness of laws and policies that promote human rights of all people including of KPs and PLHIV, conduct advocacy activities for an enabling environment for KPs and PLHIV in order to reduce stigma and discrimination and address violence against KPs, develop a policy for ethical reporting on HIV/AIDS/STI by the media and advocate with the media on responsible reporting on HIV/AIDS/STI.

NSP includes an indicator framework linked to each strategic direction which allows measuring progress against the activities. The indicator framework provides a list of impact, outcome and output indicators to enable tracking of the national response to HIV/STI and AIDS.

A costed implementation plan for 2018-2022 accompanies the NSP for HIV/STI response 2018-2022. The plan envisages an expenditure of USD 59,909,371 (LKR 9,188,133,737) over the five years of the period of NSP.

23 TRAINING AND CAPACITY BUILDING

Training and capacity building during 2017

National STD /AIDS Control Programme (NSACP) is responsible for training of all categories of STD clinic staff in the country. Training unit of NSACP conducts comprehensive training programme throughout the year according to an annual plan. Training programmes consist of pre-service training, in service training, refresher training, counseling training, undergraduate and post graduate training etc.

Figure 94: **Capacity building activities of NSACP**

Pre-service training

All categories of healthcare workers of STD clinics should undergo a mandatory training within the period of six months of enrolment to the clinics. Medical officers attached to the STD clinic should undergo compulsory two months of theory and practical training at NSACP, Colombo. Other major heath staff such as nursing officers, public health sisters, matrons, medical laboratory technicians, pharmacists, public health laboratory technicians, dispensers and public health inspectors need to undergo two weeks of training which consist of theory, practical, case discussion, small group discussion and outreach work. Minor staff such as attendants, Saukya Karya Sahayaka and lab orderly are also given one-week training which consist of relevant theory and hands on experience specially in the laboratory and clinic.

In service training

HIV and STI counselling programs were conducted for the duration of four to five days for medical officers, nursing officers and public health inspectors. This mainly consist of theory, practical, role play, small group discussions and brain storming activities to build the capacity of the heath care workers. Several numbers of government medical laboratory technicians have been trained for rapid testing of HIV.

Refresher training

These were conducted either at NSACP or at other peripheral STD clinics for one or two days to refresh the health care workers knowledge and help them to change their attitude towards patients. Private sector laboratory health staff have been trained for rapid testing of HIV.

International training

Through the training unit two medical officers, three nursing officers and one PHI were able to send to Thailand and Singapore during 2017.

Undergraduate training

Ten student groups from Colombo medical faculty and four student groups from Kothalawala Defense University attended for training period of one to two weeks respectively. They received theory and practical experiences during their stay. Undergraduate students of nursing, pharmacists, MLT and PHLT also trained according to their objectives and curriculum.

Postgraduate training

Postgraduate training of Venereology has been done since 2003. Diploma trainees, MD trainees and post MD trainees of Venereology are trained under the supervision of Consultant Venereologists. Other specialties such as diploma trainees of microbiology, family medicine and child health, MD trainees of microbiology, virology and dermatology were trained.

Table 21:**Training and capacity building by NSACP, Colombo during 2017**

Category of trainees	Number trained
Major staff- (prevention, PMTCT, treatment and care)	1144
Medical officers-(pre-service & in-service)	41
Nursing officers-(pre-service & in-service)	13
Laboratory staff-(pre-service & in-service)	217
PHI-(pre-service & in-service)	4
Pharmacist and dispensers- (in-service)	6
Minor staff-(pre-service & in-service)	27
Medical students - University of Colombo	17
Medical students - Kothalawala Defence	60
Nursing students	119
MLT students	40
PHLT students	105
Venereology PG trainees	22
Dermatology PG trainees	03
Virology PG trainees	02
Laboratory staff	120
Total	**1940**

24 IEC AND ADVOCACY PROGRAMS

Communication on STI and HIV is important to raise awareness and to achieve behaviour change among general public as well as among 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, public campaigns as well as print and electronic media.

A media conference and a media advocacy programme for high ranking media personnel were held to mark the World AIDS Day 2017.Following these programmes news supplements were published in 'Ada', 'Lankadeepa' and 'Tharunee' newspapers providing wider coverage. Through-out the year numerous articles were published in print media on STIs and HIV/AIDS. There were over 40 communication activities through electronic media including TV and radio.

Table 22: Awareness activities carried out by NSACP in 2017

Type of activity and target group	Number of programmes	Number of attendees
Key population groups	14	445
School children	5	1000
Tri forces	6	1330
Public exhibitions	20	55,350
Public-lectures	7	1120
Media conferences	2	90
Radio shows/ TV programmes	42	N/A
Newspaper supplements	3	N/A
Others	4	561
Total	**103**	**59,896**

Table 23: IEC activities work completed by district STD clinics in 2017

Type of Participants	Number of Programmes	Number of attendees
Female sex workers	114	2,347
MSM	38	1,415
Drug users	67	2,574
Beach boys	57	1,927
Prisoners	137	11,616
General public/Mixed group	603	7,673
Other	1679	318,755
Total	2695	346,307

The NSACP with district STD clinics have provided awareness on STD/HIV/AIDS to over 394,026 persons during 2017.

National communication strategy (2018-2021)

A national communication strategy (NCS) on control and prevention of STI/HIV/AIDS was launched on World AIDS Day 2017.

The strategy was developed based on current communication gaps in STI/HIV/AIDS communication, stakeholder recommendations and researches. The aim of the NCS is to deploy mass media for a comprehensive communication programme. It will be a key component in enabling the achievement of objective of 'Ending AIDS by 2025' in Sri Lanka, while breaking stigma and discrimination against those living with HIV/AIDS/STIs.

25 WORLD AIDS DAY 2017

The World AIDS Day (WAD) is commemorated on the 1st of December to remember those who lost their lives due to HIV/AIDS as well as to re-invigorate the determination and dedication for the battle against HIV/AIDS. The working theme for this year was Elimination of Mother to Child Transmission of HIV (EMTCT) by 2018 and Ending AIDS by 2025.

The National STD/AIDS Control Programme in collaboration with its partner organizations conducted an elaborated programme throughout the country to mark the WAD 2017. Global Fund, Hatton National Bank and number of other organizations financially supported this activity.

National level activities

World AIDS Day Walk

Figure 95: Starting point of the World AIDS Day walk in 2017

The walk was started from the Independence Square and ended at the Bandaranaike Memorial International Conference Hall (BMICH) premises, Colombo with the support of more than 3000 participants. Higher officials and staff of the Ministry of Health, WHO, government and non-governmental partner organizations, members of the armed forces and the police participated in this walk on 30th of November, 2017. Numerous banners and placards containing health messages related to HIV/AIDS were displayed throughout the walk and leaflets in all three languages were distributed among the general public by the participants.

At the front lawn of BMICH, the National Programme for the WAD 2017 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.

The gathering was addressed by Director General of Health Services Dr Anil Jasinghe. During this programme, the publications of National STD/AIDS Control Programme during 2017 were launched by presenting them to Director General of Health Services by Director of National STD/AIDS Control Programme.

Community based HIV rapid testing

During the month of November 2017, HIV rapid testing programmes were conducted at 20 sites and a total of 2279 people were tested. These sites included Grandpass, Mattakkuliya, Borella, Wanathamulla, Fort Railway station, Moratuwa, Dematagoda, Maradana Railway Station, Modara, Maharagama, Nugegoda, Obeysekarapura, Piliyandala, Boralesgamuwa, Kolonnawa, Mount Lavinia, Ratmalana, Badowita Akuregoda air force camp, Battaramulla Diyatha Uyana, Kaduwela, Kelaniya and Peliyagoda fish market.

Raising public awareness through mass media

Media Conference

A media workshop on HIV/AIDS was conducted on 20th of November, 2017 with participation of nearly 40 representatives from various printed and electronic media in Colombo. The workshop was addressed by senior consultants of National STD/AIDS Control Programme.

Media Advocacy Programme

An advocacy programme for the high-ranking media personnel was held on 27th of November, 2017 at Waters Edge Hotel under the patronage of Hon. Member of Parliament, Prof. Ashu Marasinghe and Secretary of Health, Nutrition and Indigenous Medicine. The Consultant Venereologists made presentations on different aspects of the national response to HIV/AIDS epidemic in Sri Lanka.

Figure 96: Media conference at Waters Edge hotel held in Nov. 2017

Figure 97: Media conference at Waters Edge hotel held in Nov. 2017

Banners and leaflets

Nearly 1400 banners containing health messages related to HIV/AIDS in Sinhalese, Tamil and English were printed and displayed all over the country during this period. Around 165,000 leaflets on HIV/AIDS were printed in Sinhalese, Tamil and English and were distributed throughout the country.

Provision of funds to peripheral STD clinics

The peripheral STD clinics were provided with a grant of Rs. 50,000 each for carrying out World AIDS Day activities. In addition, the clinics were provided with banners and leaflets and AIDS Day attire for the staff to be used in the WAD activities.

Figure 98: Participation of youth at the World AIDS Day walk in 2017

Figure 99: Colorful events from the World AIDS Day walk in 2017

Figure 100: Launching of Books at the World AIDS Day in 2017

Above figures show Dr Anil Jasinghe (DGHS) and Dr Sisira Liyanage (Director/NSACP) on the stage of WAD 2017 commemoration meeting held at BMICH premises, Colombo.

The World AIDS Day national programmes in 2017 were financially supported by the Ministry of Health, Global Fund for fighting AIDS, Tuberculosis and Malaria (GFATM), World Health Organization (WHO), Population Services Lanka and Hatton National Bank (Pvt) Ltd. National STD/AIDS Control Programme would like to acknowledge the support given by all these organizations.

WAD 2017 activities by district level STD clinics

All peripheral STD clinics conducted activities to mark the WAD 2017 in their districts. The summary of the activities is as below;

Table 24: Summary of WAD activities conducted by peripheral STD clinics

No	Clinic	Summary of the activity	Number of participants
1	Ampara	Vocational training center awareness campaign	200
2	Anuradhapura	WAD stakeholder meeting, digital screen and video Display of HIV/AIDS prevention messages	150
3	Badulla	WAD walk, Awareness programme	150
4	Balapitiya	WAD walk, Awareness programme, HIV Rapid test screening programme	200
5	Batticaloa	Awareness programme for a mixed group	333
6	Chilaw	WAD Walk, Distribution of stickers among buses and three-wheeler drivers, Awareness programme and HIV screening among youths and hotel staff.	260
7	Gampaha	Awareness programmes for general public visiting the OPD and STD clinics, HCW and Rapid HIV screening programme.	1190
8	Hambantota	Kite competition (Kites displaying HIV/AIDS health messages) and Art competition	40
9	Jaffna	Media conference with the participation of national media and local media networks operating in Northern Sri Lanka. WAD walk .	350
10	Kalmunai	World AIDS Day walk. Awareness programme for school children.	250
11	Kalubowila	Street drama awareness programme for HCW	230
12	Kalutara	World AIDS Day walk	202
13	Kandy	Awareness programmes for HCW and teachers	70
14	Kegalle	Awareness programme for youth and army, designing and distribution of desk calendars to increase HIV screening among OPD doctors, Distribution of IEC material.	244
15	Kilinochchi	Display of drama, screening of army camp	1780
16	Kurunegala	WAD Walk, Awareness programmes for army personnel, School non-academic staff and youth. Display of IEC material in hotspots and other areas.	550
17	Galle	HIV Rapid test screening and awareness programmes for three separate groups, WAD walk	560
18	Matale	Awareness programme for school children and health staff	335
19	Matara	WAD Walk, Awareness programme for target groups /school children HIV/AIDS	606
20	Monaragala	WAD walk and programme, Distribution of leaflets	250

No	Clinic	Summary of the activity	Number of participants
21	Mullaitivu	Screening programme for the youth and three wheeler drivers, Awareness programme for the RDHS staff	210
22	Negombo	Three wheeler parade	20 vehicles
23	Nuwara Eliya	WAD Walk	300
24	Polonnaruwa	Awareness programme for prisoners, MCH, Garment factory workers	100
25	Ragama	Awareness programmes for the youth, HIV screening Programmes. 'Viridu' recital and distribution of IEC material	140
26	Ratnapura	WAD poster campaign, Distribution of handbills and pocket calendars	500
27	Trincomalee	Provision of AIDS Day badges to health Institutions, Walk and awareness rally	300
28	Vavuniya	Awareness programme for mixed group WAD rally, distribution of IEC material	500
29	Wathupitiwala	Outreach HIV screening programmes, Awareness programmes for health care workers and school children.	350
30	Embilipitiya	WAD walk	1000
31	Avissawella	WAD walk	200

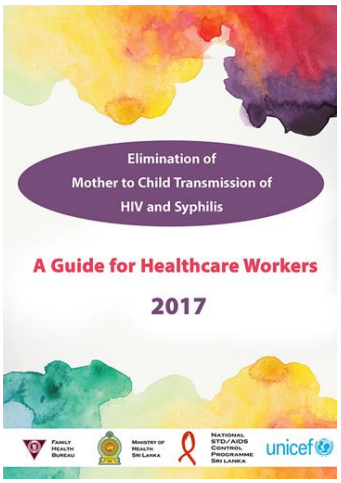
26 PUBLICATIONS

The NSACP being the main technical body responsible for guiding the national response to HIV and STD, has launched several publications during year 2017. This year the publications focused mainly on the National programme management areas. These will provide guidance in improving the National programme to achieve the goal of Ending AIDS in 2025. Two important guidelines were also published targeting the MCH staff and the tourist sector. All the functional units of the NSACP has contributed in writing, compiling and publishing these documents.

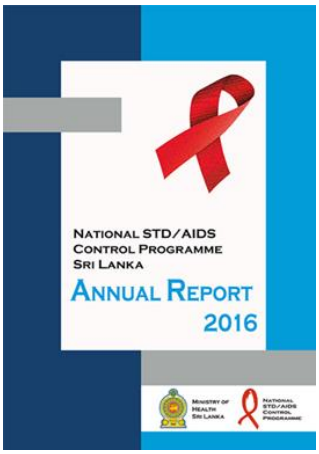
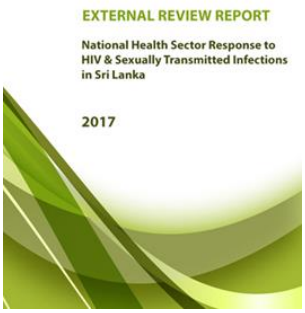
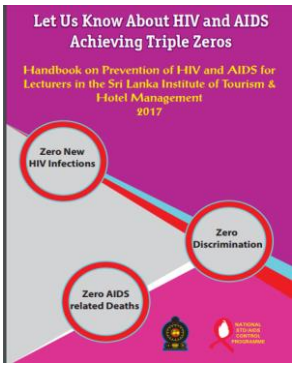
This chapter describes the publications of NSACP during 2017. Following are the list of publications in alphabetical order.

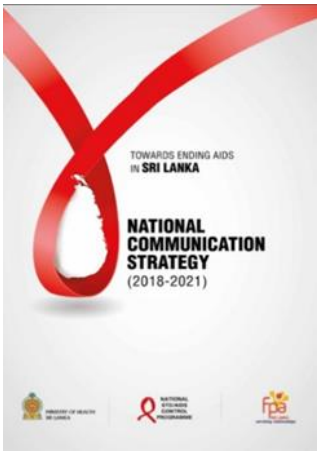
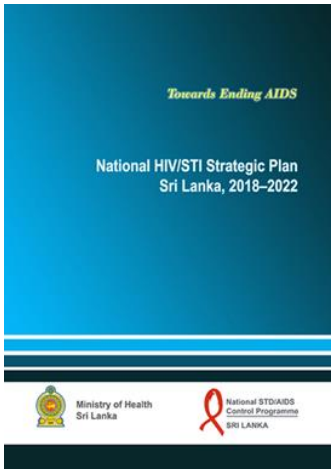
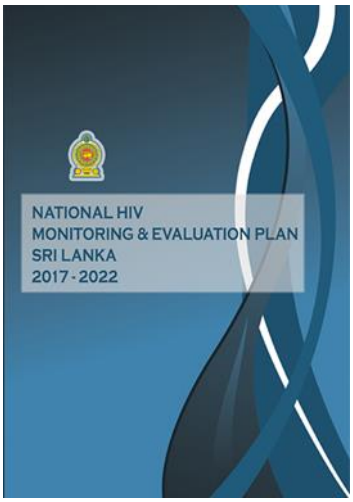
- A guide for maternal and child health care staff
- Annual Report, 2016
- External review report of the National Health sector response to HIV and STD in Sri Lanka, 2017
- Handbook on prevention of HIV/AIDS for lectures in the Sri Lanka Institute of Tourism and Hotel
- National HIV Communication Strategy, 2017
- National HIV/STI Strategic Plan Sri Lanka, 2018 - 2022
- National M&E Plan, 2017- 2022
- No secrets
- Stigma assessment of People living with HIV in Sri Lanka, 2017

A guide for maternal and child health care staff



This guideline for maternal and child healthcare staff gives comprehensive information regarding the programme for EMTCT of HIV and syphilis in Sri Lanka. It provides information on the targets and indicators of the programme, testing of pregnant women for syphilis and HIV in the ANC package, registers to be maintained at the ANC, role of the Laboratory, logistics needed at the ANC and the laboratory, management done at the STD clinic, management of an infant exposed either to HIV or syphilis and related ethical issues.

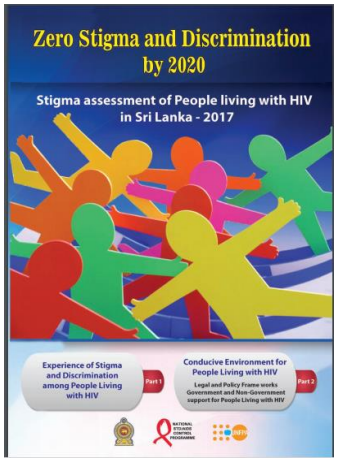
Annual Report , 2016	
. 	Early in 2017, the annual report of NSACP was published by aggregating data and information collected from over 30 service delivery centers (STD and ART centers). Annual report 2016 highlights activities conducted by NSACP and peripheral STD clinics, while giving useful insight about the HIV and STI epidemic situation of the country.
External review report , 2017	
	This publication is the report of the review conducted by a team of seven consultants (five international and two national), regarding Sri Lanka's National Response for sexually transmitted infections (STI) and HIV. The review addressed all five strategic directions of the NSP and identified major achievements, barriers and challenges faced in the last five years which provided the basis of recommendations that are presented in this document.
Handbook on prevention of HIV/AIDS for Institute of Tourism and Hotel	
M. 	This handbook is tailor made for lectures in Sri Lanka Institute of Tourism and Hotel Management. This provides core information regarding physical, mental and social changes of adolescent, prevention of HIV and other sexually transmitted infections, vulnerable factors for tourist sector and key population groups and vulnerable groups that should be clearly understood by them to keep in line with the prevention strategies used.

National HIV Communication Strategy, 2017	
	NCS is developed to deploy mass media and social media for a comprehensive communication programme, leading to raising awareness among the general population on HIV/AIDS. It is a key component in enabling the objective of 'Ending AIDS by 2025' in Sri Lanka, while breaking stigma and discrimination against those living with HIV/AIDS/STDs. Until now, communication efforts have been centered on Key populations/Most at Risk Populations (KP/MARP) engaging in high risk behaviors.
National HIV/STI strategic plan Sri Lanka, 2018 - 2022	
	The National STD/AIDS Control Programme (NSACP) of Sri Lanka has led the process of developing the National Strategic Plan (NSP) for HIV/STI Response 2018-2022. The NSP will be the guiding document for Sri Lanka's response to HIV/AIDS and sexually transmitted infections (STIs) for the next five years (2018-2022). The NSP has defined its vision, mission and goal for the next five years.
National M&E Plan, 2017- 2022	
	The purpose of any monitoring and evaluation (M&E) system is to provide the data needed to monitor progress and evaluate results to inform programme decisions and policy formulation. This document, is based on the 12 components described in the Organizing Framework for a Functional National HIV Monitoring and Evaluation System. It is for all M&E and programme staff involved in the National HIV/STI response.

No secrets

This document provides an enlightening, fascinating and challenging information for primary health care workers about human sexuality. It is also very useful for general readers interested in questions about the human behaviour, sexuality and gender diversity. It also seeks to dispel commonly accepted myths and misunderstandings surrounding human sexuality. This document is in all three languages that covers hundred facts which individuals must understand to have a safe, pleasurable and healthy sex life.

Stigma assessment of People living with HIV in Sri Lanka, 2017



This publication provides results and recommendations of the second stigma assessment conducted among people living with HIV in Sri Lanka. The assessment consisted of a descriptive cross-sectional study to assess stigma level (quantitative part), in-depth interviews to describe views from people living with HIV who are in positive networks (qualitative part), and a desk review to identify the supportive legal and policy frameworks and other available services for people living with HIV. The assessment was conducted by the Multi Sectoral Unit of the NSACP.

27 GF CONCEPT NOTE

During the year 2017, National STD/AIDS Control Programme submitted a Concept Note (CN) through the Country Coordinating Mechanism (CCM) requesting funds from the Global Fund for the period of 2019-2021.

Global Fund allocations for 2017-2019 period is USD 6,948,042.64. Sri Lanka considered innovative approaches especially for Key populations (KP) to achieve its ambitious country target of Ending AIDS in 2025. Moreover, approaches for sustainability of the KP programs when transitioning out of Global Fund support were considered.

The process was a consensus driven approach with the inputs from relevant stakeholders. Funding request was developed adhering to National HIV/STI Strategic Plan and identified gaps in funding. The value for money was considered in deciding targets and activities with highest impact, specially through evidence from external review, surveys and relevant studies.

The CCM approved the Family Planning Association (FPA) of Sri Lanka to continue as the Principal Recipient (PR) 2 while the NSACP being the PR1. Hence the financing will be dual tract, with PR1 receiving 52% of the total country allocation.

Following key documents were submitted for the funding request as specified by Global Fund.

1. Funding Request
2. Funding Landscape table justifying the funding need
3. Programmatic gap table – arriving at programme gap those need GF support
4. Detail activity budget explaining funds for each activity
5. Health product list to explain the health products estimation and budget
6. Performance Framework to explain targets and progress of the grant activities through reporting indicators
7. Prioritized above allocation request

Overall the Concept Note includes the following key areas (modules)

- Comprehensive prevention programmes for MSMs
- Comprehensive prevention programmes for people who inject drugs (PWID) and their partners
- Comprehensive prevention programmes for sex workers and their clients
- Comprehensive prevention programmes for TGs
- Comprehensive programmes for people in prisons and other closed settings
- Prevention programmes for other vulnerable populations
- Programme management
- Programmes to reduce human rights-related barriers to HIV services
- RSSH: Health management information systems and monitoring and evaluation
- Treatment, care and support

28 FINANCIAL SUMMARY

Table 25: Summary of financial details for 2017

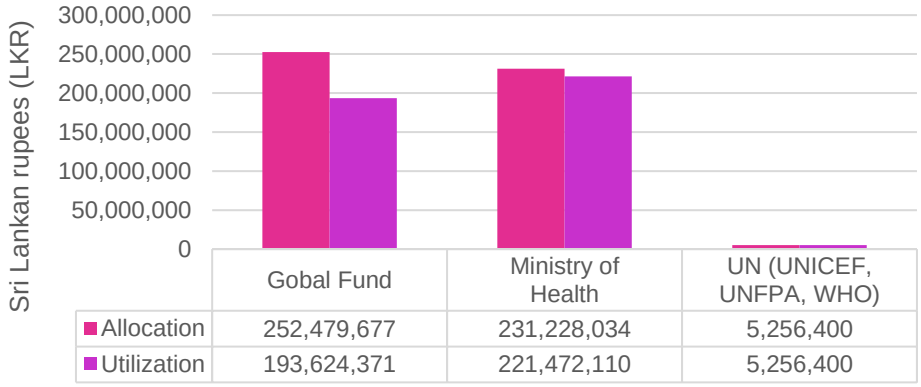
Financial Source	Description	Fund Allocation (LKR)	Fund Utilization (LKR)
1. Capital Expenditure			
Ministry of Health	Building construction	1,405,493.00	752,299.83
	World AIDS Day	9,981,250.00	6,809,880.50
	Training	250,000.00	167,500.00
	Training and Research	45,000.00	45,000.00
	DDG (PH)1	2,000,000.00	1,961,749.54
	Medical Equipment	6,390,160.00	6,371,860.07
	Purchase of laboratory equipment	10,000,000.00	10,000,000.00
	Research and Development	10,000,000.00	12,327,253.98
	Sub total	**40,071,903.00**	**38,435,543.92**
UNFPA	Consultative workshops, advocacy programmes, printing of publication	1,528,200	1,528,200.00
WHO	Consultative workshops, review meetings. training module	628,765	628,764.61
UNICEF	Prevention of mother to child transmission	3,099,435	3,099,435.02
GFATM	Human Resources (HR)	22,798,955.10	18,435,660.00
	Travel related costs (TRC)	12,548,184.00	11,780,434.00
	External Professional services (EPS)	100,600,800.00	63,183,901.00
	Health Products - Non-Pharmaceuticals (HPNP)	91,033,535.48	49,290,226.00
	Health Products - Equipment (HPE)	-	3,516,157.00
	Procurement and Supply-Chain Management costs (PSM)	18,117,576.56	35,411,472.00
	Infrastructure (INF)	-	4,407,078.00
	Non-health equipment (NHE)	2,659,026.00	297,177.00
	Communication Material and Publications (CMP)	380,000.00	4,552,686.00
	Indirect and Overhead Costs	4,341,600.00	3,046,757.00
	Sub total	**252,479,677.14**	**193,921,548.00**
Total Capital Expenditure		**297,807,979.76**	**237,613,491.55**

Cont., Table 25: Summary of financial details for 2017

Financial Source	Description	Fund Allocation (LKR)	Fund Utilization (LKR)
2. Recurrent Expenditure			
Ministry of Health	Personal emoluments (salaries etc.)	118,069,700.00	110,247,998.97
	Travelling expenses stationary and office requisites	343,500.00	345,489.62
	Fuel & supplies	3,459,110.00	3,387,990.21
	Maintenance expenditure	2,957,200.00	2,902,451.26
	Electricity and water	6,592,000.00	6,591,981.92
	Security, cleaning service and other	5,139,200.00	5,139,154.43
	Loan interest/transfers	1,000,000.00	826,078.68
	Antiretroviral drugs	18,580,593.88	18,580,593.88
	Other drugs (Non-Antiretroviral drugs)	6,818,315.44	6,818,315.44
	Surgical Items	1,398,801.12	1,398,801.12
	Total Pharmaceutical Expenditure	26,797,710.44	26,797,710.44
Total Recurrent Expenditure		**191,156,130.88**	**183,036,565.97**
Grand Total (LKR)		**488,964,110.64**	**420,650,057.52**

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

Figure 101: Financial allocation and utilization for 2017



Above figures show allocation and utilization of funds by NSACP during 2017. Utilization of funds 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. However, it should be noted that the funds allocated by the Ministry of Health of GoSL for peripheral STD clinics through the provincial allocations have not been captured in the budget shown above.

29 CONTACT INFORMATION

(Note: Contact information is given as of end 2017)

Central Province

1 Kandy STD clinic

Address	STD clinic, P.O. Box 207, Kandy
Email:	stdclinic.kandy@gmail.com
Telephone	081-2203622
Fax	081-2203923
Contact Persons	Dr (Ms.) Ganga Pathirana - Venereologist
	Dr M.I.M. Lareef (MO/IC)

2 Matale STD clinic

Address	STD clinic, District General Hospital, Matale
Email:	stdclinic.matale@gmail.com
Telephone	066-2053746
Contact persons	Dr Jagath Ranawaka – Acting Venereologist
	Dr (Ms.) H.M.G. Wijerathna (MO/IC)

3 Nuwara Eliya STD clinic

Address	STD clinic, General Hospital, Nuwara Eliya
Email:	stdclinic.nuwaraeliya@gmail.com
Telephone	052-2223210
	0522222261- Ext 345 (GH Nuwara Eliya)
Fax	052-2223476 (GH Nuwara Eliya)
Contact persons	Dr D.O.C.de Alwis – Acting Venereologist
	Dr D.S. Tissa Seneviratne (MO/IC)

Eastern Province

4 Ampara STD clinic

Address	STD clinic, General Hospital, Ampara
Email:	stdclinic.ampara@gmail.com
Telephone	063-2224239
Fax	063-2222988 (Ampara RDHS Office)
Contact person	Dr (Ms.) Sakunthala de Soyza (MO/IC)

5 Batticaloa STD clinic

Address	STD Clinic, Teaching Hospital, Batticaloa.
Email:	stdclinic.batticaloa@gmail.com
Telephone	065-2222261 (TH Batticaloa)
Fax	065-2224401 (TH Batticaloa)
Contact persons	Dr S. Anusha (MO/IC)

6 Kalmunai STD clinic

Address	STD clinic, Ashrooff Memorial Hospital, Kalmunai.
Email:	stdclinic.kalmunai@gmail.com
Telephone	067-2223660
Fax	067-2223660
Contact person	Dr (Ms.) H.P.N. Jeewani (MO/IC)

7 Trincomalee STD clinic

Address	STD clinic, General Hospital, Trincomalee
Email:	stdclinic.trincomalee@gmail.com
Telephone	026-2222563
Fax	026-2222563
Contact person	Dr V. Goureshwaran (MO/IC)

North Central Province

8 Anuradhapura STD clinic

Address	STD clinic, Teaching Hospital, Anuradhapura
Email:	stdclinic.anuradhapura@gmail.com
Telephone	025-2236461
Fax	025-2223515 (TH Anuradhapura)
Contact persons	Dr Ajith Karawita (Venereologist)
	Dr H. B. L. P. Dharmasiri (Medical officer in charge)

9 Polonnaruwa STD clinic

Address	STD clinic, General Hospital, Polonnaruwa
Email:	sticlinic.polonnaruwa@gmail.com
Telephone	027-2225787
Fax	027-2225787
Contact Person:	Dr (Ms.) Umeda Jayasingha - (Venereologist)
	Dr (Ms.) Indra Peris (MO/IC)

North Western Province

10 Chilaw STD clinic

Address	STD clinic, General Hospital, Chilaw
Email:	stdclinic.chilaw@gmail.com
Telephone	032-2220750
Fax	032-2223200 (GH Chilaw)
Contact person	Dr Priyantha Weerasingha -(Venereologist)
	Dr N. R. Amarajeewa (MO/IC)

11 Kurunegala STD clinic

Address	STD Clinic, Teaching Hospital, Kurunegala
Email:	stdclinic.kurunegala@gmail.com
Telephone	037-2224339
Fax	037-2224339
Contact persons	Dr H.A.C.W. Hathurusingha – Acting Venereologist
	Dr (Ms.) P.G.N.M. Jayathilaka (MO/IC)

Northern Province

12 Jaffna STD clinic

Address	STD Clinic, Teaching Hospital, Jaffna
Email:	stdclinic.jaffna@gmail.com
Telephone	021-2217756
Fax	021-2222262 (TH Jaffna)
Contact persons	Dr Priyantha Batagala (Acting Venereologist)
	Dr (Ms.) Tharani Guruparan (MO/IC)

13 Kilinochchi STD clinic

Address	STD Clinic, District General Hospital, Kilinochchi
Email:	stdclinic.kilinochchi@gmail.com
Telephone	021-2283709
	021-2285329 (BH Kilinochchi)- Ext. 194
Fax	021-2285327 (BH Kilinochchi)
Contact person	Dr (Ms.) Venuri Fernando (MO/IC)

14 Mannar STD clinic

Address	STD clinic, District General Hospital, Mannar
Email:	stdclinic.mannar@gmail.com
Telephone	023-2250573
Fax	023-2250748 (Mannar RDHS Office)
Contact person	Dr (Ms) Rajani Anton Sisil (MO/IC)

15 Mullaitivu STD clinic

Address	STD clinic, District General Hospital, Mullaitivu
Email:	Stdaidscontrolprogramme.mtv@gmail.com
Telephone	021-2061414
Contact person	Dr A. Dayalan (MO/IC)

16 Vavuniya STD clinic

Address	STD clinic, District General Hospital, Vavuniya
Email:	stdclinic.vavuniya@gmail.com
Telephone	024-2224575
Fax	024-2222892 (Vavuniya RDHS Office)
Contact person	Dr K. Chandrakumar (MO/IC)

Sabaragamuwa Province

17 Kegalle STD clinic

Address	STD clinic, District General Hospital, Kegalle
Email:	stdunit.kegalle@gmail.com
Telephone	035-2231222
Fax	035-2231222
Contact persons	Dr (Ms.) Geethani Samaraweera – Acting Venereologist Dr (Ms.) Lilanthi Dayananda – MO/IC

18 Ratnapura STD clinic

Address	STD clinic, Provincial General Hospital premises, Ratnapura
Email:	stdclinic.ratnapura@gmail.com
Telephone	045-2226561
Fax	045-2226561
Contact persons	Dr (Ms.) Darshani Mallikarachchi (Venereologist), Dr K. Upasena (MO/IC)

19 Embilipitiya STD clinic

Address	STD clinic, District General Hospital, Embilipitiya
Email:	stdclinic.embilipitiya@gmail.com
Telephone	No
Fax	NO
Contact persons	DR(Ms.) Dilmini Mendis - Venereologist

Southern Province

20 Balapitiya STD clinic

Address	STD Clinic, Base Hospital, Balapitiya.
Email:	stdclinic.balapitiya@gmail.com
Telephone	091-2256822
Fax	091-2256410 (BH Balapitiya)
Contact person	Dr M.W. Prasad de Silva (MO/IC)

21 Galle STD clinic

Address	STD clinic, Teaching Hospital, Mahamodara, Galle
Email:	stdclinic.mahamodara@gmail.com
Telephone	091-2245998
Fax	091-2232088
Contact person	Dr (Ms.) Darshani Wijewickrema - Venereologist

22 Hambantota STD clinic

Address	STD clinic, General Hospital, Hambantota
Email:	stdclinic.hambantota@gmail.com
Telephone	047-2222247
Fax	047-2222247
Contact persons	Dr (Ms.) Shyama Somawardana - Venereologist Dr L.K.H.M. Jayaruwan (MO/IC)

23 Matara STD clinic

Address	STD clinic, No 43, General Hospital, Matara
Email:	stdclinic.matara@gmail.com
Telephone	041-2232302
Fax	041-2232302
Contact persons	Dr (Ms.) G.A. Gayani Nanayakkara - Venereologist
	Dr S. Roshan Jayaweera (MO/IC)

Uva Province

24 Badulla STD clinic

Address	STD clinic, Room No 73, Daya Gunasekara Mawatha, Badulla.
Email:	stdclinic.badulla@gmail.com
Telephone	055-2222578
Fax	055-2222578
Contact persons	Dr (Ms.) Lasanthi Siriwardana – Acting Venereologist
	Dr R.D. Sugathadasa (MO/IC)

25 Monaragala STD clinic

Address	STD clinic, District General Hospital, Monaragala
Email:	stdclinic.monaragala@gmail.com
Telephone	055-2276826
Fax	055-2276700(RDHS Monaragala), 055- 2276912(GH Monaragala)
Contact person	Dr (Ms.) T.M. Anuradha Perera – Acting Venereologist
	Dr S.A.S. Pradeep Kumara (MO/IC)

Western Province

26 Avissawella STD clinic

Address	STD clinic, Room 5, OPD Complex, Base Hospital, Avissawella
Email:	stdclinic.avissawella@gmail.com
Telephone	036-2222261/62 – BH Avissawella (Ext. 228)
Contact person	Dr (Ms.) Manjula Rajapaksha - Venereologist
	Dr Suranga Liyanage (RHO)

27 Colombo STD clinic

Address	National STD/AIDS Control Programme, 29, De Saram Place, Colombo 10
Email	stdclinic.colombo@gmail.com
Telephone	011-2667163 (Exchange)
Hotlines	011-2695420 (Female clinic), 011-2-695430 (Male clinic)
Fax	011-2665277
Contact persons	Dr S. Liyanage (Director)
	Dr L.I. Rajapakse (Acting Director and 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)
	Dr H.P. Perera (Venereologist)

28 Gampaha STD clinic

Address	STD Clinic, District General Hospital, Gampaha
Email:	stdclinic.gampaha@gmail.com
Telephone	033-2234383
Fax	033-2222179 (GH Gampaha)
Contact person	Dr (Ms.) D.M.M.P.K. Pathiraja - Venereologist
	Dr S. B. S. Gamage (MO/IC)

29 Kalubowila STD clinic

Address	STD Clinic, Room 43, Sunandarama Rd, Kalubowila.
Email:	stdclinic.kalubowila@gmail.com
Telephone	011 4891055
Contact person	Dr Nalaka Abeygunasekara - Venereologist

30 Kalutara STD clinic

Address	STD Clinic, General Hospital, Nagoda, Kalutara
Email:	stdclinic.kalutara@gmail.com
Telephone	034-2236937
Fax	034-2236937
Contact persons	Dr (Ms.) Nimali Jayasooriya - Venereologist
	Dr (Ms.) S.A.P. Nishanthi (MO/IC)

31 Negombo STD clinic

Address	STD clinic, District General Hospital, Negombo
Email:	stdclinic.negombo@gmail.com
Telephone	031-2239016
	031-2222261(GH Negombo)
Contact persons	Dr (Ms.) Chandrika Jayakodi – Venereologist
	Dr Lionel Halahakoon (MO/IC)

32 Ragama STD clinic

Address	STD clinic, Room 70, Teaching Hospital, Ragama
Email:	stdclinic.ragama@gmail.com
Telephone	011-2960224
Fax	011-2960224
	011-2959266 (TH Ragama)
Contact persons	Dr (Ms.) Jayadari Ranatunga - Venereologist
	Dr (Ms.) Anjana Rajapaksha (MO/IC)

33 Wathupitiwala STD clinic

Address	STD Clinic, Base Hospital, Wathupitiwala
Email:	stdclinic.wathupitiwala@gmail.com
Telephone	033-2280261
Fax	033-2280927
Contact person	Dr (Ms.) P.G.Nayani Dhanuska (MO/IC)

Annex 1

Annex 1- Table 1. Number of Early (Infectious) Syphilis cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	10	6	16	9	3	12	6	6	12	4	1	5
	Matale	2	2	4	1	0	1	1	0	1	0	0	0
	Nuwara Eliya	2	2	4	3	6	9	3	1	4	3	1	4
Eastern Province	Ampara	0	0	0	1	1	2	2	2	4	2	0	2
	Batticaloa	2	3	5	0	0	0	1	0	1	1	1	2
	Kalmunai	0	0	0	0	0	0	0	1	1	0	0	0
	Trincomalee	0	0	0	0	0	0	1	0	1	0	0	0
North Central Province	Anuradhapura	1	0	1	0	0	0	0	0	0	0	0	0
	Polonnaruwa	0	0	0	0	0	0	0	0	0	0	0	0
North Western Province	Chilaw	4	2	6	0	0	0	0	0	0	0	0	0
	Kurunegala	1	0	1	0	0	0	2	0	2	4	0	4
Northern Province	Jaffna	0	0	0	3	2	5	1	1	2	0	0	0
	Kilinochchi				1	1	2	0	0	0	0	0	0
	Mannar	0	0	0	0	1	1	2	5	7	1	0	1
	Mullaitivu	-	-	-	-	-	-	0	0	0	0	0	0
	Vavuniya	0	0	0	0	0	0	0	1	1	0	0	0
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	0	0	0
	Kegalle	6	6	12	4	2	6	1	0	1	3	1	4
	Ratnapura	0	0	0	2	1	3	0	0	0	1	0	1
Southern Province	Balapitiya	3	0	3	4	3	7	4	2	6	2	0	2
	Hambanthota	0	3	3	4	2	6	0	0	0	3	0	3
	Mahamodara	20	8	28	8	6	14	2	1	3	3	1	4
	Matara	2	3	5	1	0	1	1	1	2	0	0	0
UVA Province	Badulla	0	0	0	0	0	0	1	1	2	0	1	1
	Monaragala	0	1	1	0	0	0	0	0	0	0	0	0
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	0	0	0
	Colombo	83	25	108	47	13	60	36	11	47	20	3	23
	Gampaha	0	0	0	9	1	10	0	0	0	1	1	2
	Kalubowila	20	7	27	13	6	19	3	1	4	4	0	4
	Kalutara	3	2	5	4	2	6	13	8	21	0	0	0
	Negombo	7	2	9	4	2	6	3	1	4	2	1	3
	Ragama	13	4	17	7	3	10	5	1	6	4	2	6
	Wathupitiwala	0	0	0	0	0	0	0	0	0	1	0	1
Total		**179**	**76**	**255**	**125**	**55**	**180**	**88**	**44**	**132**	**59**	**13**	**72**

Annex 1- Table 2. Number of Late Syphilis cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	31	17	48	44	23	67	28	20	48	18	6	24
	Matale	1	3	4	5	2	7	1	0	1	4	3	7
	Nuwara Eliya	2	0	2	0	0	0	0	0	0	5	6	11
Eastern Province	Ampara	6	7	13	4	4	8	3	2	5	6	4	10
	Batticaloa	7	5	12	12	5	17	12	4	16	7	3	10
	Kalmunai	1	1	2	0	0	0	1	0	1	0	0	0
	Trincomalee	4	1	5	0	1	1	7	3	10	7	2	9
North Central Province	Anuradhapura	15	19	34	6	5	11	8	8	16	4	2	6
	Polonnaruwa	21	5	26	8	2	10	18	12	30	10	6	16
North Western Province	Chilaw	24	15	39	14	5	19	9	10	19	12	7	19
	Kurunegala	33	32	65	31	27	58	28	24	52	19	14	33
Northern Province	Jaffna	1	3	4	6	1	7	8	2	10	6	4	10
	Kilinochchi	-	-	-	0	0	0	0	1	1	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-		0	0	0	0	0	0
	Vavuniya	5	3	8	3	4	7	2	5	7	3	1	4
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	0	0	0
	Kegalle	14	5	19	1	2	3	3	3	6	4	3	7
	Ratnapura	10	11	21	14	13	27	15	5	20	24	9	33
Southern Province	Balapitiya	5	5	10	2	2	4	5	3	8	9	6	15
	Hambanthota	7	1	8	0	1	1	0	1	1	4	8	12
	Mahamodara	38	16	54	35	16	51	36	13	49	28	4	32
	Matara	4	5	9	14	4	18	6	3	9	11	3	14
UVA Province	Badulla	33	10	43	18	18	36	14	11	25	15	4	19
	Monaragala	4	5	9	1	5	6	4	2	6	2	2	4
Western Province	Avissawella	-	-	-	-	-	-		-	-	0	0	0
	Colombo	264	150	414	244	139	383	182	84	266	153	98	251
	Gampaha	27	11	38	2	6	8	5	5	10	7	0	7
	Kalubowila	71	38	109	48	21	69	44	29	73	44	18	62
	Kalutara	16	14	30	15	6	21	13	10	23	5	9	14
	Negombo	31	12	43	18	7	25	15	11	26	18	6	24
	Ragama	74	23	97	56	13	69	32	15	47	22	11	33
	Wathupitiwala	11	8	19	12	10	22	6	2	8	2	1	3
Total		**760**	**425**	**1185**	**613**	**342**	**955**	**505**	**288**	**793**	**449**	**240**	**689**

Annex 1- Table 3. Number of Gonorrhoea cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	25	6	31	13	0	13	12	2	14	5	1	6
	Matale	1	2	3	1	0	1	2	1	3	7	1	8
	Nuwara Eliya	9	3	12	3	3	6	4	1	5	0	0	0
Eastern Province	Ampara	1	0	1	2	0	2	1	0	1	2	0	2
	Batticaloa	1	0	1	6	4	10	2	1	3	0	0	0
	Kalmunai	0	0	0	3	1	4	5	9	14	2	2	4
	Trincomalee	4	1	5	2	0	2	2	0	2	6	0	6
North Central Province	Anuradhapura	18	4	22	15	3	18	9	0	9	2	0	2
	Polonnaruwa	8	0	8	25	12	37	31	16	47	11	3	14
North Western Province	Chilaw	3	0	3	1	0	1	3	2	5	3	0	3
	Kurunegala	6	1	7	12	3	15	8	1	9	2	1	3
Northern Province	Jaffna	3	0	3	10	1	11	1	1	2	2	0	2
	Kilinochchi				4	1	5	1	0	1	2	0	2
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	1	0	1	0	0	0
	Vavuniya	13	0	13	1	0	1	7	0	7	6	0	6
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-		0	1	1
	Kegalle	11	5	16	10	3	13	6	2	8	8	3	11
	Ratnapura	5	1	6	8	3	11	6	1	7	8	2	10
Southern Province	Balapitiya	5	1	6	4	2	6	3	1	4	2	0	2
	Hambanthota	19	23	42	9	19	28	5	4	9	9	6	15
	Mahamodara	14	12	26	10	7	17	5	1	6	4	0	4
	Matara	13	5	18	7	2	9	9	2	11	4	0	4
UVA Province	Badulla	4	1	5	5	4	9	1	0	1	5	4	9
	Monaragala	6	2	8	7	0	7	2	0	2	0	0	0
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	0	0	0
	Colombo	168	26	194	81	36	117	60	11	71	54	15	69
	Gampaha	7	0	7	7	1	8	6	0	6	2	0	2
	Kalubowila	53	10	63	38	9	47	17	6	23	19	0	19
	Kalutara	9	0	9	10	5	15	8	1	9	11	5	16
	Negombo	17	1	18	13	2	15	7	0	7	8	3	11
	Ragama	32	3	35	22	4	26	11	3	14	6	0	6
	Wathupitiwala	9	3	12	0	0	0	0	0	0	0	0	0
Total		**464**	**110**	**574**	**329**	**125**	**454**	**235**	**66**	**301**	**190**	**47**	**237**

Annex 1- Table 4. Number of Non-Gonococcal infections reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	30	230	260	25	184	209	17	106	123	15	83	98
	Matale	5	4	9	4	8	12	6	14	20	8	38	46
	Nuwara Eliya	4	6	10	0	5	5	2	7	9	1	14	15
Eastern Province	Ampara	7	1	8	8	1	9	5	0	5	9	0	9
	Batticaloa	4	4	8	16	15	31	7	14	21	3	3	6
	Kalmunai	0	0	0	0	0	0	0	0	0	9	4	13
	Trincomalee	0	0	0	1	0	1	3	0	3	2	0	2
North Central Province	Anuradhapura	24	7	31	36	10	46	24	19	43	19	20	39
	Polonnaruwa	1	0	1	4	3	7	2	1	3	10	1	11
North Western Province	Chilaw	7	85	92	7	95	102	6	154	160	5	57	62
	Kurunegala	35	204	239	61	290	351	89	364	453	153	562	715
Northern Province	Jaffna	9	3	12	6	1	7	12	3	15	6	1	7
	Kilinochchi	-	-	-	0	0	0	1	0	1	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	2	0	2	3	0	3
	Vavuniya	10	0	10	8	0	8	6	1	7	1	0	1
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	2	0	2
	Kegalle	73	14	87	39	34	73	11	8	19	8	34	42
	Ratnapura	16	5	21	12	9	21	13	10	23	10	24	34
Southern Province	Balapitiya	7	4	11	2	2	4	2	10	12	4	6	10
	Hambanthota	15	4	19	25	14	39	14	1	15	20	7	27
	Mahamodara	18	89	107	12	65	77	11	31	42	10	15	25
	Matara	18	14	32	33	12	45	10	8	18	10	15	25
UVA Province	Badulla	9	1	10	1	3	4	3	2	5	2	2	4
	Monaragala	4	12	16	4	10	14	4	36	40	13	25	38
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	1	2	3
	Colombo	142	341	483	108	421	529	162	327	489	160	358	518
	Gampaha	13	108	121	6	113	119	24	128	152	18	81	99
	Kalubowila	42	114	156	61	127	188	91	81	172	104	169	273
	Kalutara	7	17	24	7	11	18	14	35	49	28	34	62
	Negombo	33	150	183	33	118	151	22	104	126	12	160	172
	Ragama	46	50	96	32	89	121	23	116	139	24	64	88
	Wathupitiwala	4	25	29	5	23	28	3	15	18	2	13	15
Total		**583**	**1492**	**2075**	**556**	**1663**	**2219**	**589**	**1595**	**2184**	**672**	**1792**	**2464**

Annex 1- Table 5. Number of Genital Herpes cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	65	122	187	69	129	198	53	105	158	62	95	157
	Matale	12	39	51	12	24	36	27	30	57	14	42	56
	Nuwara Eliya	8	7	15	6	10	16	4	11	15	8	25	33
Eastern Province	Ampara	28	42	70	21	44	65	22	37	59	13	40	53
	Batticaloa	6	12	18	12	14	26	7	21	28	2	11	13
	Kalmunai	2	2	4	1	10	11	4	9	13	4	6	10
	Trincomalee	22	18	40	13	14	27	15	10	25	9	20	29
North Central Province	Anuradhapura	66	69	135	56	67	123	78	68	146	47	74	121
	Polonnaruwa	43	52	95	39	42	81	49	63	112	39	58	97
North Western Province	Chilaw	25	43	68	30	58	88	33	63	96	32	59	91
	Kurunegala	92	138	230	99	162	261	90	150	240	60	143	203
Northern Province	Jaffna	17	3	20	14	6	20	13	14	27	12	16	28
	Kilinochchi	-	-	-	7	5	12	4	6	10	8	13	21
	Mannar	0	0	0	0	1	1	1	1	2	0	0	0
	Mullaitivu	-	-	-	-	-	-	4	2	6	10	2	12
	Vavuniya	41	20	61	44	37	81	43	29	72	10	20	30
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	1	2	3
	Kegalle	44	85	129	47	87	134	44	59	103	38	77	115
	Ratnapura	52	68	120	62	85	147	56	64	120	66	63	129
Southern Province	Balapitiya	19	39	58	23	41	64	18	38	56	21	38	59
	Hambanthota	37	21	58	24	26	50	28	39	67	30	49	79
	Mahamodara	41	73	114	40	66	106	58	74	132	37	86	123
	Matara	51	44	95	28	67	95	31	63	94	41	46	87
UVA Province	Badulla	38	71	109	20	58	78	28	83	111	39	91	130
	Monaragala	9	26	35	5	33	38	9	36	45	12	45	57
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	3	3	6
	Colombo	224	183	407	212	182	394	220	180	400	208	177	385
	Gampaha	55	52	107	54	83	137	58	76	134	33	61	94
	Kalubowila	139	167	306	142	154	296	145	166	311	111	129	240
	Kalutara	22	57	79	19	49	68	30	73	103	56	83	139
	Negombo	26	52	78	31	61	92	26	44	70	38	69	107
	Ragama	54	81	135	68	80	148	89	77	166	74	66	140
	Wathupitiwala	22	40	62	20	32	52	15	27	42	15	35	50
Total		**1165**	**1563**	**2728**	**1260**	**1626**	**2886**	**1218**	**1727**	**2945**	**1153**	**1744**	**2897**

Annex 1- Table 6. Number of Genital warts cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	41	41	82	56	48	104	54	48	102	54	38	92
	Matale	10	7	17	9	12	21	10	5	15	16	18	34
	Nuwara Eliya	6	2	8	5	2	7	4	2	6	3	5	8
Eastern Province	Ampara	19	11	30	15	19	34	16	19	35	10	11	21
	Batticaloa	4	5	9	5	2	7	5	9	14	9	4	13
	Kalmunai	0	1	1	2	0	2	2	1	3	2	1	3
	Trincomalee	5	4	9	4	7	11	8	7	15	9	2	11
North Central Province	Anuradhapura	39	30	69	63	34	97	56	41	97	62	37	99
	Polonnaruwa	28	18	46	32	20	52	29	27	56	30	35	65
North Western Province	Chilaw	34	23	57	38	29	67	41	27	68	49	33	82
	Kurunegala	73	66	139	93	89	182	93	116	209	96	101	197
Northern Province	Jaffna	11	6	17	19	2	21	24	7	31	21	10	31
	Kilinochchi				1	2	3	1	2	3	4	1	5
	Mannar	0	0	0	3	0	3	1	1	2	0	0	0
	Mullaitivu	-	-	-	-	-	-	4	0	4	1	0	1
	Vavuniya	12	5	17	16	8	24	25	10	35	12	5	17
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	4	2	6
	Kegalle	43	34	77	39	36	75	23	31	54	40	34	74
	Ratnapura	29	33	62	39	37	76	28	28	56	37	31	68
Southern Province	Balapitiya	15	13	28	14	16	30	18	16	34	21	8	29
	Hambanthota	38	17	55	25	31	56	41	55	96	35	27	62
	Mahamodara	54	42	96	49	35	84	48	46	94	44	36	80
	Matara	25	28	53	35	30	65	32	30	62	44	38	82
UVA Province	Badulla	12	20	32	24	29	53	24	27	51	27	20	47
	Monaragala	8	5	13	4	12	16	10	11	21	5	9	14
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	4	6	10
	Colombo	253	122	375	250	108	358	237	100	337	232	102	334
	Gampaha	35	31	66	23	31	54	33	35	68	30	25	55
	Kalubowila	102	86	188	118	76	194	110	65	175	109	79	188
	Kalutara	37	41	78	34	48	82	34	45	79	66	79	145
	Negombo	46	39	85	37	32	69	52	42	94	49	52	101
	Ragama	72	66	138	86	37	123	76	57	133	87	59	146
	Wathupitiwala	17	8	25	9	26	35	13	16	29	17	24	41
Total		**1068**	**804**	**1872**	**1147**	**858**	**2005**	**1152**	**926**	**2078**	**1229**	**932**	**2161**

Annex 1- Table 7. Number of Trichomonasis cases reported from STD clinics during 2014-2017													
Province	Clinic	2014			2015			2016			2017		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	2	0	2	1	5	6	0	5	5	0	3	3
	Matale	1	0	1	0	0	0	0	0	0	0	1	1
	Nuwara Eliya	0	0	0	0	0	0	0	0	0	1	2	3
Eastern Province	Ampara	0	0	0	0	1	1	0	0	0	0	0	0
	Batticaloa	2	6	8	1	8	9	1	7	8	0	1	1
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	7	1	8	2	1	3
North Central province	Anuradhapura	0	1	1	0	0	0	0	1	1	0	0	0
	Polonnaruwa	0	0	0	0	2	2	0	1	1	0	0	0
North Western Province	Chilaw	0	1	1	0	1	1	0	2	2	0	1	1
	Kurunegala	0	8	8	0	3	3	0	4	4	0	9	9
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
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Mullaitivu	-	-	-	-	-	-	0	0	0	0	0	0
	Vavuniya	0	1	1	0	0	0	0	0	0	0	0	0
Sabaragamuwa Province	Embilipitiya	-	-	-	-	-	-	-	-	-	0	0	0
	Kegalle	1	16	17	0	15	15	0	3	3	0	5	5
	Ratnapura	0	2	2	0	0	0	0	1	1	0	4	4
Southern Province	Balapitiya	0	2	2	0	0	0	0	0	0	0	3	3
	Hambanthota	0	0	0	0	1	1	0	0	0	1	0	1
	Mahamodara	0	0	0	0	3	3	0	3	3	0	0	0
	Matara	0	1	1	0	0	0	0	0	0	0	3	3
UVA Province	Badulla	0	3	3	1	2	3	0	0	0	0	0	0
	Monaragala	0	0	0	0	0	0	0	11	11	0	0	0
Western Province	Avissawella	-	-	-	-	-	-	-	-	-	0	0	0
	Colombo	5	20	25	7	41	48	0	7	7	0	20	20
	Gampaha	0	2	2	0	4	4	0	1	1	0	0	0
	Kalubowila	0	15	15	3	10	13	1	4	5	1	8	9
	Kalutara	0	1	1	2	2	4	0	1	1	0	3	3
	Negombo	0	11	11	0	3	3	1	3	4	6	1	7
	Ragama	1	7	8	0	3	3	0	0	0	0	2	2
	Wathupitiwala	0	0	0	0	0	0	0	0	0	0	0	0
Total		**12**	**97**	**109**	**15**	**104**	**119**	**10**	**55**	**65**	**11**	**67**	**78**

Annex 2

Annex 2- Table 1. Number of clinic attendees and details of clinic attendances for STD clinics during 2017													
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	515	533	1,048	207	346	553	1,892	2,319	4,211	2,345	4,473	6,818
	Matale	117	113	230	54	79	133	291	315	606	489	691	1,180
	Nuwara Eliya	136	242	378	32	95	127	243	333	576	594	566	1,160
Eastern Province	Ampara	138	188	326	70	111	181	393	442	835	804	6,091	6,895
	Batticaloa	64	138	202	19	25	44	856	757	1,613	1,194	12,980	14,174
	Kalmunai	115	93	208	17	13	30	109	87	196	881	548	1,429
	Trincomalee	117	111	228	70	54	124	291	254	545	1,113	7,107	8,220
North Central Province	Anuradhapura	376	330	706	231	229	506	565	744	1,576	2,907	6,792	10,081
	Polonnaruwa	206	239	445	186	234	420	403	468	871	1,105	3,279	4,384
North Western Province	Chilaw	359	496	855	135	266	401	651	740	1,391	914	722	1,636
	Kurunegala	747	1,153	1,900	411	971	1,382	2,076	3,178	5,254	2,430	2,775	5,205
Northern Province	Jaffna	160	121	281	77	66	143	306	226	532	4,449	7,573	12,022
	Kilinochchi	66	70	136	34	22	56	209	605	814	887	2,573	3,460
	Mannar	20	21	41	2	2	4	21	22	43	293	1,592	1,885
	Mullaitivu	28	29	57	20	7	27	33	33	66	3,319	3,634	6,953
	Vavuniya	82	80	162	43	32	75	167	140	307	1,116	3,454	4,570
Sabaragamuwa Province	Embilipitiya	23	37	60	9	14	23	47	73	120	16	16	32
	Kegalle	243	312	555	133	261	394	818	959	1,777	1,068	1,328	2,396
	Ratnapura	455	452	907	163	173	336	950	1,013	1,963	1,151	1,611	2,762
Southern Province	Balapitiya	112	109	221	65	79	144	215	219	434	1,058	2,050	3,108
	Hambanthota	364	272	636	141	135	276	602	476	1,078	1,404	5,451	6,855
	Mahamodara	380	348	728	162	189	351	1,299	1,166	2,465	933	1,404	2,337
	Matara	412	264	676	138	148	286	1,035	677	1,712	1,312	4,225	5,537
UVA Province	Badulla	320	410	730	145	242	387	970	1,114	2,084	2,619	14,460	17,079
	Monaragala	109	192	301	32	106	138	209	464	673	930	959	1,889
Western Province	Avissawella	26	18	44	14	12	26	65	49	114	5	17	22
	Colombo	3,470	1,918	5,388	1,188	1,396	2,584	13,510	4,987	18,497	4,072	3,261	7,333
	Gampaha	294	295	589	163	214	377	1,028	906	1,934	605	891	1,496
	Kalubowila	814	645	1,459	413	487	900	4,035	2,743	6,778	1,194	1,031	2,225
	Kalutara	560	466	1,026	213	352	565	1,531	1,482	3,013	1,483	1,552	3,035
	Negombo	325	475	800	150	331	481	1,285	1,586	2,871	988	1,099	2,087
	Ragama	532	425	957	268	282	550	2,294	1,604	3,898	1,045	746	1,791
	Wathupitiwala	124	143	267	65	108	173	212	265	477	290	590	880
Total		**11,809**	**10,738**	**22,547**	**5,106**	**7,091**	**12,197**	**38,611**	**30,446**	**69,324**	**45,791**	**105,145**	**150,936**

Annex 2- Table 2. Details of cervical cytology screening during the 2017					
Province	Clinic	Number screened for cervical cytology during the 2017	Total number of reports received	Number of satisfactory samples	Number reported as CIN-1 or above
Central Province	Kandy	61	44	30	0
	Matale	13	16	12	0
	Nuwara Eliya	0	0	0	0
Eastern Province	Ampara	0	0	0	0
	Batticaloa	0	0	0	0
	Kalmunai	3	0	0	0
	Trincomalee	0	0	0	0
North Central province	Anuradhapura	49	49	44	0
	Polonnaruwa	3	3	3	0
North Western Province	Chilaw	16	14	14	0
	Kurunegala	103	84	71	6
Northern Province	Jaffna	22	22	16	0
	Kilinochchi	0	0	0	0
	Mannar	0	0	0	0
	Mullaitivu	0	0	0	0
	Vavuniya	0	0	0	0
Sabaragamuwa Province	Embilipitiya	0	0	0	0
	Kegalle	50	54	52	2
	Ratnapura	32	25	25	1
Southern Province	Balapitiya	0	0	0	0
	Hambanthota	0	0	0	0
	Mahamodara	43	39	32	0
	Matara	7	7	7	0
UVA Province	Badulla	59	53	52	1
	Monaragala	0	0	0	0
Western Province	Avissawella	6	5	5	0
	Colombo	903	903	876	49
	Gampaha	5	5	5	0
	Kalubowila	372	245	239	9
	Kalutara	51	16	15	0
	Negombo	56	45	21	0
	Ragama	83	35	34	1
	Wathupitiwala	0	0	0	0
Total		**1937**	**1664**	**1553**	**69**

Annex 2- Table 3. Samples screened for syphilis – 2017																	
Province	Clinic	Number tested by VDRL				Number VDRL positive				Number TPRA/TPHA tested				Number TPRA/TPHA positive			
		STD	ANC	Pre-Emp.	Other	STD	ANC	Pre-emp.	Other	STD	ANC	Pre-emp.	Other	STD	ANC	Pre-emp.	Other
Central Province	Kandy	2261	21379	2756	3828	89	61	2	42	1202	47	2	1238	31	1	2	24
	Matale	292	6876	802	180	3	0	0	0	203	0	0	130	3	0	0	0
	Nuwara Eliya	405	10451	938	200	34	44	5	2	405	2551	9	2	16	6	0	0
Eastern Province	Ampara	449	5266	870	67	30	3	0	0	240	3	0	0	15	2	0	0
	Batticaloa	215	11415	1336	2776	0	0	0	0	0	0	0	0	0	0	0	0
	Kalmunai	264	7906	1198	447	0	0	0	0	24	0	0	0	0	0	0	0
	Trincomalee	228	8765	1753	1703	25	136	22	25	128	103	11	368	22	1	2	6
North Central Province	Anuradhapura	834	15573	5332	2885	18	8	0	0	244	3460	1160	485	23	0	0	0
	Polonnaruwa	671	3967	1617	4738	21	21	4	22	131	21	4	80	18	4	1	8
North Western Province	Chilaw	1251	15047	1165	2688	5	4	0	0	1252	1	0	173	21	0	0	0
	Kurunegala	2679	25629	4059	583	148	21	0	2	2352	0	0	74	50	0	0	3
Northern Province	Jaffna	281	9343	1790	5213	4	140	22	75	143	140	22	85	5	3	0	4
	Kilinochchi	135	1615	1217	300	0	1	0	0	0	0	0	0	0	0	0	0
	Mannar	449	1990	249	82	2	2	0	0	445	2	0	0	4	0	0	0
	Mullaitivu	1867	1455	0	5	0	1	0	0	90	1	0	5	0	0	0	0
	Vavuniya	1939	2762	1567	249	3	1	0	1	899	1	0	244	13	0	0	1
Sabaragamuwa Province	Embilipitiya	88	0	0	32	0	0	0	0	88	0	0	32	0	0	0	0
	Kegalle	710	12559	1526	933	31	19	2	8	672	13	0	124	13	2	0	3
	Ratnapura	1952	17739	601	5044	52	63	0	7	1933	132	0	2380	23	3	0	19
Southern Province	Balapitiya	247	4551	592	1297	7	5	1	5	17	1	0	8	12	1	0	7
	Hambanthota	610	10520	2701	1246	25	25	2	15	311	546	19	5	15	4	1	1
	Mahamodara	1294	10937	1966	1539	157	128	40	40	1144	121	45	296	32	4	1	11
	Matara	709	11905	2277	699	12	1	0	1	696	1	0	478	29	0	0	1
UVA Province	Badulla	1510	20847	1473	2464	79	111	5	19	581	110	5	260	14	3	0	2
	Monaragala	408	2796	963	939	5	14	3	5	103	14	3	5	3	0	0	4
Western Province	Avissawella	41	0	16	8	0	0	0	0	0	0	0	0	0	0	0	0
	Colombo	11568	41499	6816	15696	827	258	15	415	6616	10465	1928	5180	475	14	1	473
	Gampaha	855	14901	1177	1086	2	12	0	1	547	9	4	316	25	0	0	12
	Kalubowila	2827	297	57	1931	84	0	0	13	1710	0	0	480	93	0	0	18
	Kalutara	1548	19987	2466	1294	66	36	2	3	1404	36	2	3	23	3	0	2
	Negombo	1743	6535	607	794	58	20	0	4	1197	1776	0	4	61	1	0	3
	Ragama	2494	8314	881	2325	42	5	1	2	987	11	3	6	34	1	0	1
	Wathupitiwala	274	276	547	332	4	0	0	0	4	0	0	0	4	0	0	0
Total		**43,098**	**333,102**	**51,315**	**63,603**	**1833**	**1140**	**126**	**707**	**25,768**	**19,565**	**3217**	**12,461**	**1077**	**53**	**8**	**603**

Annex 2 **Table 4. Reason for attendance Among New STD clinic attendees in 2017**													
Province	Clinic	Contact of patients			Voluntary			Referral from magistrate/court			Others		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	19	8	27	262	89	351	3	12	15	234	376	610
	Matale	10	12	22	42	28	70	2	1	3	64	71	135
	Nuwara Eliya	35	12	47	30	14	44	15	35	50	56	181	237
Eastern Province	Ampara	13	6	19	45	43	88	20	45	65	67	105	172
	Batticaloa	1	1	2	3	1	4	8	59	67	52	77	129
	Kalmunai	14	1	15	48	31	79	0	7	7	43	36	79
	Trincomalee	5	3	8	21	7	28	11	61	72	78	39	117
North Central Province	Anuradhapura	6	7	13	186	132	318	102	117	219	67	151	218
	Polonnaruwa	14	7	21	124	128	252	53	96	149	15	8	23
North Western Province	Chilaw	45	24	69	111	68	179	55	157	212	120	213	333
	Kurunegala	135	99	234	281	288	569	84	146	230	241	554	795
Northern Province	Jaffna	8	3	11	25	5	30	86	80	166	122	106	228
	Kilinochchi	2	0	2	10	3	13	1	9	10	53	58	111
	Mannar	3	0	3	0	1	1	5	11	16	12	9	21
	Mullaitivu	0	0	0	4	1	5	6	9	15	18	19	37
	Vavuniya	6	4	10	10	7	17	2	35	37	64	36	100
Sabaragamuwa Province	Embilipitiya	0	0	0	3	2	5	7	13	20	20	28	48
	Kegalle	62	26	88	105	81	186	3	1	4	119	226	345
	Ratnapura	30	21	51	163	101	264	107	156	263	155	174	329
Southern Province	Balapitiya	10	4	14	44	17	61	3	19	22	55	69	124
	Hambanthota	12	14	26	132	39	171	85	71	156	118	142	260
	Mahamodara	25	18	43	122	54	176	42	44	86	191	232	423
	Matara	22	17	39	113	53	166	118	51	169	159	143	302
UVA Province	Badulla	15	17	32	79	56	135	65	113	178	161	224	385
	Monaragala	22	6	28	22	12	34	26	74	100	39	100	139
Western Province	Avissawella	7	2	9	7	5	12	3	3	6	9	8	17
	Colombo	159	126	285	2002	525	2527	17	336	353	1292	930	2222
	Gampaha	35	18	53	78	61	139	33	45	78	148	171	319
	Kalubowila	63	45	108	446	163	609	23	83	106	286	350	636
	Kalutara	137	95	232	169	122	291	45	44	89	209	175	384
	Negombo	36	24	60	90	160	250	51	98	149	123	166	289
	Ragama	36	29	65	162	69	231	69	85	154	265	242	507
	Wathupitiwala	0	0	0	69	45	114	4	3	7	50	96	146
Total		**987**	**649**	**1636**	**5008**	**2411**	**7419**	**1154**	**2119**	**3273**	**4705**	**5515**	**10220**

Annex 2-Table 5. HIV Testing and Counselling Details from STD clinics during 2017																
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	
			Positive	Negative		Positive	Negative		Positive	Negative		Positive	Negative		Positive	Negative
Central Province	Kandy	80	0	69	27	3	23	0	0	0	4	0	4	2204	9	1448
	Matale	12	0	12	11	0	11	1	0	1	1	0	1	418	1	417
	Nuwara Eliya	1	0	1	0	0	0	0	0	0	0	0	0	184	0	124
Eastern Province	Ampara	3	0	3	3	0	3	0	0	0	0	0	0	783	0	783
	Batticaloa	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0	233	0	233
	Trincomalee	0	0	0	1	0	1	3	0	3	0	0	0	301	1	300
North Central Province	Anuradhapura	86	0	86	198	0	198	0	0	0	20	0	20	0	0	0
	Polonnaruwa	34	7	21	29	7	22	0	0	0	0	0	0	0	0	0
North Western Province	Chilaw	37	0	37	0	0	0	0	0	0	0	0	0	720	1	551
	Kurunegala	100	0	93	21	1	20	17	0	17	179	0	179	2644	9	2635
Northern Province	Jaffna	5	0	5	13	0	13	1	0	1	8	0	8	0	0	0
	Kilinochchi	0	0	0	0	0	0	0	0	0	0	0	0	132	0	108
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0	1064	2	1062
	Mullaitivu	0	0	0	0	0	0	0	0	0	0	0	0	578	0	578
	Vavuniya	1	0	1	0	0	0	0	0	0	15	0	15	804	0	804
Sabaragamuwa Province	Embilipitiya	4	1	3	0	0	0	0	0	0	0	0	0	0	0	0
	Kegalle	10	0	10	22	0	21	0	0	0	4	0	4	868	1	867
	Ratnapura	24	0	24	2	0	2	1	0	1	67	0	60	1695	2	1601
Southern Province	Balapitiya	34	0	34	379	0	379	0	0	0	0	0	0	944	0	944
	Hambanthota	136	0	136	0	0	0	0	0	0	174	0	174	401	0	388
	Mahamodara	47	0	39	3	0	3	7	0	7	63	0	61	1192	9	883
	Matara	25	0	24	7	1	6	0	0	0	103	0	58	627	3	367
UVA Province	Badulla	6	0	6	3	0	3	0	0	0	8	0	8	0	0	0
	Monaragala	2	0	2	0	0	0	0	0	0	6	0	6	0	0	0
Western Province	Avissawella	0	0	0	0	0	0	0	0	0	0	0	0	61	0	61
	Colombo	483	0	386	406	20	362	48	0	38	7	1	5	4376	53	3838
	Gampaha	40	0	40	16	0	16	1	0	1	0	0	0	683	1	659
	Kalubowila	271	0	235	587	9	519	13	0	12	13	0	13	4348	9	3833
	Kalutara	17	0	17	29	0	29	2	0	2	38	0	38	1098	5	1093
	Negombo	108	0	65	96	2	82	19	0	14	108	0	69	986	5	617
	Ragama	32	0	16	92	11	46	1	0	0	31	0	15	1449	11	714
	Wathupitiwala	25	0	25	41	0	41	22	0	22	0	0	0	323	0	315
Total		**1625**	**8**	**1392**	**1986**	**54**	**1800**	**136**	**0**	**119**	**849**	**1**	**738**	**29116**	**122**	**25,223**

Annex 2- Table 6.Contacts for syphilis, gonorrhea, non-gonococcal infections and trichomoniasis treated during 2017													
Province	Clinic	contacts of syphilis treated			contacts of gonorrhea treated			contacts of non-gonococcal treated			contacts of trichomoniasis treated		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	0	0	0	0	0	0	0	0	0	0	0
	Matale	1	1	2	2	1	3	1	2	3	0	0	0
	Nuwara Eliya	6	0	6	0	0	0	0	0	0	0	1	1
Eastern Province	Ampara	0	1	1	0	0	0	0	0	0	0	0	0
	Batticaloa	1	1	2	0	0	0	0	0	0	0	0	0
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	2	1	2	0	1	1	0	0	0	0	0	0
North Central Province	Anuradhapura	2	4	6	0	2	2	0	0	0	0	1	1
	Polonnaruwa	6	4	10	4	1	5	0	0	0	0	0	0
North Western Province	Chilaw	1	0	1	0	0	0	1	0	1	0	0	0
	Kurunegala	9	4	13	0	1	1	31	29	60	3	3	6
Northern Province	Jaffna	2	4	6	0	0	0	0	0	0	0	0	0
	Kilinochchi	0	0	0	0	0	0	0	0	0	0	0	0
	Mannar	2	0	2	0	0	0	0	0	0	0	0	0
	Mullaitivu	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	0	1	1	0	0	0	0	0	0	0	0	0
Sabaragamuwa Province	Embilipitiya	0	0	0	1	0	1	0	0	0	0	0	0
	Kegalle	2	2	4	3	1	4	8	2	10	0	0	0
	Ratnapura	7	11	18	2	2	4	0	0	0	0	0	0
Southern Province	Balapitiya	0	6	6	0	0	0	0	0	0	0	0	0
	Hambanthota	4	2	6	4	8	12	3	12	15	0	0	0
	Mahamodara	3	4	7	0	1	1	1	2	3	0	0	0
	Matara	1	1	2	0	1	1	0	1	1	0	0	0
UVA Province	Badulla	2	0	2	2	2	4	0	0	0	0	0	0
	Monaragala	0	0	0	0	0	0	5	5	10	0	0	0
Western Province	Avissawella	0	0	0	0	0	0	0	0	0	0	0	0
	Colombo	25	19	44	7	6	13	32	25	57	2	7	9
	Gampaha	1	0	1	0	1	1	0	0	0	0	0	0
	Kalubowila	13	9	22	5	2	7	52	46	98	7	1	8
	Kalutara	5	1	6	3	4	6	0	0	0	0	0	0
	Negombo	6	1	7	1	2	3	13	3	16	1	1	2
	Ragama	2	4	6	2	0	2	3	6	9	0	0	0
	Wathupitiwala	0	0	0	0	0	0	0	0	0	0	0	0
Total		**103**	**81**	**183**	**36**	**36**	**71**	**150**	**133**	**283**	**13**	**14**	**27**

Annex 2- Table 7. Details of the awareness programmes conducted by STD clinics in 2017									
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	97	12786	4	45000	12	483	0	0
	Matale	30	2315	1	275	12	760	0	0
	Nuwara Eliya	18	1550	2	200	0	0	1	500
Eastern Province	Ampara	59	4686	3	500	0	0	24	1856
	Batticaloa	126	6470	0	0	0	0	0	0
	Kalmunai	10	600	0	0	0	0	0	0
	Trincomalee	44	2971	0	0	0	0	0	0
North Central Province	Anuradhapura	68	5729	2	300	3	150	6	1200
	Polonnaruwa	38	9933	0	0	0	0	4	516
North Western Province	Chilaw	89	8705	1	1500	2	235	4	338
	Kurunegala	126	13778	5	8500	23	1577	7	5235
Northern Province	Jaffna	60	4520	0	0	4	160	1	350
	Kilinochchi	55	4380	0	0	0	0	3	400
	Mannar	4	270	0	0	3	320	0	0
	Mullaitivu	33	3858	0	0	28	1481	0	0
	Vavuniya	41	2711	0	0	0	0	1	250
Sabaragamuwa Province	Embilipitiya	6	350	0	0	0	0	1	1000
	Kegalle	47	8369	1	7000	9	278	0	0
	Ratnapura	67	7887	4	11569	0	0	1	600
Southern Province	Balapitiya	40	1976	0	0	2	896	0	0
	Hambanthota	62	4962	0	0	26	1686	0	0
	Mahamodara	11	1360	0	0	2	70	29	1794
	Matara	16	2649	1	6500	13	1284	6	4058
UVA Province	Badulla	113	13708	0	0	0	0	2	453
	Monaragala	80	4061	0	0	2	1075	38	1656
Western Province	Avissawella	11	1355	0	0	1	45	5	2800
	Colombo	24	2196	20	55350	9	290	13	11353
	Gampaha	86	8929	0	0	3	170	0	0
	Kalubowila	29	2340	1	200	10	249	47	1276
	Kalutara	69	5942	3	1460	1	30	8	582
	Negombo	33	2925	1	120	3	77	1	49
	Ragama	57	2957	0	0	0	0	22	1667
	Wathupitiwala	8	2917	0	0	0	0	4	390
Total		**1657**	**160145**	**49**	**138474**	**168**	**11316**	**228**	**38323**

Annex 2- Table 8. Samples tested for HIV infection during 2017									
Province	Clinic	No. screened for HIV (ELISA,PA,RAPID)				No. of screening positive samples			
		STD pt. samples	Antenatal samples	Pre-emp. samples	Other samples	STD pt. samples	Antenatal samples	Pre-emp. samples	Other samples
Central Province	Kandy	2099	17038	27	6614	13	1	0	2
	Matale	305	6855	2	305	2	7	0	1
	Nuwara Eliya	405	10451	0	632	6	6	0	2
Eastern Province	Ampara	445	5266	0	654	0	0	0	0
	Batticaloa	202	11415	0	2776	0	0	0	0
	Kalmunai	146	10460	1070	98	0	0	0	0
	Trincomalee	228	8765	11	1896	1	6	0	1
North Central province	Anuradhapura	834	15573	2610	2968	6	0	0	2
	Polonnaruwa	614	3967	0	4703	3	2	0	4
North Western Province	Chilaw	1252	15047	10	2688	3	0	0	0
	Kurunegala	3232	25629	3	1427	43	3	0	0
Northern Province	Jaffna	286	9343	0	6288	7	2	0	3
	Kilinochchi	135	1615	0	753	0	1	0	0
	Mannar	449	1990	0	82	1	0	0	0
	Mullaitivu	872	1455	0	5	0	0	0	0
	Vavuniya	915	2762	0	1631	1	0	0	0
Sabaragamuwa Province	Embilipitiya	108	0	0	32	1	0	0	0
	Kegalle	701	12568	0	1337	12	11	0	2
	Ratnapura	2205	17539	0	2375	2	3	0	2
Southern Province	Balapitiya	247	4551	1144	629	0	0	0	0
	Hambanthota	610	10520	915	1042	8	2	0	3
	Mahamodara	1309	17021	16	1969	6	1	0	12
	Matara	770	11905	6	934	5	0	0	3
UVA Province	Badulla	1805	20847	488	1766	10	19	0	4
	Monaragala	408	2796	0	939	1	10	0	0
Western Province	Avissawella	45	0	3	13	0	0	0	0
	Colombo	8214	41499	3951	43501	55	6	0	272
	Gampaha	970	14901	17	2946	8	0	0	2
	Kalubowila	2281	299	52	3472	21	1	0	18
	Kalutara	1924	20025	10	1802	18	2	0	1
	Negombo	1979	6447	1	2448	6	1	0	2
	Ragama	3137	8314	0	2325	27	1	0	4
	Wathupitiwala	274	276	130	352	0	0	0	1
Total		**39406**	**337139**	**10466**	**101402**	**266**	**85**	**0**	**341**

Annex 2-Table 9. Number of patients with confirmed syphilis diagnoses completing treatment during 2017													
Province	Clinic	Number of diagnosed with syphilis			Number completed treatment			No. of pregnant women diagnosed with syphilis			No. completed treatment		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	22	7	29	14	7	21	0	0	0	0	0	0
	Matale	2	1	3	2	1	3	0	0	0	0	0	0
	Nuwara Eliya	8	1	9	1	0	1	0	6	6	0	1	1
Eastern Province	Ampara	6	3	9	6	3	9	0	1	1	0	1	1
	Batticaloa	8	4	12	8	4	12	0	0	0	0	2	2
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	6	1	7	5	1	6	0	0	0	0	0	0
North Central province	Anuradhapura	4	3	7	4	1	5	0	0	0	0	0	0
	Polonnaruwa	9	6	15	8	6	14	0	4	4	0	4	4
North Western Province	Chilaw	10	9	19	9	9	18	0	0	0	0	4	4
	Kurunegala	23	14	37	17	10	27	0	0	0	0	0	0
Northern Province	Jaffna	6	6	12	6	4	10	0	3	3	0	3	3
	Kilinochchi	0	0	0	0	0	0	0	0	0	0	0	0
	Mannar	2	0	2	2	0	2	0	0	0	0	0	0
	Mullaitivu	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	3	1	4	3	1	4	0	0	0	0	1	1
Sabaragamuwa Province	Embilipitiya	0	0	0	0	0	0	0	0	0	0	0	0
	Kegalle	7	5	12	5	5	10	0	1	1	0	1	1
	Ratnapura	25	10	35	20	9	29	0	3	3	0	3	3
Southern Province	Balapitiya	11	6	17	8	6	14	0	2	2	0	2	2
	Hambanthota	6	8	14	6	7	13	0	2	2	0	2	2
	Mahamodara	32	5	37	28	4	32	0	2	2	0	2	2
	Matara	12	3	15	12	3	15	0	0	0	0	0	0
UVA Province	Badulla	15	5	20	15	5	20	0	0	0	0	0	0
	Monaragala	4	2	6	2	1	3	0	1	1	0	1	1
Western Province	Avissawella	0	0	0	0	0	0	0	0	0	0	0	0
	Colombo	174	102	276	120	62	182	0	6	6	0	6	6
	Gampaha	8	1	9	6	0	6	0	0	0	7	1	8
	Kalubowila	48	18	66	40	17	57	0	0	0	0	0	0
	Kalutara	6	9	15	5	6	11	0	3	3	0	5	5
	Negombo	17	6	23	12	6	18	0	1	1	0	1	1
	Ragama	22	9	31	19	7	26	0	1	1	0	1	1
	Wathupitiwala	2	2	4	2	1	3	0	0	0	0	0	0
Total		**498**	**247**	**745**	**385**	**186**	**571**	**0**	**36**	**36**	**0**	**40**	**48**

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