National STD/AIDS Control Programme Sri Lanka

Annual Report 2015

Ministry of Health Sri Lanka

National STD/AIDS Control Programme

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2015

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Foreword

National STD/AIDS Control Programme (NSACP) of the Ministry of Health of Sri Lanka is working under the broad vision of providing quality sexual health services for a healthier nation. Established as a specialized public health programme of the Ministry of Health, NSACP is responsible for coordinating, planning and implementing the HIV National Strategic Plan in harmony with the AIDS Policy of Sri Lanka.

At the end of 2015, the NSACP was providing preventive and curative services through 30 full-time STD clinics and 23 branch clinics, distributed island wide. Of these, 13 clinics have the capacity to provide antiretroviral treatment (ART) services for people living with HIV.

The importance of collection and dissemination of strategic Information related to STD and HIV is well recognized and it is coordinated and executed by the Strategic Information Management (SIM) unit of the NSACP. The Annual Report 2015 provides a summary of key activities conducted by the NSACP during 2015 and data on STI and HIV reported from all the STD clinics. NSACP strongly believes in the importance of STI surveillance in the current low HIV prevalence context.

I thank all contributors to this document which is an important source of information on HIV and STIs in Sri Lanka. The hard work and commitment of the staff of the SIM unit as well as all reporting units are highly appreciated. I hope that the information available in this document will be used to further strengthen the national response to HIV in Sri Lanka.

Dr Sisira Liyanage

Director
National STD/AIDS Control Programme

April 7, 2016

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Abbreviations

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

Abbreviations

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

Abbreviations

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

Introduction

Introduction

The National STD/AIDS control programme (NSACP) of the Ministry of Health, is the principal government organization that is responsible for the national response to HIV/AIDS in Sri Lanka. Being a specialized public health programme of the Ministry of health, NSACP is responsible for coordinating, planning and implementation of the HIV National Strategic Plan and the AIDS Policy in the country. The headquarters of the NSACP is situated at 29, De Saram Place Colombo 10, Sri Lanka. As of end 2015, there are 30 full-time STD clinics and 23 branch STD clinics in Sri Lanka. Of these STD clinics, 13 have the capacity to provide antiretroviral treatment (ART) services. The only ART facility outside of NSACP is located in Base hospital Angoda (IDH). NSACP networks with all these clinics.

Figure 1: **Headquarters of the National STD/AIDS control programme**

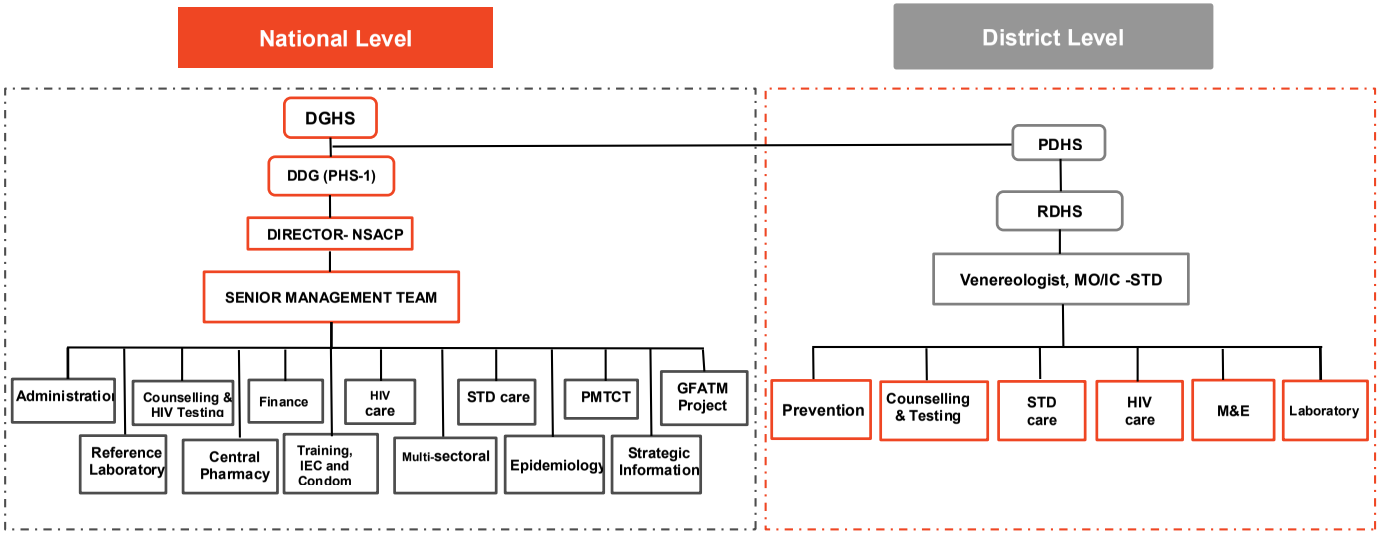
Vision

Quality sexual health services for a healthier nation

Mission

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

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



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

Mid-term review 2015

The mid-term review (MTR) of the 2013-2017 National Strategic Plan (NSP) took place during January to February 2015. The review which was built upon the previous reviews in 2006 and 2011 examined whether the implementation of the national response for control of HIV and sexually transmitted infections (STI) in Sri Lanka is going in the right direction, and whether it is on the right track to meet the targets defined in the NSP (2013-2017).

The two main objectives of the process were to provide a snapshot of achievements against the NSP goals and targets under the five thematic areas and to recommend ways to maximize the results of key thematic areas over the remaining period of the strategy. The five thematic areas examined by the review were prevention, diagnosis, treatment and care, strategic information management, supportive environment, health systems strengthening and supply chain management.

In addition, there were few main specific objectives governing the whole process. They were; assessment and documentation of progress towards targets, assessment of coverage and quality of prevention and treatment services, service utilization by key populations (KPs), identification of specific areas requiring improvements, and prioritizing those most likely to deliver results, assessment of continued relevance of key results areas and approaches of NSP, development of a short list of recommended focus areas with limited number of high impact activities and targets achievable within existing resources, capacity of stakeholders, documentation of lessons learned, challenges and suggestions of cross-cutting themes such as gender integration, people living with HIV (PLHIV) and right to health.

In preparation of the MTR, three main groups were formulated; the steering committee, the core group and five working groups. The steering committee had a membership of 61 members representing all stakeholders of the national programme. The core group was formed within the steering committee (with the agreement of the steering committee members) to work on specific responsibilities of the steering committee. The core group had a total of 12 members and they represented the Ministry of Health, country coordinating mechanism of the GFATM, the NSACP, NGOs, UN agencies and people living with HIV (PLHIV). The five working groups formulated under the five thematic areas facilitated the desk review and the field reviews which were used as the two main methods of collecting relevant information for the review.

The core group with the assistance of the WHO was instrumental in selecting the review team. Three local (Professor A. Pathmeswaran, Dr Neelamani Hewageegana and

Professor Nalika Gunawardane) and three international reviewers (Dr Tobi Saidel, Dr N Kumarasamy and Mr Nicolas Tavagnutti) representatives from the PLHIV (Ms Princy Mangelika), MSM organizations (Mr Jude Fernando), FSW organizations (Ms Kusum Jayalath), and Civil society organizations (Ms Nanditha Katugampola) comprised the review team.

The main conclusions and recommendations of the review were as follows:

Epidemic Focus

Sri Lanka has a low level epidemic and the response must be focused on populations, which includes the FSWs and the MSMs that have the greatest epidemic potential. Currently the DUs have a low epidemic potential but need to be focused on them switching to injecting. Only the prisons with large numbers of KPs should be prioritized for interventions and the youth and the general population are not drivers of the epidemic and general awareness is adequate for those two categories.

Prevention

The current intervention model needs to be revisited and inadequacies that have been identified need to be addressed. All the interventions planned should be geared towards keeping the prevalence among the FSW and the MSM populations low and doing so the districts need to be prioritized and more realistic targets should be set for interventions considering the available local evidence and population turnover.

Diagnosis, Treatment and Care

Access to testing for KPs through alternate models need to be expanded and the counsellors at the NGOs need to be trained on HIV testing and counselling. Necessary backup machines to be strengthened at the NSACP and the CD4 testing need to be expanded to the eight sites where ART is dispensed currently. Further, ongoing training of physicians involved in HIV care need to be planned. HIV testing and counselling need to be offered to all pregnant mothers island wide and where relevant rapid testing needs to be made available for screening at the ANC sites.

Strategic Information

Key population size estimation, HIV sentinel surveillance and the IBBS survey need to be streamlined and focused when and where relevant. Need to device better ways of making use of available data and improve the necessary areas of data recording such as the mode of transmission etc.

Supportive Environment

Decriminalize the sexual activity between members of the same sex and bring in appropriate amendments to the Vagrants ordinance. Further empower the positive community to improve self-reliance and facilitate sustainability of their organizations.

Health Systems Strengthening

Gaps identified with relation to the service delivery at the STD clinics need to be addressed with special emphasis on opening up STD clinics at Killinochchi, Mannar and Batticaloa and filling staff vacancies at the STD clinics. To get the SPC procure all the needy drugs and devices to the National programme instead of utilizing the staff at the NSACP for such activities. The procedures for procuring the ARVs need to be strengthened including registration and importation. Ensure the proper storage and dispense of ARV and to ensure the quality assurance of the drugs while in the country. The laboratory facilities at the STD clinics need to be strengthened and a strategic mechanism need to be devised to ensure ARV adherence and contact tracing of the HIV positive people. The collaboration between the national level and the district level administration need to be improved and plans need to be devised for continuation of activities for the KPs at the end of financial support by the Global Fund. Also sources to cover the financial needs of patients in need of ARV need to be resorted.

Situation of HIV epidemic in Sri Lanka

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

Since the identification of the first HIV infected Sri Lankan in 1987, a cumulative total of 2308 HIV positive persons have been reported up to end 2015. During 2015, 235 HIV cases were reported to the National STD/AIDS control programme (NSACP). This is the highest number reported in a year and this amounts to about 4.5 new HIV cases per week. However, the reported numbers represent only a fraction of HIV infected people in the country as many infected persons may perhaps not be aware of their HIV status and in addition, stigma and discrimination towards HIV infected people adversely affect voluntary testing for HIV.

Following sources of data are used to describe the current situation of HIV infection in the country as of end 2015:

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

HIV case reporting data

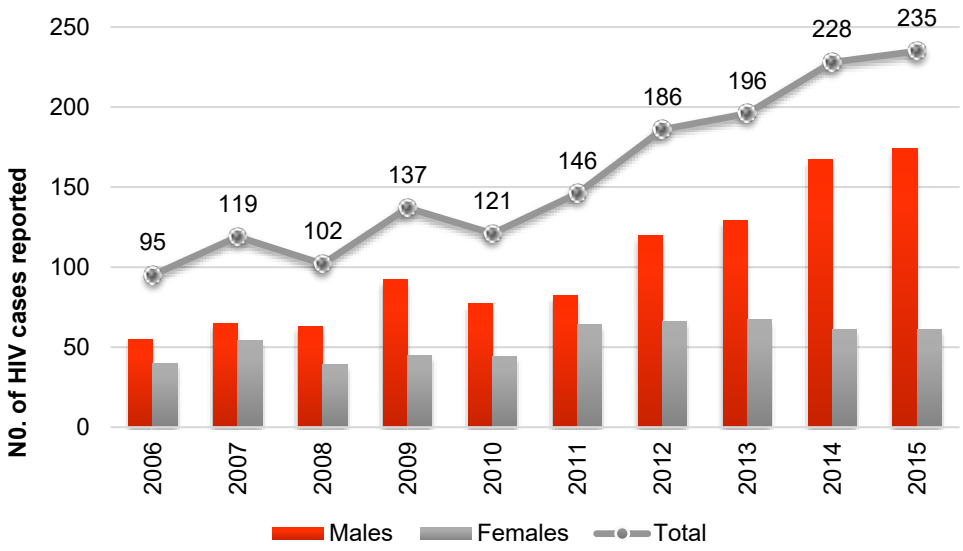
HIV infection is not a notifiable condition in Sri Lanka. Therefore, HIV case reporting is not a robust method of knowing the HIV situation in the country. However, this is one of the main sources of data available in the country. Since Western-Blot, the confirmatory test for HIV, is available only at the National reference laboratory of the NSACP, all confirmed HIV positive cases get reported. However, it is not uncommon to find incomplete basic epidemiological information about the infected persons. Further, another concern is 'double counting' as some persons get tested more than once after the initial test results reveal that they are HIV positive, in order to recheck their HIV status. However, NSACP takes all possible efforts to avoid these errors by rechecking laboratory data.

Summary of findings from HIV cases reported are given below.

Trends of reported HIV cases

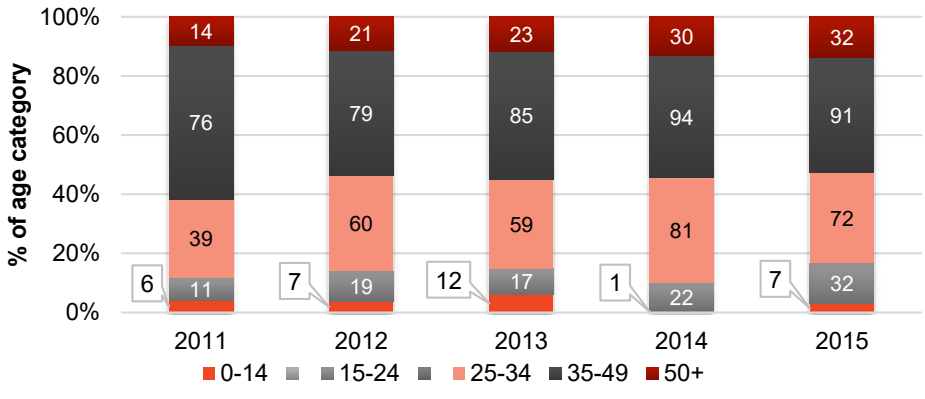
Reported HIV cases show a steady upward trend. In addition to increase in new HIV infections, increase in testing facilities better surveillance and reporting have contributed to this trend. Number of cases reported annually have increased by 147% during the last 10 years.

Figure 3: Trends of reported HIV cases by sex



Above graph indicates the proportion of males and females among reported HIV cases. Since 2011, proportion of males with HIV are gradually increasing. The male to female ratio of cumulative reported cases as of end 2015 was 1.7:1. However, during 2015 the male to female ratio increased to 2.8:1.

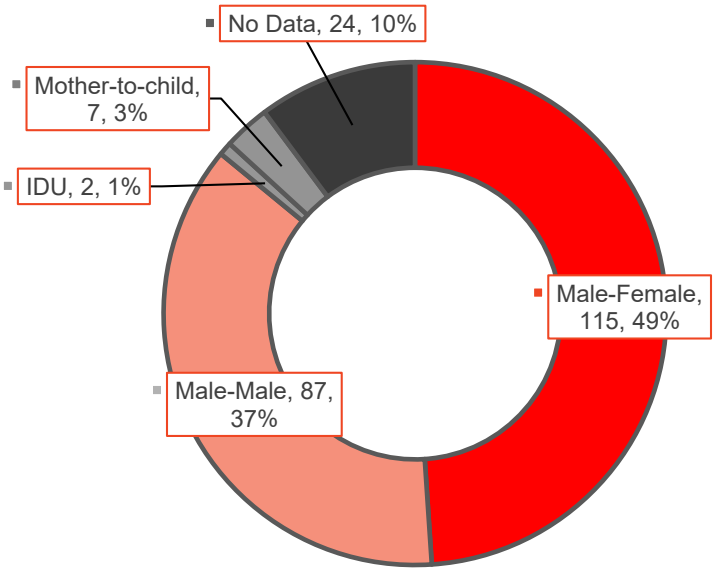
Figure 4: Age categories of reported HIV cases, 2011-2015



Above graph shows the number and the percentage by age categories of reported HIV cases during the last five years. Consistently the majority have been between 25-34 and 35-49 age

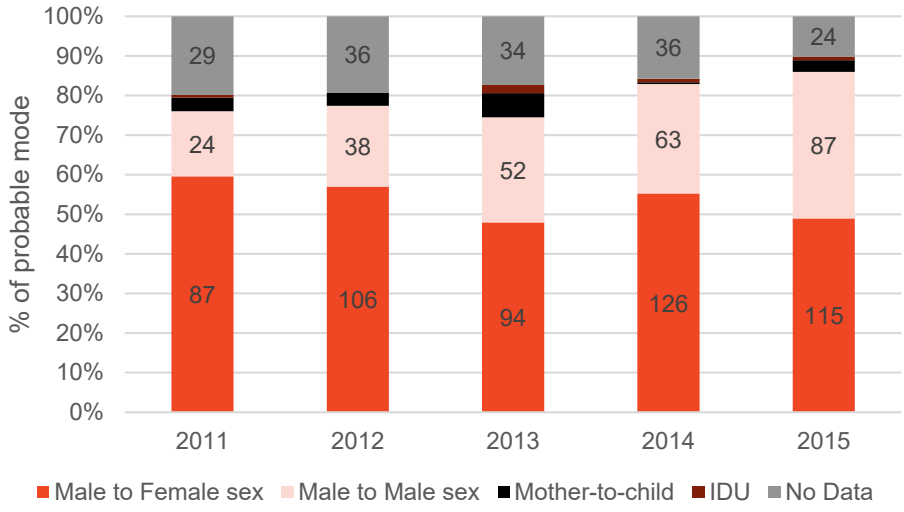
categories. Age category 0-14 represents mother to child transmitted cases. There were 7 such cases reported in 2015. Another notable trend is increasing number of cases in the 15-24 age category.

Figure 5: Probable modes of transmission in 2015 (N=235)



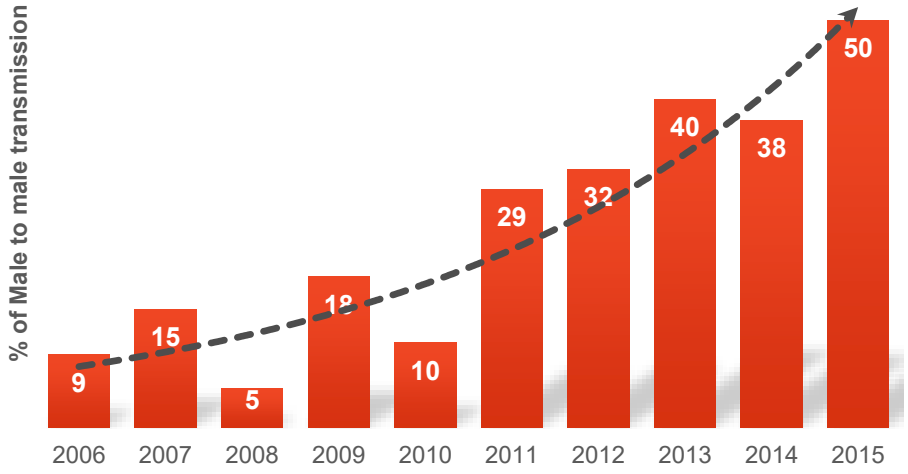
Sexual transmission accounted for 86% of all cases reported during 2015. However, in 10% of cases adequate data was not available to ascertain the probable mode of transmission.

Figure 6: Probable modes of HIV transmission of reported HIV cases 2011-2015



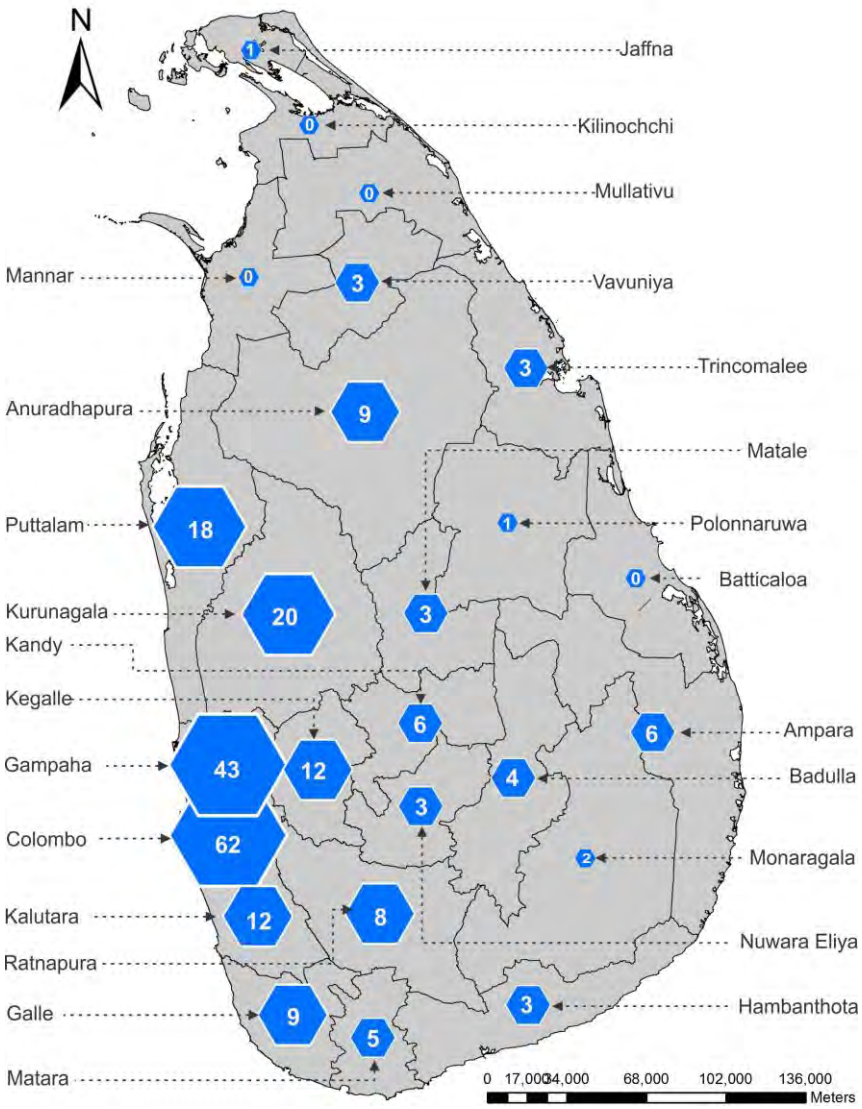
As shown in both graphs above, the proportion of male to male HIV transmission is gradually increasing. Nearly 50% of all males reported with HIV gave a history of male to male sexual contacts. Most of these men are married, thus causing added implications on transmission to women and to their babies.

Figure 7: Percentage of male to male transmission among reported male HIV cases



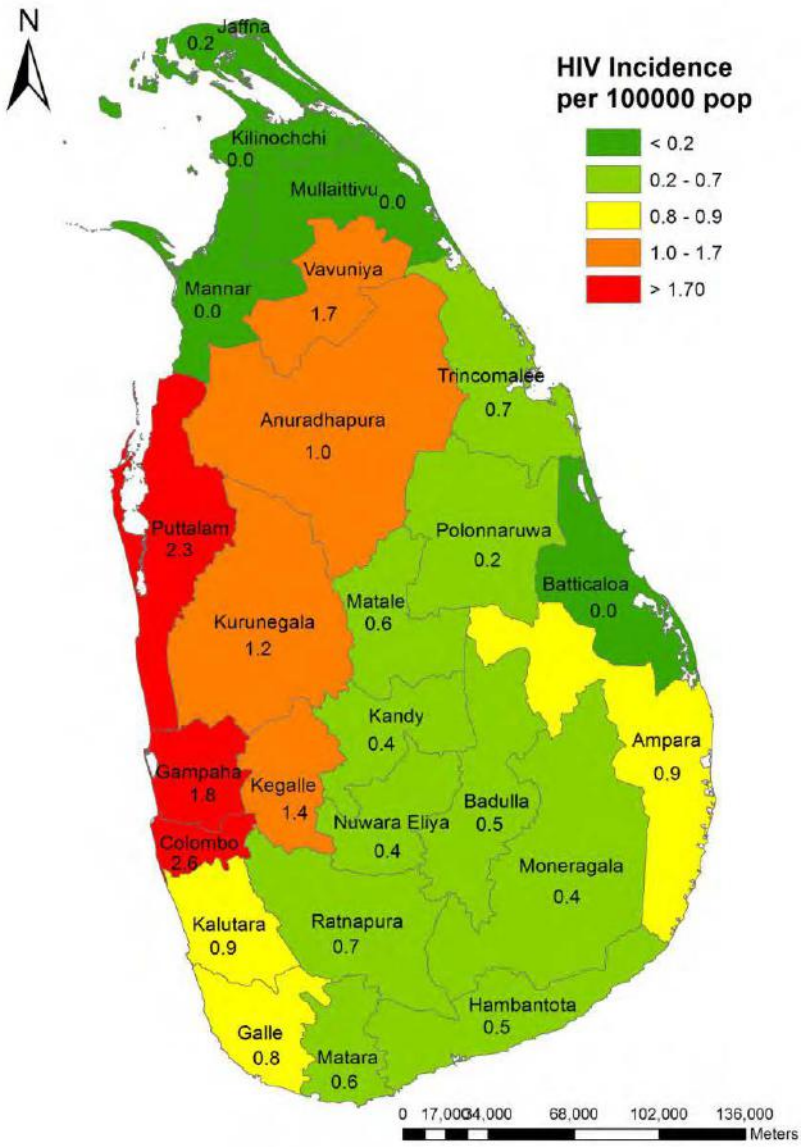
Geographical distribution of reported HIV cases

Figure 8: Number of HIV cases reported from each district during 2015



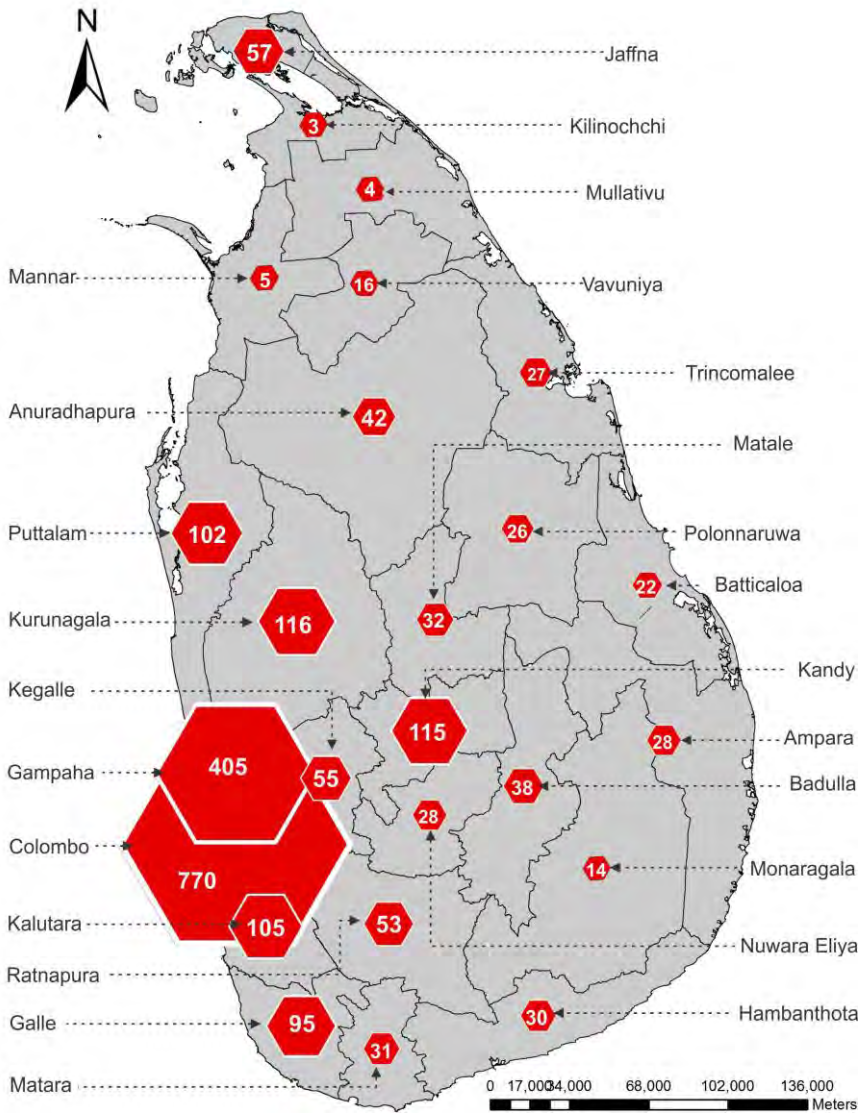
This figure shows the number of HIV cases reported from each district. Districts in Western and North Western provinces reported higher numbers than districts in other provinces. Kilinochchi, Mullativu, Mannar and Batticaloa did not report any HIV cases during 2015.

Figure 9: Rate of HIV cases reported in 2015 per 100,000 population



As shown in figure above, Colombo, Gampaha and Puttalam districts had the highest rate of reported HIV cases during 2015. Lowest rates were reported from districts in the Northern province.

Figure 10: Cumulative number of HIV cases reported, 1987- 2015



Above figure shows the cumulative number of HIV cases reported from each district from 1987 to end of 2015. Colombo, Gampaha, Kurunegala, Kandy, Kalutara and Puttalam districts have more than 100 cumulative HIV cases reported up to end 2015.

Figure 11 : Cumulative rate of HIV cases reported per 100,000 population

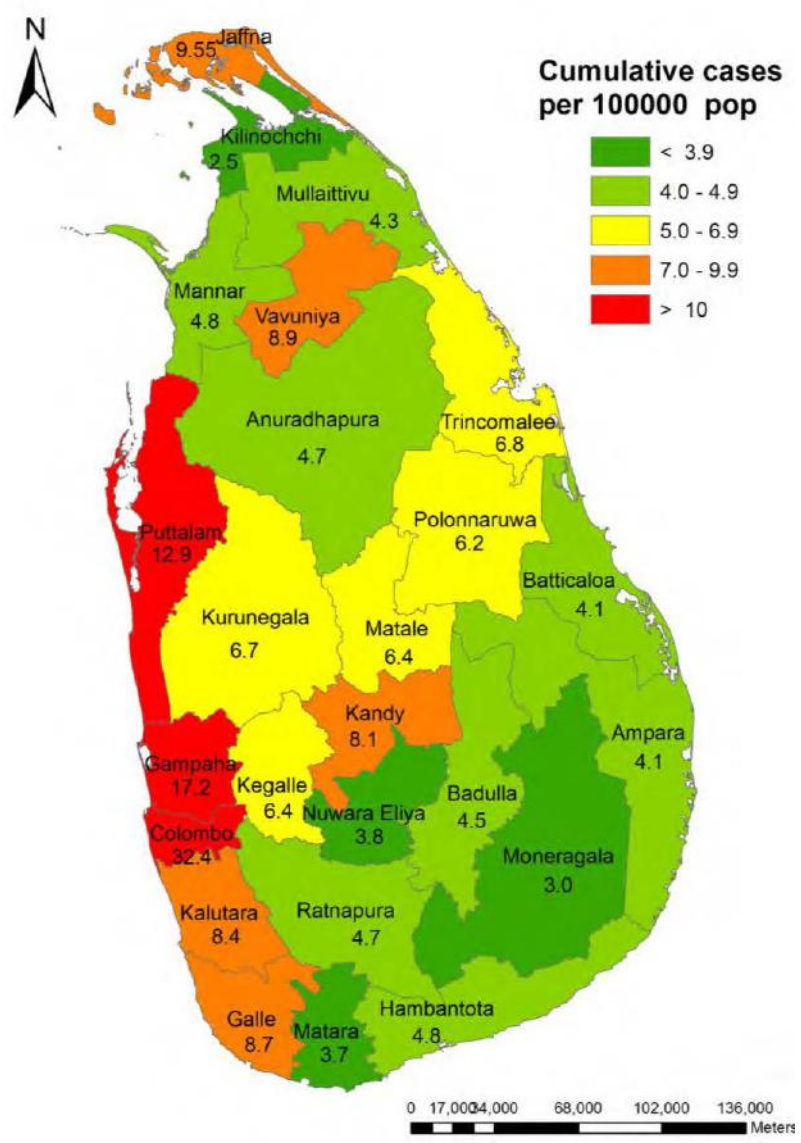
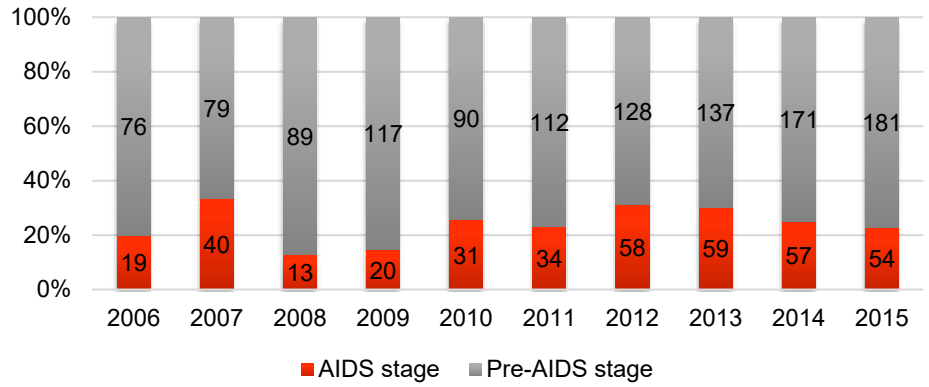


Figure 11 indicates the cumulative rate of HIV cases reported per 100,000 populations in each district. Similar to the rate of newly reported HIV case in 2015, Colombo, Gampaha and Puttalam districts had the highest prevalence rates.

Stage of HIV diagnosis

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

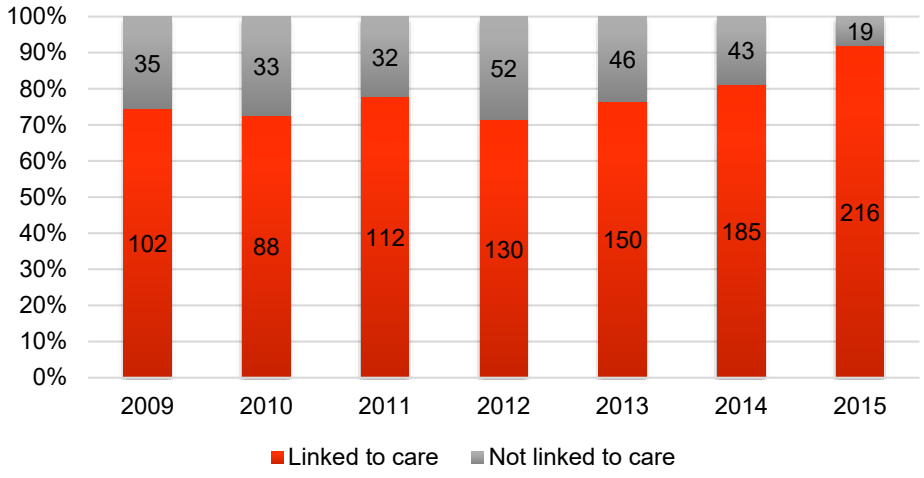
Figure 12: Number and percent of reported HIV cases by stage, 2006-2015



Linking with HIV care services

In the ideal scenario, all diagnosed cases should be linked to care. Figure below shows the number and proportion of reported HIV cases who were linked to HIV care services within the reported year. Since 2012 the proportions of linking to care shows an increase.

Figure 13 : Percentage and number of PLHIV linked to HIV care

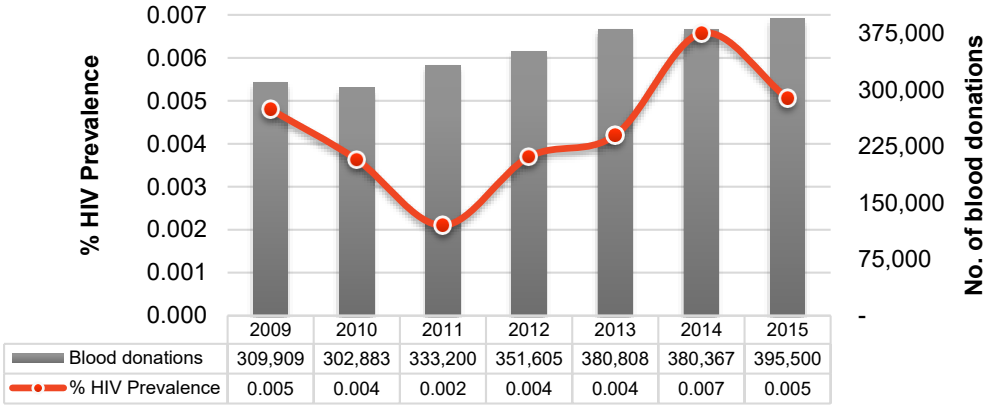


During 2015 over 90% of reported HIV cases were linked to care during the same year. Stringent measures taken over the years to motivate all diagnosed HIV positive cases to link with HIV services have been productive.Net-working with private hospitals and laboratories and engaging with newly diagnosed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

HIV in donated blood

In Sri Lanka over three hundred thousand donated blood units are screened annually for transfusion transmissible infections (TTI). The National Blood Transfusion Service is promoting voluntary, unpaid, blood donors and conducting comprehensive pre-donor screening to ensure safer blood donations.

Figure 14 : Trend of HIV infections in donated blood



	2009	2010	2011	2012	2013	2014	2015
Blood donations	309,909	302,883	333,200	351,605	380,808	380,367	395,500
% HIV Prevalence	0.005	0.004	0.002	0.004	0.004	0.007	0.005

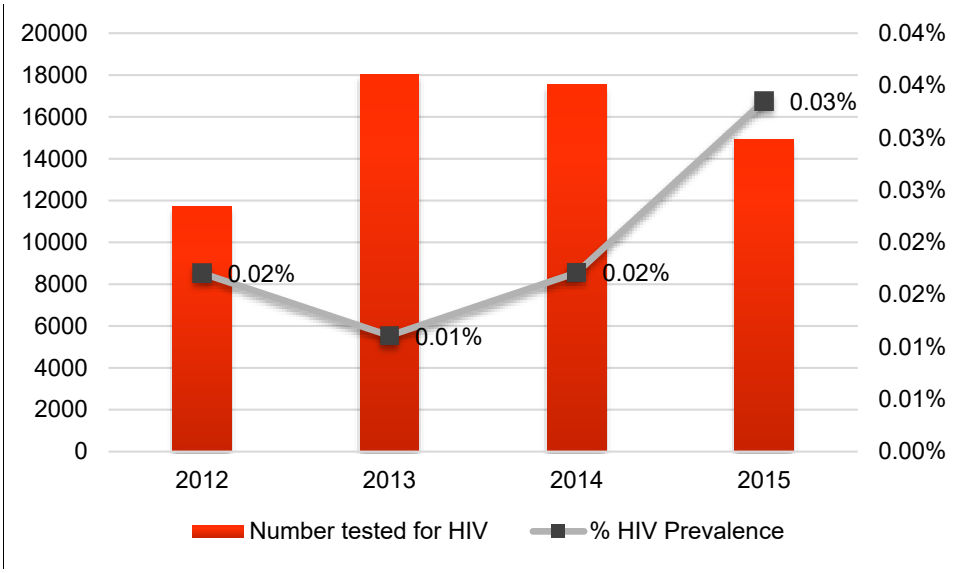
Above graph indicates the HIV prevalence among blood donors from 2009 to 2015. Since 2011, HIV prevalence seems to be increasing from 0.004% to 0.007%. However, the same trend did not continue in 2015. It is estimated that HIV prevalence is < 0.1% in the general population of Sri Lanka. Although blood donors are representing the general population, due to the pre-donor screening process, HIV prevalence is considerably low in donated blood. Increasing HIV sero-positivity rate indicates the necessity to further strengthen pre-donor screening procedure and establishing other mechanisms to safeguard donated blood.

NSACP provided counselling and HIV services to 19 out of 20 (95%) HIV positive donors detected during 2015. It is expected that these services will minimize future donations by these HIV positive donors and will also prevent HIV transmission to their sexual partners.

HIV in antenatal screening

Prior to scaling up of the Prevention of Mother to Child Transmission programme, two premier maternity hospitals namely the De Soysa Maternity Hospital (DMH) and the Castle Street Hospital for Women (CSHW) have been screening antenatal mothers for HIV since early 2000. Antenatal HIV prevalence is taken as a proxy prevalence of the general population. However, these two hospitals represent urban antenatal women and their HIV prevalence is considered higher than the rural antenatal prevalence. Graph given below shows a gradual increase of HIV prevalence among antenatal women since 2013.

Figure 15 : HIV testing in DMH and CSHW 2012-2015



Sri Lankan HIV estimations for 2015

At the time of printing of this report, only final draft estimate HIV data were available for 2015. As such, there is a possibility that these preliminary data could undergo minor changes once the final data are released by UNAIDS, Geneva during the latter part of 2016.

HIV Estimation for 2015 was carried out using Spectrum software version 5.4. Following table summarizes the key HIV estimated figures for 2015.

- People living with HIV in 2015 - 4200
- Estimated new HIV infections in 2015 - 550
- Estimated AIDS deaths in 2015 - 130
- Estimated HIV prevalence in 2015 - < 0.1

Figure 16: Estimated size of HIV population (15-49 year) by risk group, 2011-2015

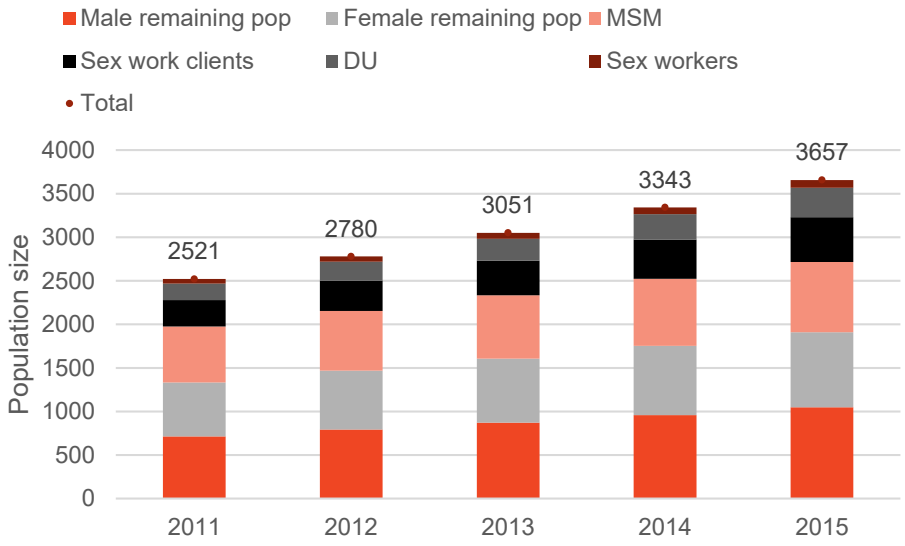


Figure 16 shows the total (male and female) HIV population in 15-49 age group by risk groups. Male and female remaining population has contributed to over 50% of all estimated PLHIV due to large population size. Of the risk groups, MSM have contributed to the largest portions of PLHIV.

HIV testing services

"Concepts of HIV testing is evolving over time depending on the methods available to manage the HIV epidemic. Over the years, different terminologies like VCT and HTC were used. The latest term is HTS which stands for HIV testing services"

The term HIV testing services (HTS) is used to embrace the full range of services that should be provided together with HIV testing. These include,

- **Counseling** (pre-test information and post-test counseling)
- **Correct results**
- **Linkage** to appropriate HIV prevention, treatment and care services and other clinical and support services,
- **Quality assurance** in coordination with laboratory services

A public health and human rights-based approach is important for delivery of HTS which can be assured through following "5**C**s" in all models of HTS and circumstances as given in the WHO publication on Consolidated Guidelines on HIV Testing Services (July 2015).

- **C**onsent (verbal consent is sufficient)
- **C**onfidentiality (shared confidentiality is encouraged)
- **C**ounseling (pre-test information personal or for groups, post-test counseling)
- **C**orrect results (assurance of quality through internal as well as external mechanisms to provide correct results)
- **C**onnection (linkage to prevention, treatment and care services)

Focused and strategic approaches are needed to enhance HTS to support the new UN 90-90-90 global HIV targets which are; by 2020, 90% of all people living with HIV will know their HIV status, by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. This can be achieved only after achieving the first '90'. To achieve these targets, the NSACP plans to increase HTS in the coming years through multiple approaches.

Table 1: HIV testing in 2015

	Types of blood samples screened for HIV	Number Tested	Number Positive	Positivity Rate
1.	Blood donor screening (NBTS & private sector blood banks)	399,500	20	0.01%
2.	Private Hospitals and Laboratories	217,889	46	0.02%
3.	Antenatal Mothers	279,196	11	0.004%
4.	STD clinic samples*	79,900	144	0.18%
5.	Tri–forces	25,969	01	0.004%
6.	Prison HTC programme	11,382	03	0.03%
7.	TB screening	7,827	10	0.13%
	Total	1,021,663	235	0.02%

** (STD clinic samples include STD clinic attendees, testing symptomatic patients, outreach samples and testing of contacts of known HIV positives)*

In 2015, over 1 million blood samples were tested for HIV and of them, 235 persons were found to be positive giving an overall test positivity rate of 0.02%. The highest test positivity rate is seen among STD clinic samples (which included STD clinic attendees, symptomatic patients, outreach samples and contacts of attendees - 0.18%) followed by TB screening samples (0.13%).

Following table shows the status of HIV testing among key populations.

Table 2: HIV testing among key population groups in 2015 by NSACP

Type of key population	Number of HIV tests	
	Male	Female
Sex workers	69	1625
Men who have sex with men	1945	-
Drug users	2618	40
Prisoners	11,309	981

HIV testing among most-at-risk populations needs to be increased and the NSACP plans to use innovative approaches in coming years to escalate HIV testing.

Providing outreach services has been a long standing approach of the NSACP and new services have been added to the service package offered to recipients. HIV testing services

are increasingly becoming a component of the package offered through outreach services. The service providers need to explore further ways of improving HIV testing among most at risk population groups all over the country.

Table 3: HIV screening through outreach activities by all STD clinics - 2015

	Type of outreach activity	Number Tested
1.	Prison blood survey	11,384
2.	Female sex workers	490
3.	Male sex workers	31
4.	Men who have sex with men	237
5.	Drug user survey	1,072
6.	Colombo municipal council survey	323
7.	World AIDS Day 2015, At Galleface	85
8.	Fish market survey	310
9.	Others	21,453
	Total	**35,385**

Figure 17: Rapid HIV testing site organized on the World AIDS Day

HIV testing services

Figure 18: Outreach HIV testing organized on the World AIDS Day

Improving HIV testing services and follow up is the key to manage the HIV epidemic in the country. Therefore, escalation of HIV testing services is the most important starting point in achieving this.

There are a few aspects that need careful consideration in the attempt to enhance HIV testing services. The population groups that need to be reached with HIV testing services on priority basis and the best testing strategies that need to be used in different contexts within the country are two such important aspects. Therefore, the NSACP in the coming years will work to agree on priority groups for HIV testing service coverage and appropriate testing strategies for identified groups.

HIV treatment, care and support services

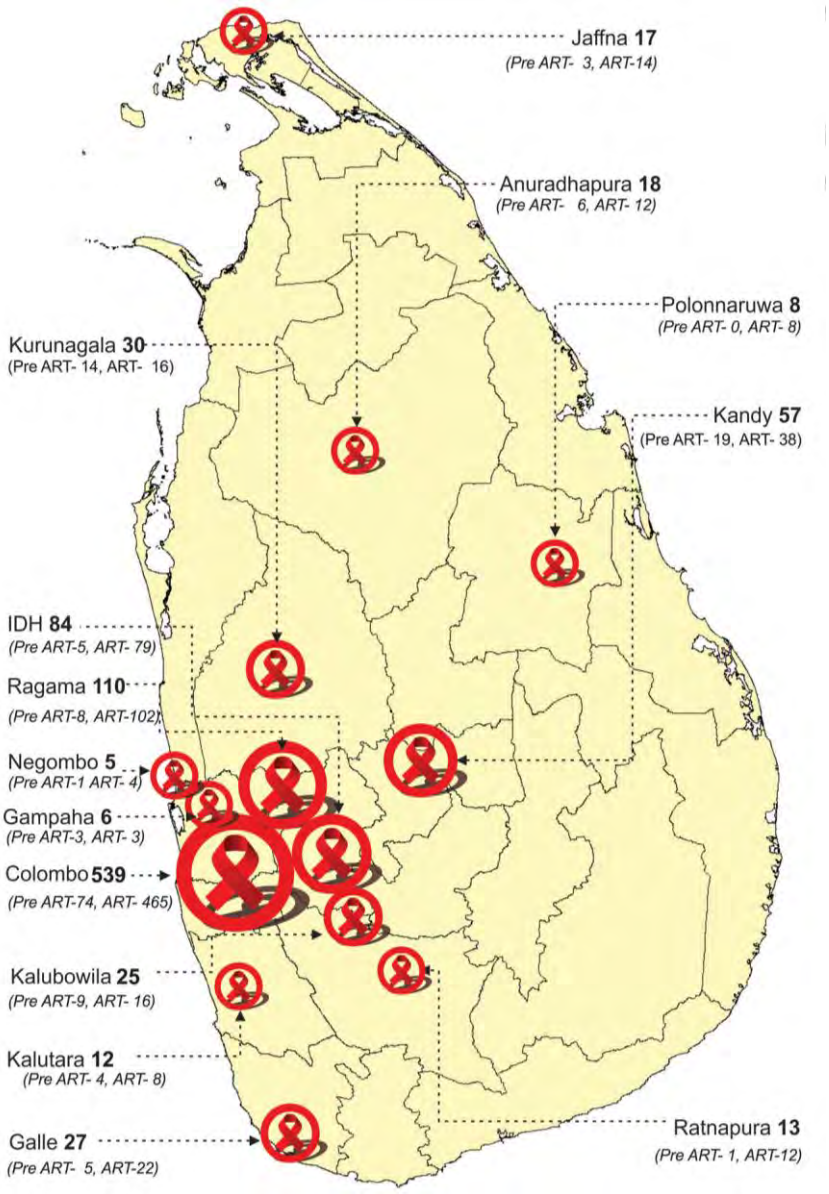
"During 2015, NSACP decided to purchase all ARV drugs from the Ministry of Health budget and to initiate ART for all people living with HIV irrespective of their CD4 count"

Globally there were significant policy changes regarding HIV care services during 2015. UNAIDS came up with 90-90-90 targets, i.e. 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression by the year 2020. Under the "treat all" strategy, WHO has recommended to provide ART for all people living with HIV (PLHIV) regardless of their CD4 count.

Figure 19: ARV dispensing at the Central pharmacy of NSACP

By the end of 2015, a total of 948 PLHIV were under HIV care services and of them 803 were on ART. During 2015, 235 persons were diagnosed with HIV. Of them 216 (92%) were registered in HIV care services during the same year. Number of PLHIV who are actively followed up in HIV care services (excluding lost to follow-up) as of end 2015 are given below.

Figure 20: Location of ART centres and number in HIV care as of end 2015



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

Table 4: Number of PLHIV* in pre-ART and ART stage as of 2015

ART Center	Pre-ART	ART	Total	Percent
1. Colombo	76	469	545	57.6%
2. Ragama	7	102	109	11.5%
3. IDH	4	79	83	8.8%
4. Kandy	19	37	56	5.9%
5. Kurunegala	11	16	27	2.9%
6. Galle	5	22	27	2.9%
7. Kalubowila	10	16	26	2.7%
8. Jaffna	3	14	17	1.8%
9. Anuradhapura	4	12	16	1.7%
10. Ratnapura	0	12	12	1.3%
11. Kalutara	2	8	10	1.1%
12. Polonnaruwa	0	9	9	1.0%
13. Gampaha	3	3	6	0.6%
14. Negombo	0	4	4	0.4%
Grand Total	**144**	**803**	**947**	**100.0%**

(Lost to follow up cases excluded)*

Comprehensive HIV care services

Comprehensive services including ART services are provided to PLHIV to reduce illness, improve quality of life and also to prevent further transmission. The services offered include counseling, support for disclosure and partner notification, screening for STI, TB, CMV, toxoplasma, Hepatitis B and C infections, screening for non-communicable diseases, Cotrimoxazole prophylaxis and Hepatitis B vaccination. In addition, females are offered services for family planning, regular Pap smear screening and PMTCT services in pregnancy.

National STD/AIDS control programme of the Ministry of Health is the sole provider of ART in Sri Lanka. Except base hospital Angoda (IDH), all other ART centers are STD clinics coming under the National STD/AIDS control programme.

HIV treatment, care and support services

In Sri Lanka, antiretroviral treatment (ART) was added to the HIV care programme in late 2004. The ART programme was initiated with financial support of the World Bank and was continued with the support of the Global Fund until 2015. Based on the concept paper submitted in 2014, the Ministry of Health has initiated the process to procure ARV drugs from 2016 through government funds. This can be considered as a major step in improving HIV care services in Sri Lanka. In addition, an allocation of LKR 500,000 per year has been approved by MOH for the local purchase of essential drugs for opportunistic infections or emergency ART requirements. However, the Global Fund will continue to provide second-line ARV drugs for 2016.

During 2015, the eligibility criteria considered for ART initiation was CD4 cell count less than 500 cells/µl. However, sero-discordant couples, members belonging to key populations, prisoners, TB patients and pregnant women were eligible to initiate ART irrespective of their CD4 cell count. In line with the recent WHO guidelines, NSACP took a decision to start ART for all diagnosed PLHIV irrespective their CD4 count from 2016.

During the year 2015, thirty four (34) deaths of PLHIV were reported, out of which 32 deaths were due to AIDS. Twenty five (25) of these deaths were among those diagnosed in 2015 and they were diagnosed in the late stage with AIDS.

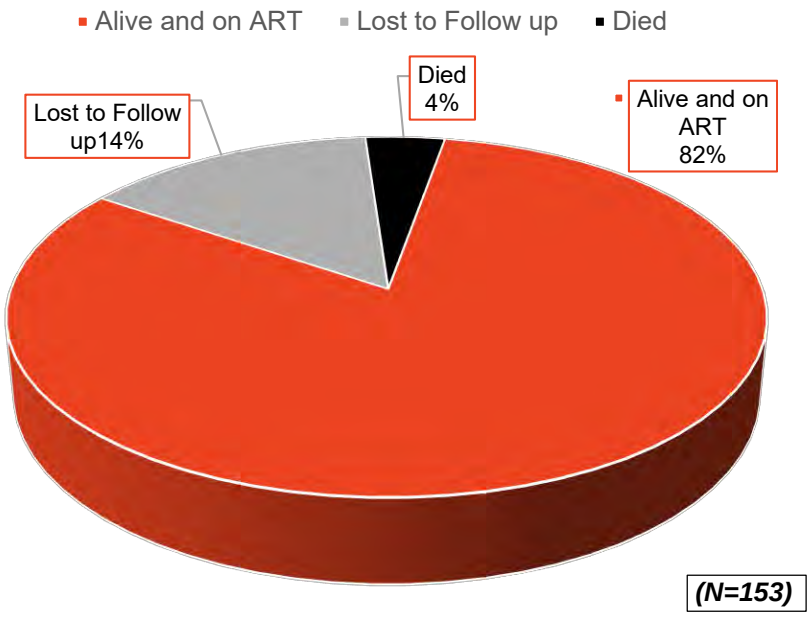
Cascade analysis for 2014 and 2015

During 2015, a total of 1,021,663 were tested for HIV and 235 were diagnosed as having HIV. Of them 216 were linked to services and 187 were started on ART. In the year 2014 out of the 228 diagnosed 185 were linked with services and 144 were started on ART. Of them 95 had a viral load testing 12 months after ART initiation. Of these, 90 PLHIV (95 %) had achieved viral suppression (less than 1000 copies/mL) 12 months after ART initiation.

Table 5: Outcome of PLHIV who initiated ART in 2014 after 12 months

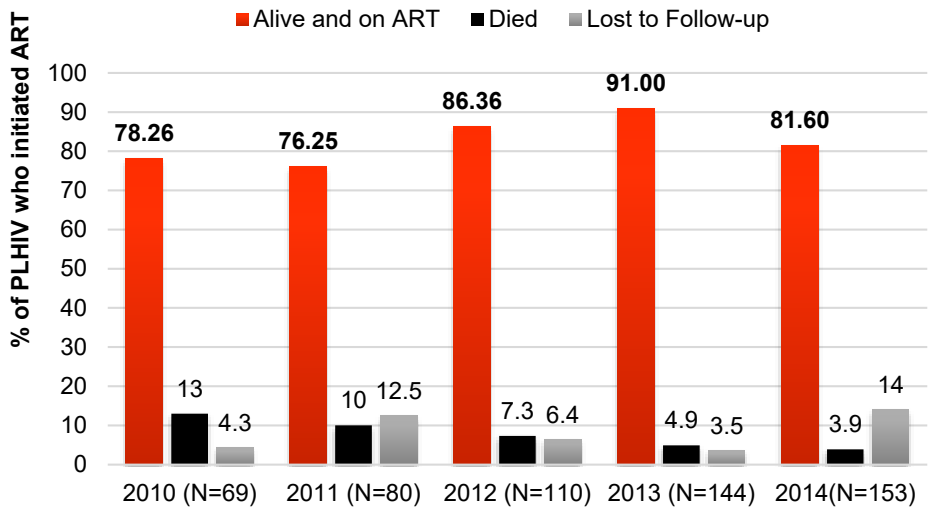
		Number of patients who started ART in 2014				
		All	Male		Female	
			<15	15+	<15	15+
a.	Original net cohort started on ART in 2014 (N)	153	3	110	1	39
Status of these PLHIV after 12 months of starting ART						
b.	On original 1st line regimen	124	3	85	1	35
c.	On 2nd line regimen (Switched)	1	0	1	0	0
d.	Stopped (S)	0	0	0	0	0
e.	Died (D)	6	0	3	0	3
f.	Lost to follow-up (F)	22	0	21	0	1
g.	Number alive and on ART (A) = {N-(S+D+F)}	125	3	86	1	35
h.	**Percent of cohort alive and on ART (A/N*100)**	**81.7%**	**100.0%**	**78.2%**	**100.0%**	**89.7%**

Figure 21: Outcome of PLHIV who initiated ART in 2014 after 12 months



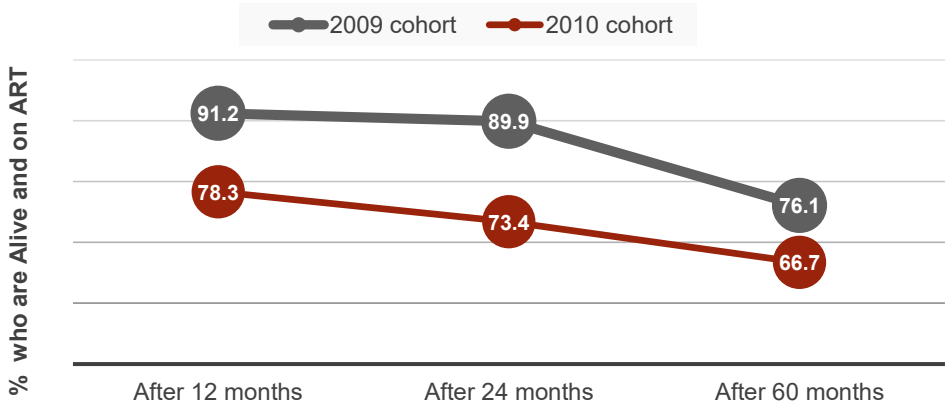
Lost to follow-up during HIV care

Figure 22: Percentage of 12 month outcomes in cohorts of PLHIV, 2010-2014



Among PLHIV who initiated ART in 2014, 22 (14%) were lost to follow-up after 12 months of ART. Defaulter tracing protocol was developed and services were improved. Attempt has been made to trace all defaulted PLHIV through telephone, letter or home visits.

Figure 23: Percentage who were alive and on ART for 2009 and 2010 cohorts



Opportunistic infections during 2015

Table 6: Details of opportunistic infections in the year of 2015

Opportunistic infection	Number	Percent
Candidiasis (oral / oesophageal)	51	37%
***Pneumocystis jiroveci* pneumonia**	27	20%
Tuberculosis	24	18%
Pneumonia	16	12%
Herpes zoster	9	7%
CMV retinitis	3	2%
Mycobacterium avium complex (MAC)	3	2%
Cryptococcal meningitis	2	1%
Toxoplasmosis	2	1%
Total	**137**	**100%**

Opportunistic infections were reported from 137 PLHIV who were receiving HIV care during 2015. Candidiasis, PJP and tuberculosis were more frequent than other opportunistic infections. In addition, 38 PLHIV were diagnosed as having STIs during 2015.

ART regimens (ARV drug combinations)

Combination ART regimen; tenofovir, emtricitabine and efavirenz were used as the preferred first-line ART regimen in the year 2015 according to the new guidelines. New ARV drugs received in 2015 included atazanavir, darunavir and raltegravir which can be considered as second or third-line options.

Table 7: ART regimens used in 2015

ARV Regimen	Number of PLHIV		Grand Total
	First-line ARV	Second-line ARV	
TDF+FTC+EFV	371	3	374
AZT+3TC+EFV	259	0	259
AZT+3TC+NVP	62	1	63
TDF+FTC+LPV/r	15	23	38
AZT+3TC+LPV/r	18	6	24
ABC+3TC+EFV	10	0	10
TDF+FTC+ATV/r	5	3	8
TDF+FTC+RAL	6	2	8
ABC+3TC+LPV/r	2	4	6
AZT+3TC+RAL	3	1	4
TDF+FTC+NVP	4	0	4
ABC+TDF+FTC+LPV/r	0	2	2
RAL+3TC+DRV/r	1	1	2
ABC+3TC+NVP	1	0	1
Grand Total	**757**	**46**	**803**

Table 8: Cost of ARV regimen per patient per year

ARV Regimen	Cost/patient /year (USD)	Cost/patient /year (LKR)*
TDF+FTC+NVP	98.04	14,411.88
AZT+3TC+NVP	98.40	14,464.80
TDF+FTC+EFV	110.64	16,264.08
AZT+3TC+EFV	120.84	17,763.48
ABC+3TC+NVP	190.20	27,959.40
ABC+3TC+EFV	202.80	29,811.60
TDF+FTC+ATV/r	310.80	45,687.60
TDF+FTC+LPV/r	815.04	119,810.88
AZT+3TC+LPV/r	825.24	121,310.28
ABC+3TC+LPV/r	907.20	133,358.40
ABC+TDF+FTC+LPV/r	952.44	140,008.68
TDF+FTC+RAL	1,955.04	287,390.88
AZT+3TC+RAL	1,965.24	288,890.28
RAL+3TC+DRV/r	4,753.80	698,808.60

** Conversion rate 147LKR /USD*

Antiretroviral drugs for children

Most of the children living with HIV are on ART. The details are given below.

Table 9: ARV regimens used in children as of end 2015

ARV Regimen	First-line ARV	Second-line ARV	Total
AZT+3TC+EFV	11	-	11
AZT+3TC+LPV/r	6	2	8
AZT+3TC+NVP	5	-	5
ABC+3TC+EFV	4	-	4
ABC+3TC+LPV/r	2	1	3
TDF+FTC+EFV	2	-	2
TDF+FTC+LPV/r	-	2	2
ABC+3TC+LPV/r	-	1	1
Grand Total	31	6	37

TB/HIV collaborative activities

NSACP works closely with the National Programme for Tuberculosis Control and Chest Diseases (NPTCCD) of Sri Lanka. All newly diagnosed PLHIV and PLHIV with symptoms are referred to NPTCCD for screening to exclude TB. During 2015, 24 PLHIV were diagnosed as having TB, of these 12 were extra-pulmonary TB cases. All of them were started on anti-TB treatment. INAH prophylaxis was commenced for 33 PLHIV during 2015 for latent TB infections.

Counselling and other services

At the time of diagnosis counselling services on prevention, ART adherence, family planning, disclosure, pregnancy and on various social issues were offered to PLHIV by the medical officers. To further improve counseling services a check list for counseling was developed. PLHIV who needed psychiatric therapy were referred to psychiatrists in respective institutions. In addition, the nutrition services unit of NHSL provided their services to PLHIV whenever necessary.

Training of PLHIV on HIV care services

Two training programs were conducted for 60 PLHIV organizations at the NSACP. During the one-day training many aspects relevant to available services including importance of adherence to ART, disclosure to partners, prevention of infections, EMTCT services etc. were discussed. These programmes were funded by the GOSL.

National ART guideline

The guideline for use of ART for prevention and treatment of HIV, which is being used currently was developed by the NSACP in 2014. However, as there had been several changes in the WHO guidelines during the years 2014 and 2015, the guideline will be updated in 2016. Several new documents were added to improve quality of HIV care services including guidelines on defaulter tracing, contact tracing, follow-up check list and counseling check list.

Subcommittee of NAC on HIV care and counselling

Subcommittee for HIV care and counselling of the National AIDS committee (NAC) had meetings every 4 months during 2015. The members of the subcommittee include medical administrators, consultants, PLHIV, representatives of the international funding agencies, and other relevant stakeholders. Regular meetings were held with officials of the Medical Supplies Division of the Ministry of Health and State Pharmaceutical Corporation to streamline the ART procurement process.

Training of healthcare workers on HIV care

Twelve (12) two-day training programmes on comprehensive care for management of PLHIV and to address issues related to stigma and discrimination were conducted in major hospitals throughout the island with support of the Global Fund. These hospitals are Polonnaruwa, Horana, Kandy, Mahamodara, Puttalam, Homagama, Gampola, Wathupitiwala, Karawanella, Kurunegala and Mawanella. A total of 315 health care workers were trained in these programmes. In addition, healthcare workers of the NSACP, National Hospital Colombo, Teaching Hospital Peradeniya, General Hospital Matara and Base Hospital Awissawella were trained with government funds.

IEC material for PLHIV

During 2015, IEC materials on positive living, disclosure and importance of ART, adherence, resistance development etc. were developed using government funds.

HIV drug resistance early warning indicators

Poor adherence and frequent default were the main reasons for development of treatment failure. Currently Sri Lanka does not have laboratory monitoring facilities to monitor HIV drug resistance mutations. During 2015, 24 samples were sent to India for resistance testing with WHO assistance. Of these, nine (9) samples showed resistance (NNRTI alone-4, NNRTI and NRTI-4, NRTI and PI-1).

WHO has introduced few early warning indicators (EWI) which can be used to predict drug resistance among PLHIV who are on ART. The purpose of implementing an HIV drug resistance EWI monitoring system is to assess the extent to which ART programmes are functioning to optimize prevention of HIV drug resistance.

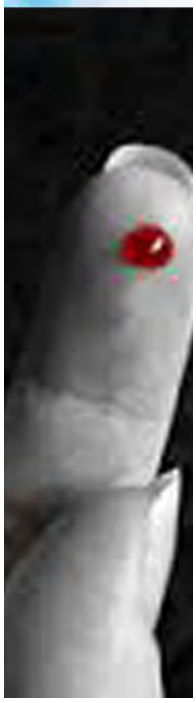
Scaling up ART services

As Venereologists were appointed to STD clinics Ratnapura, Galle, Kegalle, Kalutara, Negombo, Anuradapura and Kurunegala in 2015, it was not necessary to continue outreach monthly ART visits to above clinics. ART visits were continued to STD clinics in Jaffna, Polonnaruwa and Gampaha. ART services in Uva and the Eastern provinces need to be developed by appointing Venereologists or through monthly ART visits in 2016.

Challenges

Though efforts are taken to improve ART services based on the latest changes in the WHO ART guideline, ART coverage still remains low in the country. One important reason is the limited number of people in key populations getting tested for HIV. Linking diagnosed PLHIV with services has improved over the years. Retention of patients in care services is satisfactory; however, there is room for further improvement. Currently pre-ART services are available at all district STD clinics manned by medical officers. However, establishing ART services at district level is important in Uva and Eastern provinces.

Post exposure prophylaxis for HIV



PEP (post-exposure prophylaxis) is a short term antiretroviral treatment course to reduce the likelihood of HIV infection after a potential accidental exposure.

PEP is prescribed to reduce the risk if somebody has been exposed to HIV. Accidental exposure to HIV can occur in the healthcare setting due to:

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

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

Taking adequate measures to prevent exposure to blood and body fluid is the most important strategy for preventing exposure to HIV in the healthcare settings. However, accidents can occur and the National STD/AIDS control programme is considering the provision of counselling and antiretroviral drugs as post exposure prophylaxis for occupational exposure as an important service.

Guidance on PEP is given in the Ministry of Health general circular letter referenced 36/2001. This circular outlines recommendation for the management of Healthcare workers who experienced accidental exposure to blood and other body fluids. To update this circular, a consultative workshop was held on 27th November 2015 with the participation of venereologists and microbiologists.

At the beginning, PEP for healthcare workers was available in few STD clinics. However antiretroviral drugs for PEP are now available in all STD clinics island wide. In addition, measures have been taken to make PEP drugs available outside working hours by keeping a stock of drugs in a place that is functioning round the clock. Table 10 gives a summary of the contact details of these places where PEP drugs were available during 2015.

Post exposure prophylaxis for HIV

Following services are provided by STD clinics of NSACP for PEP.

- Counselling for healthcare workers after accidental exposure to potential infectious material.
- Risk assessment and advice on further management.
- Provision of PEP drugs when indicated.
- Provision of HIV testing (ELISA) for healthcare workers at the baseline, at 6 weeks and 3 months after the exposure.
- Testing of the source blood for HIV (Rapid and ELISA).

Summary of Statistics on PEP during 2015

- A total of 2258 healthcare workers were counselled and was assessed their risk during 2015 in 21 STD clinics.
- Twenty-five (25) healthcare workers were initiated on PEP, however only 19 healthcare workers completed the full course of PEP for 28 days. Of these 13 were from Colombo STD clinic.
- Following combinations of antiretrovirals were given as PEP:
  - TDF+FTC+LPV/r (13 healthcare workers)
  - TDF+FTC+ EFV (7 healthcare workers)
  - AZT+3TC+LPV/r (1 healthcare worker)
  - AZT+3TC+EFV (3 healthcare workers)
  - TDF+FTC+RAL (1 health care worker)
- None of the healthcare workers who received PEP were subsequently diagnosed with HIV.

Summary of statistics on PEP during 2015 at NSACP

- A total of 340 healthcare workers were offered PEP services which comprised only 15.1% out of all registered for PEP Services island wide.
- Nineteen healthcare workers were started on PEP. Thirteen health care workers continued the full course of PEP, whereas 6 healthcare workers discontinued PEP due to a negative HIV test on source blood.

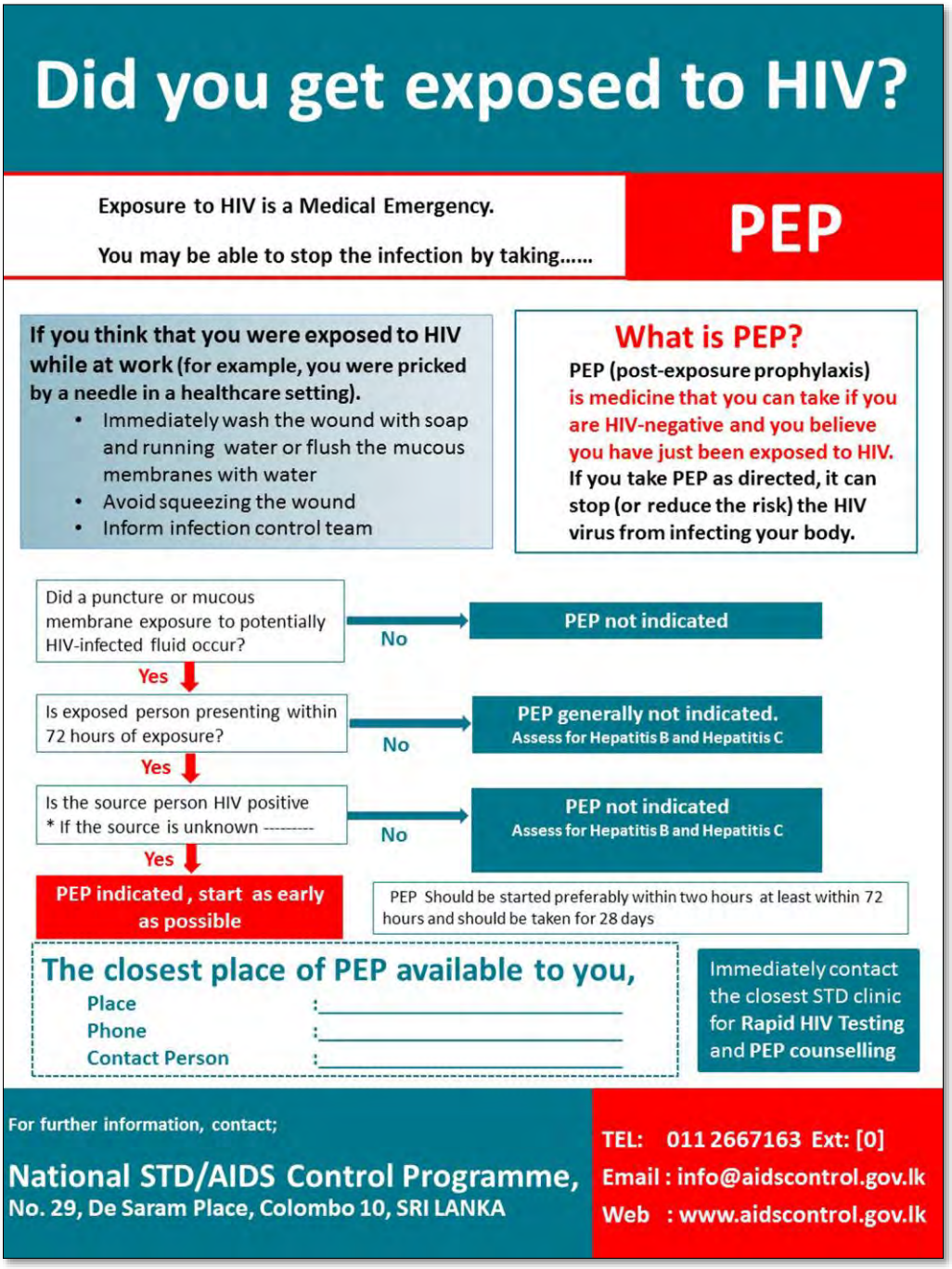
Table 10: Location information of ART for PEP in Sri Lanka during 2015

District	Institution	Unit of location	Contact Number
Anuradhapura	TH - Anuradhapura	Medical ICU	025 2236461
Badulla	PGH – Badulla	ETU	055 2222261 Ext.322
	STD clinic – Badulla	STD clinic	055 2222578
	BH – Diyathalawa	ICU	057 2229061 Ext.357
Batticaloa	STD clinic - Batticaloa	STD clinic	065 2222261
Colombo	National hospital of Sri Lanka	ETU/OPD	011 2691111 Ext.2429
	Lady Ridgeway hospital	Indoor dispensary	011 2693711-2 Ext.219, 242
	De Soysa maternity hospital	Theatre	011 2696224-5 Ext.326
	Castle Street hospital for women	Intensive care unit(ICU)	011 2696231-2 Ext.230
	Eye hospital	Room 4A injection room	011 2693911-5 Ext.231
	TH- Sri Jayawardenapura	ETU	011 2802695-6 Ext.3018 3019
	TH- Kalubowila	ETU	011 2763261 Ext.277
	STD Clinic- Kalubowila	STD clinic	011 4891055
	National institute for mental health	Pharmacy	011 2578234-5 Ext.222
	BH- Angoda(IDH)	Infection control unit	011 2411284 Ext.264
Galle	TH – Karapitiya	Pharmacy/ETU	091 2232250 Ext.7813
	STD clinic – Galle	STD Clinic	091 2245998
Gampaha	TH – Ragama	ICU	011 2959261
	STD clinic – Ragama	STD clinic	011 2960224
	DGH – Gampaha	Primary care unit(PCU)	033 2296897 Ext.112, 113
	DGH – Negombo	MICU	031 2222261 Ext.104
	Chest hospital - Welisara	OPD/ETU	011 2960509

Cont., table 10: Location information of ART for PEP in Sri Lanka during 2015

District	Institution	Unit of location	Contact Number
Jaffna	Teaching hospital Jaffna	OPD	021 2222261
Kalutara	GH – Kalutara	Accident & emergency unit	034 2222261 Ext.250
	STD Clinic - Kalutara	STD clinic	034 2236937
	BH – Panadura	ETU	038 2222261 Ext.243
	BH– Horana	Theatre	034 2261261 Ext.319
Kandy	TH– Kandy	ETU	081 2233338, 081 2234208
	STD clinic – Kandy	STD clinic	081 2203622
Kegalle	STD clinic – Kegalle	STD clinic	035 2231222
Kilinochchi	Base Hospital -Kilinochchi	STD clinic	021 2285327
Kurunegala	TH – Kurunegala	ICU-Accident & Emergency	037 2233906 Ext.907, 208
Matara	DGH – Matara	ETU	041 2222261 Ext.161
Matara	STD clinic – Matara	STD clinic	041 2232302
Monaragala	STD clinic - Monaragala	Primary care unit	055 2276261 Ext.215, 213
Nuwara Eliya	GH Nuwara Eliya	PCU/STD clinic	052 2234393 Ext.321
Polonnaruwa	GH- Polonnaruwa	Infection control unit	027 2222384 Ext.121
Ratnapura	STD clinic - Ratnapura	Clinic	045 2226561
	GH - Ratnapura	ICU	045 2225396 Ext.225, 337
	BH - Embilipitiya	ICU	047 2230261 Ext.126, 129
Trinchomalee	STD clinic-Trinchomalee	ICU	
Vauniya	District general hospital-Vavuniya	Emergency treatment unit	024 2224575

Figure 24: A poster on PEP developed for healthcare workers in 2015



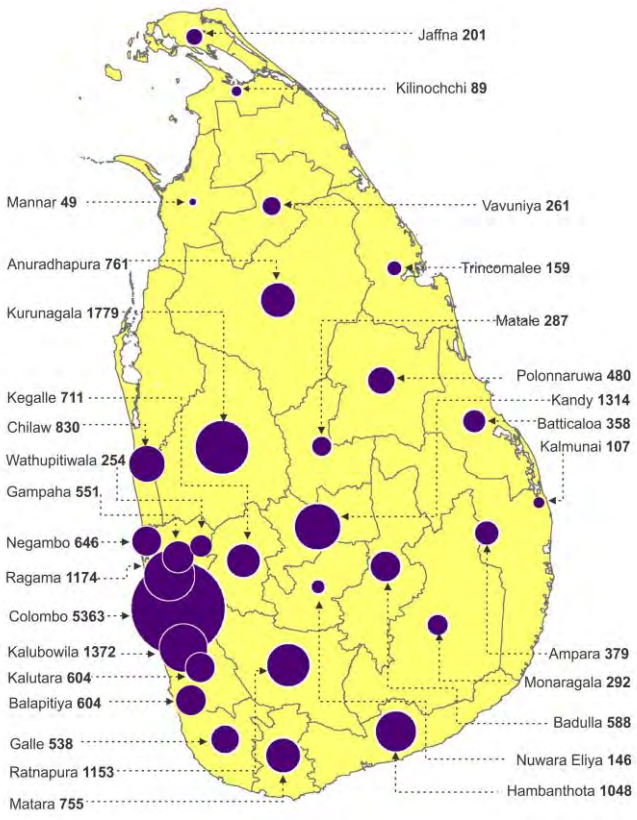
"Sexually transmitted infections (STIs) are infections that are spread primarily through sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites.

Several infections can also be transmitted from mother to child during pregnancy, childbirth and through blood products and tissue transfer."

Sexually transmitted infections

One of the primary objectives of the National STD/AIDS control programme is to provide comprehensive care for sexually transmitted infections (STIs). The most common sexually transmitted infections (STIs) are genital herpes, non-gonococcal infections, genital warts, gonorrhoea, chlamydial infection, syphilis and trichomoniasis. People who have contracted STIs are encouraged to seek services from STD clinics distributed throughout the island. All service delivery points are equipped with specially trained staff who provide curative and preventive services. A summary of the number of new patients registered for treatment at central and peripheral clinics for 2015 is shown in the map.

Figure 25: New patients registered in STD clinics during 2015



A total of 22,809 new patients had received services from the National STD/AIDS Control Programme during 2015. The Central clinic Colombo is the clinic with the highest service utilization serving the highly populated capital of the country. These patients are managed according to the standard guidelines on STD management, which include appropriate

treatment, contact tracing, regular follow up and defaulter tracing. Of these 30 STD clinics, 13 clinics have the capacity to provide antiretroviral treatment services for people living with HIV (PLHIV).

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

Table 11: Diagnoses reported from STD clinics during 2015

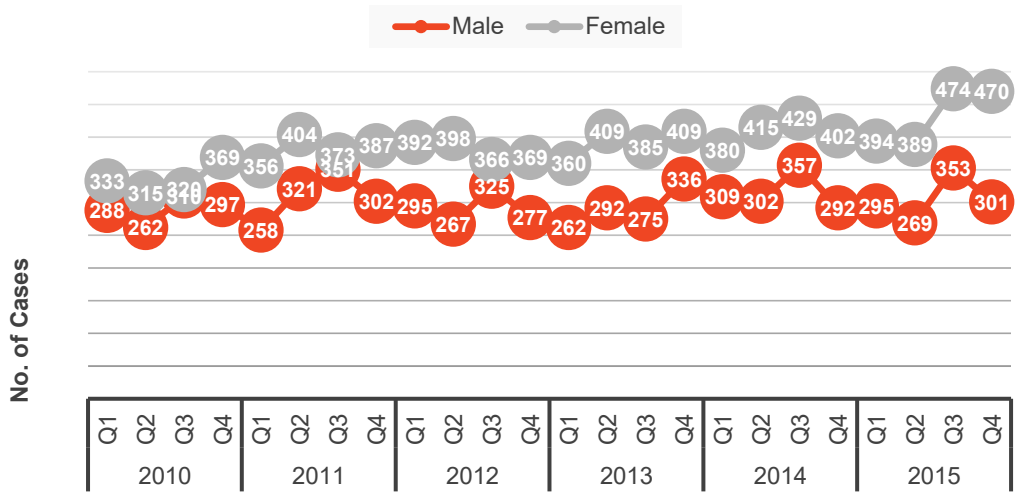
Diagnosis	Male		Female		Total	
	No.	%	No.	%	No.	%
Genital Herpes	1,218	22%	1,727	21%	2,945	21%
Candidiasis	971	17%	1,618	20%	2,589	19%
Non-gonococcal infec.	556	10%	1,663	20%	2,219	16%
Genital Warts	1,147	20%	858	10%	2,005	14%
Bacterial Vaginosis	-	0%	1,426	17%	1,426	10%
Late syphilis	613	11%	342	4%	955	7%
Gonorrhoea	329	6%	125	2%	454	3%
Early Syphilis	125	2%	55	1%	180	1%
Trichomoniasis	15	0%	104	1%	119	1%
Chlamydia	35	1%	31	0%	66	0%
Early Congenital Syphilis	3	0%	4	0%	7	0%
Late Congenital Syphilis	4	0%	3	0%	7	0%
Opthalmia neonatorum	2	0%	1	0%	3	0%
Chancroid	2	0%	1	0%	3	0%
Other STI	466	8%	192	2%	658	5%
Total STI	**5,650**	**100%**	**8,202**	**100%**	**13,852**	**100%**

The above table summarizes the total diagnoses made of all STD clinic attendees during 2015. Genital herpes has been reported as the commonest presentation. Significant proportions of clinic attendees have been seeking care for candidiasis (19%) and bacterial vaginosis (10%) though they do not belong to the category of STIs.

1. Genital herpes

Genital herpes had been the most commonly reported diagnosis among those who attended STD services. The graph below summarizes the total number of male and female patients reported during the last six-years. There are more females than males among reported cases. There is an upward trend of number of reported cases over the years.

Figure 26: Genital herpes from all STD Clinics, 2010 - 2015

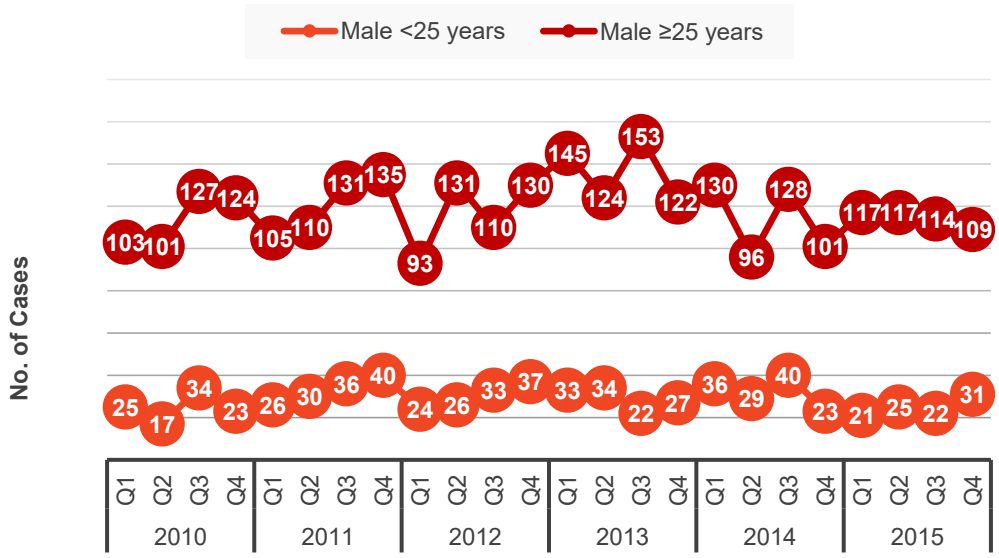


More female cases may be due to more frequent recurrences among females. The possibility of neonatal herpes is a concern when providing care to pregnant women with genital herpes. They need regular follow up and may need suppressive therapy to avoid fetal complications.

2. Non-gonococcal urethritis and cervicitis.

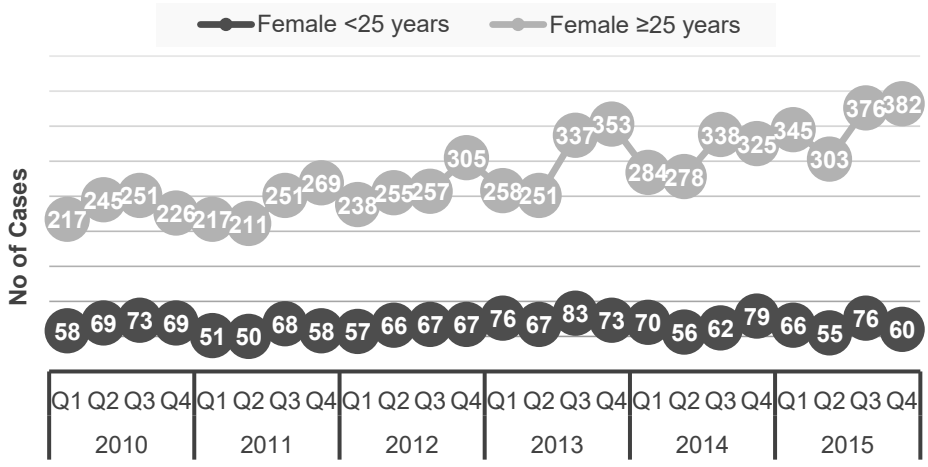
Non-gonococcal urethritis and cervicitis are caused by a number of infectious agents other than *Neisseria gonorrhoeae*. *Chlamydia trachomatis* is one of the commonest causative agents. Currently specific diagnostic tests for *C. trachomatis* are not available in most of the STD clinics and a tentative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

Figure 27: Male non-gonococcal urethritis cases in all STD clinics, 2010-2015



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

Figure 28: Non-gonococcal cervicitis in females all STD clinics end of 2015



3. Chlamydia trachomatis

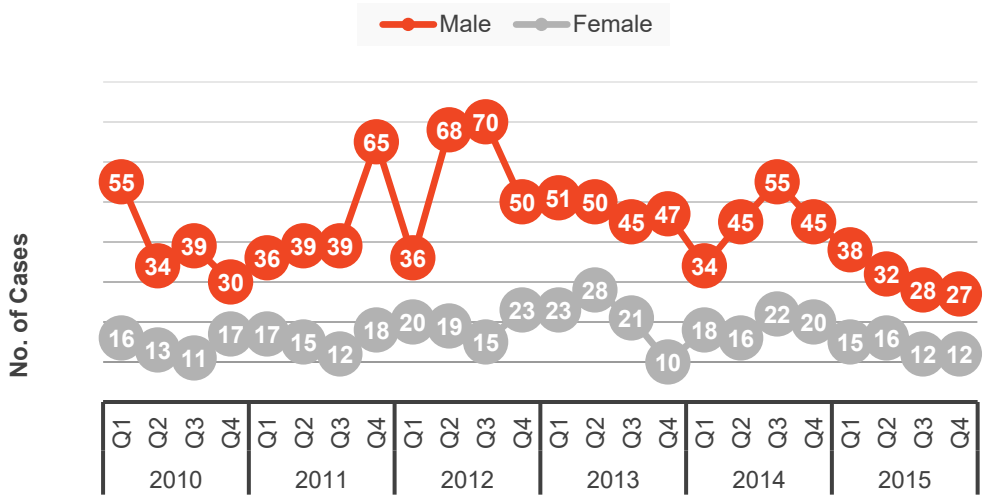
As mentioned above, specific diagnostic tests for chlamydia infection were not available in STD clinics during 2015. According to a clinic based study carried out among Colombo STD clinic

attendees in 2015, the prevalence of genital chlamydia among female attendees was 17.1 % (37/216) and among male attendees was 5.1% (13/252). Among infected females 64.8% (24/37) were asymptomatic. Prevalence among commercial sex workers was 20.4% (20/98) (p=0.001) and men having sex with men was 1.5% (1/65) (p>0.05*) (Proceedings of the annual scientific sessions of Sri Lanka college of Venereologists-2015).*

4. Syphilis

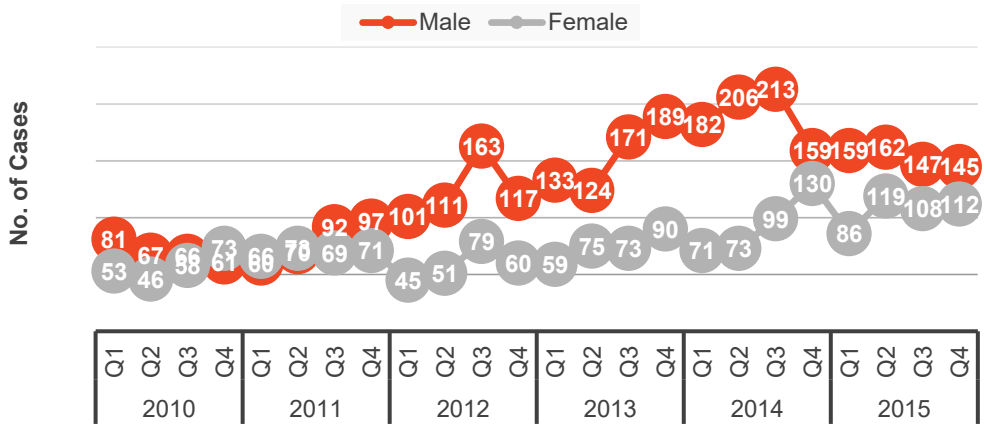
Syphilis is an important bacterial STI which has a long natural history with a potential for in utero infection resulting in adverse outcomes. Highly effective treatment is available which reduce the risk of mother to child transmission. The following two graphs summarize the total number of early and late syphilis infections reported from all STD clinics of NSACP.

Figure 29: Early syphilis in all STD clinics 2010-2015



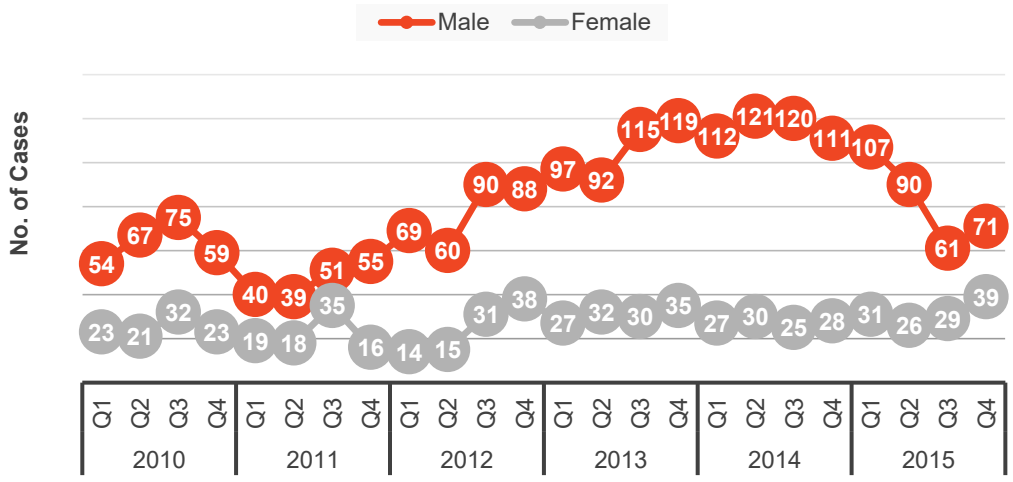
Early syphilis, also known as infectious syphilis, is defined as syphilis infections which are diagnosed within 2 years of the infection. Syphilis diagnoses made two years after the infection are named late or non-infectious syphilis.

Figure 30: Late syphilis from all STD clinics, 2010- 2015



5. Gonorrhoea

Figure 31: Gonorrhoea cases from all STD clinics, 2010-2015



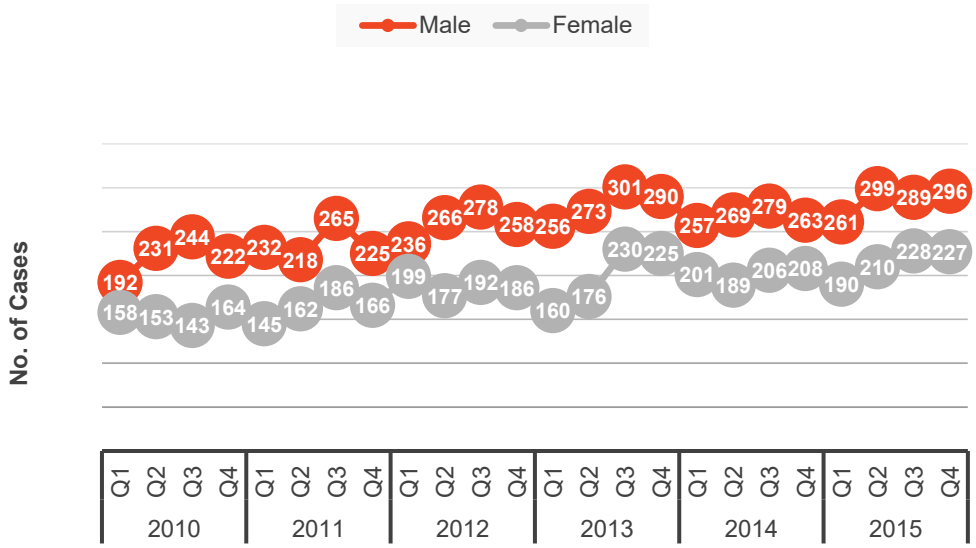
The above graph indicates the number of total gonorrhea and presumptive gonorrhoea cases reported during the last six years. Where culture facilities are not available presumptive gonococcal infections are diagnosed using microscopy. Gonorrhoea urethritis gives rise to intense symptoms in males such as burning pain when passing urine and a purulent discharge

from the urethra. However, most females with gonococcal infection may remain asymptomatic. More males are reported with gonorrhoea. Increasing trend of gonorrhoea was observed among both males and females during the last two quarters of 2015.

6. Genital warts.

Genital warts are mainly caused by Human Papilloma virus, types 6 and 11. Infected females carry a risk of developing cervical carcinoma mainly due to the high risk of oncogenic types such as HPV types16 and 18. Cervical carcinoma remains as one of the major causes of cancer in Sri Lanka. The following graph indicates the number of patients that received services for genital warts during last six years.

Figure 32: Genital wart cases from all STD clinics, 2010 - 2015



7. Trichomoniasis

Trichomoniasis is a sexually transmitted disease caused by a protozoan. It is usually symptomatic only in females. The disease is diagnosed by visualization of the organism in a wet smear or in a urine deposit. The graph below demonstrates the total number of male and female patients reported during the year 2015.

Figure 33: Trichomoniasis cases from all STD clinics, 2010- 2015

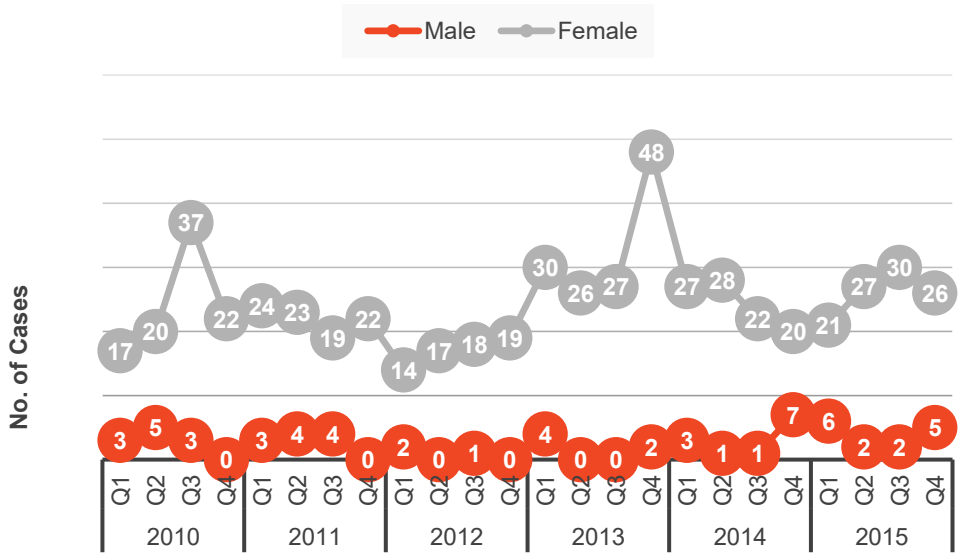


Table 12: Number of reported early (infectious) syphilis cases, 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	14	2	16	7	3	10	10	6	16	9	3	12
	Matale	0	0	0	4	2	6	2	2	4	1	0	1
	Nuwara Eliya	2	3	5	5	5	10	2	2	4	3	6	9
Eastern Province	Ampara	2	0	2	0	0	0	0	0	0	1	1	2
	Batticaloa	4	5	9	1	0	1	2	3	5	0	0	0
	Kalmunai	3	0	3	1	0	1	0	0	0	0	0	0
	Trincomalee	3	1	4	1	0	1	0	0	0	0	0	0
North Central province	Anuradhapura	0	0	0	2	2	4	1	0	1	0	0	0
	Polonnaruwa	0	0	0	1	0	1	0	0	0	0	0	0
North Western Province	Chilaw	0	0	0	0	0	0	4	2	6	0	0	0
	Kurunegala	2	2	4	3	0	3	1	0	1	0	0	0
Northern Province	Jaffna	1	0	1	2	2	4	0	0	0	3	2	5
	Kilinochchi	-	-	-	-	-	-	-	-	-	1	1	2
	Mannar	0	0	0	0	0	0	0	0	0	0	1	1
	Vavuniya	0	0	0	0	0	0	0	0	0	0	0	0
Sabaragamuwa Province	Kegalle	3	2	5	2	3	5	6	6	12	4	2	6
	Ratnapura	4	1	5	0	0	0	0	0	0	2	1	3
Southern Province	Balapitiya	0	0	0	2	1	3	3	0	3	4	3	7
	Galle	15	1	16	8	6	14	20	8	28	8	6	14
	Hambanthota	0	0	0	2	0	2	0	3	3	4	2	6
	Matara	12	7	19	6	3	9	2	3	5	1	0	1
Uva Province	Badulla	6	2	8	3	2	5	0	0	0	0	0	0
	Monaragala	0	0	0	2	1	3	0	1	1	0	0	0
Western Province	Colombo	96	30	126	104	37	141	83	25	108	47	13	60
	Gampaha	1	0	1	1	0	1	0	0	0	9	1	10
	Kalubowila	20	4	24	13	1	14	20	7	27	13	6	19
	Kalutara	4	2	6	2	3	5	3	2	5	4	2	6
	Negombo	6	5	11	3	3	6	7	2	9	4	2	6
	Ragama	26	9	35	16	7	23	13	4	17	7	3	10
	Wathupitiwala	0	1	1	2	1	3	0	0	0	0	0	0
Total		**224**	**77**	**301**	**193**	**82**	**275**	**179**	**76**	**255**	**125**	**55**	**180**

Table 13: Number of late syphilis cases reported, 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	30	14	44	37	18	55	31	17	48	44	23	67
	Matale	0	0	0	0	2	2	1	3	4	5	2	7
	Nuwara Eliya	0	0	0	0	0	0	2	0	2	0	0	0
Eastern Province	Ampara	4	3	7	7	2	9	6	7	13	4	4	8
	Batticaloa	3	0	3	5	8	13	7	5	12	12	5	17
	Kalmunai	0	0	0	1	0	1	1	1	2	0	0	0
	Trincomalee	0	0	0	2	2	4	4	1	5	0	1	1
North Central province	Anuradhapura	16	5	21	12	8	20	15	19	34	6	5	11
	Polonnaruwa	6	2	8	1	0	1	21	5	26	8	2	10
North Western Province	Chilaw	4	0	4	10	11	21	24	15	39	14	5	19
	Kurunegala	19	26	45	20	19	39	33	32	65	31	27	58
Northern Province	Jaffna	0	0	0	2	3	5	1	3	4	6	1	7
	Kilinochchi	-	-	-	-	-	-	-	-	-	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	7	11	18	9	4	13	5	3	8	3	4	7
Sabaragamuwa Province	Kegalle	0	0	0	8	3	11	14	5	19	1	2	3
	Ratnapura	18	11	29	18	15	33	10	11	21	14	13	27
Southern Province	Balapitiya	4	0	4	3	2	5	5	5	10	2	2	4
	Galle	23	20	43	48	13	61	38	16	54	35	16	51
	Hambanthota	17	8	25	23	13	36	7	1	8	0	1	1
	Matara	10	3	13	11	3	14	4	5	9	14	4	18
Uva Province	Badulla	6	7	13	25	23	48	33	10	43	18	18	36
	Monaragala	0	0	0	0	1	1	4	5	9	1	5	6
Western Province	Colombo	222	131	353	239	145	384	264	150	414	244	139	383
	Gampaha	13	6	19	8	11	19	27	11	38	2	6	8
	Kalubowila	40	17	57	34	17	51	71	38	109	48	21	69
	Kalutara	13	10	23	21	13	34	16	14	30	15	6	21
	Negombo	6	8	14	16	16	32	31	12	43	18	7	25
	Ragama	29	15	44	56	19	75	74	23	97	56	13	69
	Wathupitiwala	2	0	2	1	2	3	11	8	19	12	10	22
Total		**492**	**297**	**789**	**617**	**373**	**990**	**760**	**425**	**1185**	**613**	**342**	**955**

Table 14: Number of gonorrhoea cases 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	18	13	31	26	12	38	25	6	31	13	0	13
	Matale	3	1	4	4	0	4	1	2	3	1	0	1
	Nuwara Eliya	17	15	32	20	22	42	9	3	12	3	3	6
Eastern Province	Ampara	1	0	1	4	0	4	1	0	1	2	0	2
	Batticaloa	6	1	7	13	3	16	1	0	1	6	4	10
	Kalmunai	1	0	1	1	0	1	0	0	0	3	1	4
	Trincomalee	19	1	20	11	0	11	4	1	5	2	0	2
North Central province	Anuradhapura	18	13	31	24	1	25	18	4	22	15	3	18
	Polonnaruwa	17	0	17	3	1	4	8	0	8	25	12	37
North Western Province	Chilaw	2	0	2	3	1	4	3	0	3	1	0	1
	Kurunegala	3	4	7	18	3	21	6	1	7	12	3	15
Northern Province	Jaffna	4	0	4	7	0	7	3	0	3	10	1	11
	Kilinochchi	-	-	-	-	-	-	-	-	-	4	1	5
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	5	0	5	10	2	12	13	0	13	1	0	1
Sabaragamuwa Province	Kegalle	2	0	2	23	11	34	11	5	16	10	3	13
	Ratnapura	15	4	19	10	2	12	5	1	6	8	3	11
Southern Province	Balapitiya	2	4	6	9	1	10	5	1	6	4	2	6
	Galle	15	2	17	10	3	13	14	12	26	10	7	17
	Hambanthota	15	4	19	15	18	33	19	23	42	9	19	28
	Matara	7	2	9	10	2	12	13	5	18	7	2	9
Uva Province	Badulla	7	3	10	4	1	5	4	1	5	5	4	9
	Monaragala	0	0	0	4	2	6	6	2	8	7	0	7
Western Province	Colombo	75	18	93	108	18	126	168	26	194	81	36	117
	Gampaha	5	1	6	13	1	14	7	0	7	7	1	8
	Kalubowila	24	9	33	39	13	52	53	10	63	38	9	47
	Kalutara	6	0	6	10	1	11	9	0	9	10	5	15
	Negombo	5	1	6	6	1	7	17	1	18	13	2	15
	Ragama	14	2	16	16	5	21	32	3	35	22	4	26
	Wathupitiwala	1	0	1	2	0	2	9	3	12	0	0	0
Total		**307**	**98**	**405**	**423**	**124**	**547**	**464**	**110**	**574**	**329**	**125**	**454**

Table 15: Number of non-gonococcal urethritis and cervicitis reported, 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	42	226	268	24	242	266	30	230	260	25	184	209
	Matale	0	0	0	5	3	8	5	4	9	4	8	12
	Nuwara Eliya	20	18	38	18	14	32	4	6	10	0	5	5
Eastern Province	Ampara	6	0	6	14	0	14	7	1	8	8	1	9
	Batticaloa	1	0	1	2	3	5	4	4	8	16	15	31
	Kalmunai	0	0	0	1	0	1	0	0	0	0	0	0
	Trincomalee	0	0	0	2	0	2	0	0	0	1	0	1
North Central province	Anuradhapura	40	19	59	51	2	53	24	7	31	36	10	46
	Polonnaruwa	6	0	6	0	0	0	1	0	1	4	3	7
North Western Province	Chilaw	6	93	99	16	60	76	7	85	92	7	95	102
	Kurunegala	52	140	192	70	237	307	35	204	239	61	290	351
Northern Province	Jaffna	17	6	23	3	0	3	9	3	12	6	1	7
	Kilinochchi	-	-	-	-	-	-	-	-	-	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Vauniya	0	0	0	8	0	8	10	0	10	8	0	8
Sabaragamuwa Province	Kegalle	1	0	1	77	50	127	73	14	87	39	34	73
	Ratnapura	15	17	32	12	4	16	16	5	21	12	9	21
Southern Province	Balapitiya	8	21	29	7	12	19	7	4	11	2	2	4
	Galle	31	80	111	23	100	123	18	89	107	12	65	77
	Hambanthota	10	3	13	13	4	17	15	4	19	25	14	39
	Matara	6	44	50	14	30	44	18	14	32	33	12	45
Uva Province	Badulla	7	8	15	6	6	12	9	1	10	1	3	4
	Monaragala	0	0	0	2	0	2	4	12	16	4	10	14
Western Province	Colombo	141	239	380	144	290	434	142	341	483	108	421	529
	Gampaha	40	102	142	17	103	120	13	108	121	6	113	119
	Kalubowila	43	81	124	57	82	139	42	114	156	61	127	188
	Kalutara	13	33	46	5	45	50	7	17	24	7	11	18
	Negombo	28	108	136	42	124	166	33	150	183	33	118	151
	Ragama	46	63	109	22	60	82	46	50	96	32	89	121
	Wathupitiwala	5	11	16	5	27	32	4	25	29	5	23	28
Total		**584**	**1312**	**1896**	**660**	**1498**	**2158**	**583**	**1492**	**2075**	**556**	**1663**	**2219**

Table 16: Number of genital herpes cases reported, 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	80	107	187	69	95	164	65	122	187	69	129	198
	Matale	7	20	27	13	32	45	12	39	51	12	24	36
	Nuwara Eliya	10	6	16	8	12	20	8	7	15	6	10	16
Eastern Province	Ampara	14	21	35	26	34	60	28	42	70	21	44	65
	Batticaloa	1	6	7	11	11	22	6	12	18	12	14	26
	Kalmunai	2	4	6	2	4	6	2	2	4	1	10	11
	Trincomalee	23	18	41	21	13	34	22	18	40	13	14	27
North Central province	Anuradhapura	58	47	105	53	70	123	66	69	135	56	67	123
	Polonnaruwa	31	54	85	29	50	79	43	52	95	39	42	81
North Western Province	Chilaw	39	58	97	38	55	93	25	43	68	30	58	88
	Kurunegala	94	109	203	79	101	180	92	138	230	99	162	261
Northern Province	Jaffna	11	7	18	2	3	5	17	3	20	14	6	20
	Kilinochchi	-	-	-	-	-	-	-	-	-	7	5	12
	Mannar	0	0	0	0	0	0	0	0	0	0	1	1
	Vavuniya	39	13	52	26	22	48	41	20	61	44	37	81
Sabaragamuwa Province	Kegalle	11	16	27	33	54	87	44	85	129	47	87	134
	Ratnapura	74	102	176	71	97	168	52	68	120	62	85	147
Southern Province	Balapitiya	26	41	67	29	48	77	19	39	58	23	41	64
	Galle	34	66	100	26	78	104	41	73	114	40	66	106
	Hambanthota	23	26	49	18	38	56	37	21	58	24	26	50
	Matara	54	77	131	45	49	94	51	44	95	28	67	95
Uva Province	Badulla	33	70	103	32	73	105	38	71	109	20	58	78
	Monaragala	0	0	0	4	13	17	9	26	35	5	33	38
Western Province	Colombo	195	225	420	227	182	409	224	183	407	212	182	394
	Gampaha	45	74	119	29	55	84	55	52	107	54	83	137
	Kalubowila	128	166	294	133	150	283	139	167	306	142	154	296
	Kalutara	37	71	108	33	76	109	22	57	79	19	49	68
	Negombo	32	44	76	35	36	71	26	52	78	31	61	92
	Ragama	58	70	128	53	85	138	54	81	135	68	80	148
	Wathupitiwala	5	7	12	20	27	47	22	40	62	20	32	52
Total		**1164**	**1525**	**2689**	**1165**	**1563**	**2728**	**1260**	**1626**	**2886**	**1218**	**1727**	**2945**

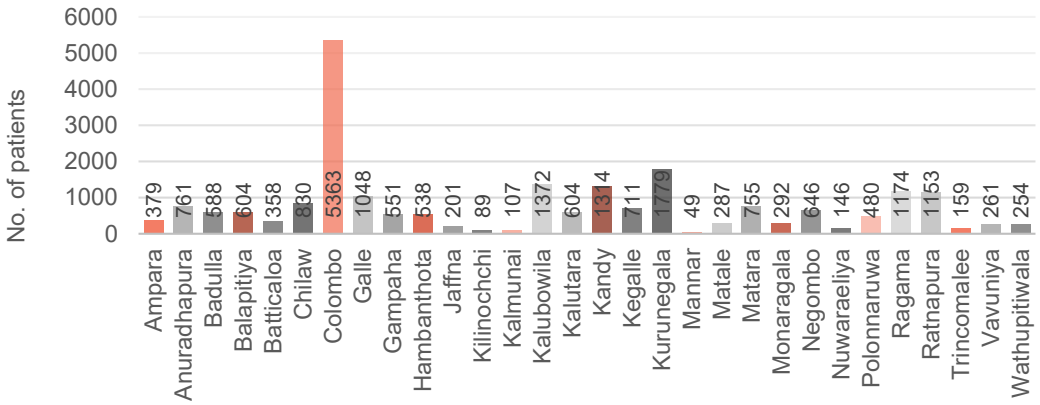
Table 17: Number of genital warts cases reported, 2012 - 2015													
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	63	45	108	52	39	91	41	41	82	56	48	104
	Matale	5	7	12	15	10	25	10	7	17	9	12	21
	Nuwara Eliya	7	9	16	3	2	5	6	2	8	5	2	7
Eastern Province	Ampara	21	12	33	18	20	38	19	11	30	15	19	34
	Batticaloa	6	2	8	4	8	12	4	5	9	5	2	7
	Kalmunai	0	1	1	0	3	3	0	1	1	2	0	2
	Trincomalee	17	6	23	17	10	27	5	4	9	4	7	11
North Central province	Anuradhapura	66	48	114	65	40	105	39	30	69	63	34	97
	Polonnaruwa	30	27	57	25	26	51	28	18	46	32	20	52
North Western Province	Chilaw	34	21	55	37	25	62	34	23	57	38	29	67
	Kurunegala	71	66	137	68	78	146	73	66	139	93	89	182
Northern Province	Jaffna	3	4	7	3	1	4	11	6	17	19	2	21
	Kilinochchi	-	-	-	-	-	-	-	-	-	1	2	3
	Mannar	0	0	0	0	1	1	0	0	0	3	0	3
	Vavuniya	15	2	17	15	6	21	12	5	17	16	8	24
Sabaragamuwa Province	Kegalle	22	21	43	58	43	101	43	34	77	39	36	75
	Ratnapura	49	36	85	40	26	66	29	33	62	39	37	76
Southern Province	Balapitiya	15	11	26	17	7	24	15	13	28	14	16	30
	Galle	37	36	73	36	33	69	54	42	96	49	35	84
	Hambanthota	25	8	33	26	21	47	38	17	55	25	31	56
	Matara	26	22	48	39	21	60	25	28	53	35	30	65
Uva Province	Badulla	13	17	30	14	23	37	12	20	32	24	29	53
	Monaragala	0	0	0	5	4	9	8	5	13	4	12	16
Western Province	Colombo	233	115	348	275	110	385	253	122	375	250	108	358
	Gampaha	32	32	64	35	42	77	35	31	66	23	31	54
	Kalubowila	102	86	188	90	58	148	102	86	188	118	76	194
	Kalutara	27	36	63	50	42	92	37	41	78	34	48	82
	Negombo	45	24	69	44	35	79	46	39	85	37	32	69
	Ragama	72	55	127	59	47	106	72	66	138	86	37	123
	Wathupitiwala	2	5	7	10	10	20	17	8	25	9	26	35
Total		**1038**	**754**	**1792**	**1120**	**791**	**1911**	**1068**	**804**	**1872**	**1147**	**858**	**2005**

Table 18: Number of trichomoniasis cases reported, 2012 - 2015												
Province	STD clinic	2012			2013			2014			2015		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	12	12	0	15	15	2	0	2	1	5	6
	Matale	0	0	0	0	0	0	1	0	1	0	0	0
	Nuwara Eliya	0	0	0	0	1	1	0	0	0	0	0	0
Eastern Province	Ampara	0	0	0	0	0	0	0	0	0	0	1	1
	Batticaloa	0	0	0	0	1	1	2	6	8	1	8	9
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0	0	0	0
North Central province	Anuradhapura	0	0	0	2	1	3	0	1	1	0	0	0
	Polonnaruwa	0	0	0	0	0	0	0	0	0	0	2	2
North Western Province	Chilaw	0	1	1	0	0	0	0	1	1	0	1	1
	Kurunegala	1	1	2	0	17	17	0	8	8	0	3	3
Northern Province	Jaffna	0	0	0	0	0	0	0	0	0	0	0	0
	Kilinochchi	-	-	-	-	-	-	-	-	-	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	0	0	0	0	3	3	0	1	1	0	0	0
Sabaragamuwa Province	Kegalle	0	0	0	0	15	15	1	16	17	0	15	15
	Ratnapura	1	3	4	2	4	6	0	2	2	0	0	0
Southern Province	Balapitiya	0	1	1	0	1	1	0	2	2	0	0	0
	Galle	0	3	3	0	2	2	0	0	0	0	3	3
	Hambanthota	0	0	0	0	1	1	0	0	0	0	1	1
	Matara	0	4	4	0	0	0	0	1	1	0	0	0
Uva Province	Badulla	0	4	4	1	10	11	0	3	3	1	2	3
	Monaragala	0	0	0	0	0	0	0	0	0	0	0	0
Western Province	Colombo	1	30	31	0	31	31	5	20	25	7	41	48
	Gampaha	0	1	1	0	3	3	0	2	2	0	4	4
	Kalubowila	0	6	6	1	6	7	0	15	15	3	10	13
	Kalutara	0	0	0	0	1	1	0	1	1	2	2	4
	Negombo	0	1	1	0	5	5	0	11	11	0	3	3
	Ragama	0	1	1	0	4	4	1	7	8	0	3	3
	Wathupitiwala	0	0	0	0	0	0	0	0	0	0	0	0
Total		**3**	**68**	**71**	**6**	**121**	**127**	**12**	**97**	**109**	**15**	**104**	**119**

Monitoring STD services - 2015

Curative and preventive services on sexual health are provided to people by the central and peripheral STD clinics situated throughout the island. These services are utilized by many people from various risk levels related to sexual health, ranging from most at risk population (including female sex workers, men who have sex with men and drug users etc.) and the vulnerable population (migrant workers, prisoners etc.) and the general population such as antenatal mothers. The data on the services delivered are collected regularly and analyzed strategically for the purpose of monitoring and evaluation of the whole programme. This is carried out using the recording and reporting formats of all STD clinics by the Strategic information management unit of the National STD/AIDS control programme.

Figure 34: New patients registered at STD clinics during 2015

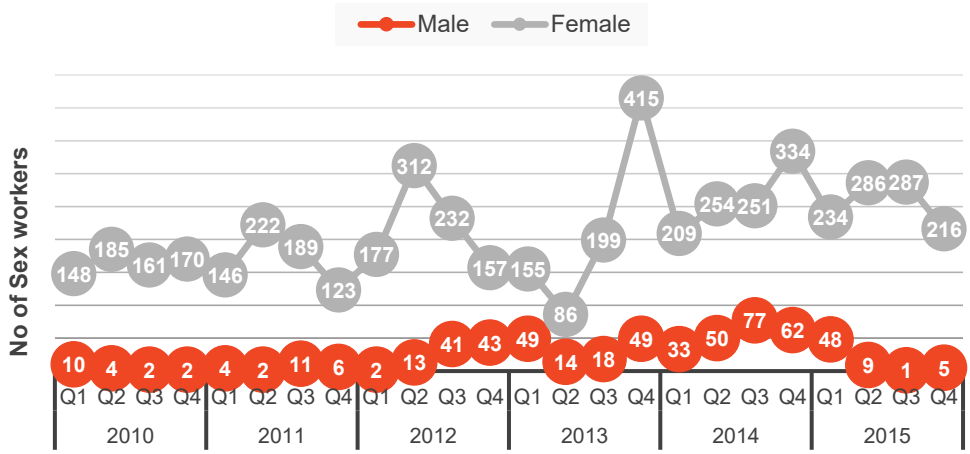


Above graph shows the number of new patients (excluding previously attended patients or clinic attendees at subsequent visits) registered at STD clinics. Seven STD clinics given in the table 19 had more than 1000 new patients registered during 2015.

Table 19: New patients registered at STD clinics in 2015

STD clinic	New patients registered		
	Male	Female	Total
1. Colombo	3562	1801	5363
2. Kurunegala	778	1001	1779
3. Kalubowila	761	611	1372
4. Kandy	664	650	1314
5. Ragama	706	468	1174
6. Ratnapura	639	514	1153
7. Galle	655	393	1048

Figure 35: New sex workers registered in all STD clinic 2010-2015

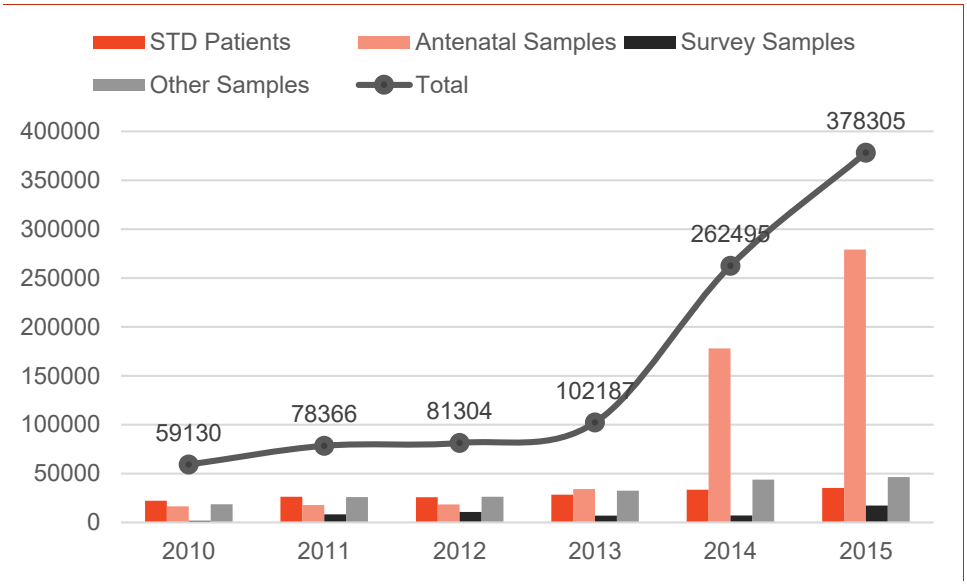


The above graph shows the number of new male and female sex workers registered at all STD clinics for services. All these clinic attendees were provided a comprehensive care package including screening and treatment for STIs, counselling and testing for HIV, education on safer sexual behavior and promotion and provision of condoms. They were encouraged to come for services on a regular basis for STI /HIV screening. Number of male sex workers are declining towards the end of 2015. This may be due to a reporting bias as most of the male sex workers may not reveal their risk category.

HIV screening services

Various categories of people are provided with HIV screening services at the STD clinics. The following graph illustrates the number of different types of samples screened for HIV during the year 2015. The number of samples have increased dramatically with time with an increased contribution coming from the antenatal screening for elimination of mother to child transmission of HIV.

Figure 36: Number and type of samples screened for HIV, 2010 - 2015



HIV testing and counselling services for most at risk populations

The female sex workers, men who have sex with men and drug users require regular screening and follow up due to their risky sexual behavior. The National STD/AIDS control programme conducts targeted interventions for these high risk groups to increase the screening and detection of early infections.

The following table illustrates HIV testing and counselling services provided by the NSACP for STD clinic attendees including most-at-risk populations.

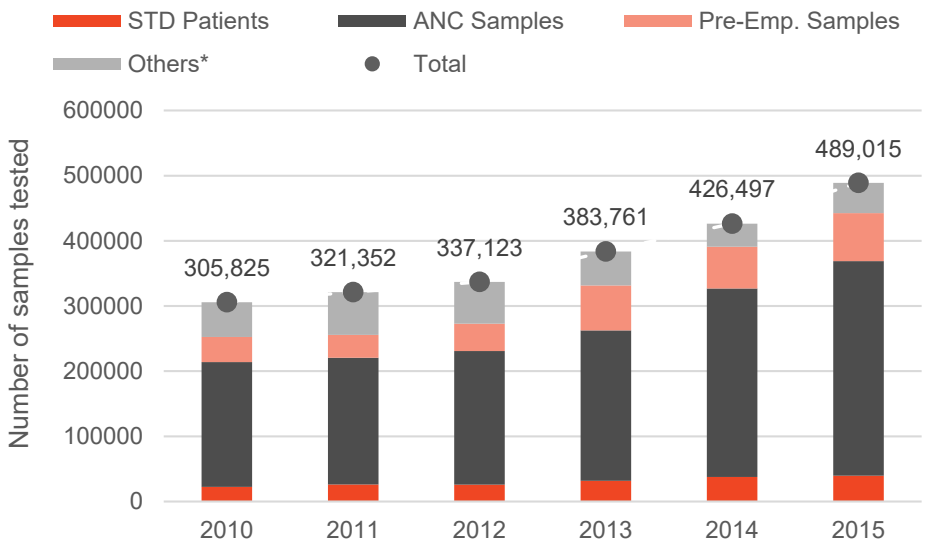
Table 20: HIV testing and counselling services for most at risk populations

Testing Category	Clinic based testing			Outreach testing		
	HIV tested	Received Results		HIV tested	Received Results	
Female sex workers	1135	754	(66%)	490	466	(95%)
MSM	1708	1037	(61%)	237	180	(76%)
Drug Users	1586	659	(42%)	1072	977	(91%)
Prisoners	-	-	-	11384	11378	(100%)
Others*	47290	42911	(91%)	21453	21207	(99%)

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

Men who have sex with men (MSM) had low rates of returning for HIV test results in both clinic based as well as outreach HIV testing. Drug users and female sex workers had low rates for receiving HIV test results in clinic based HIV screening.

Figure 37: 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 STD clinic attendees are routinely offered screening services and blood samples from antenatal mothers are screened for syphilis at the laboratories of local STD clinics.

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

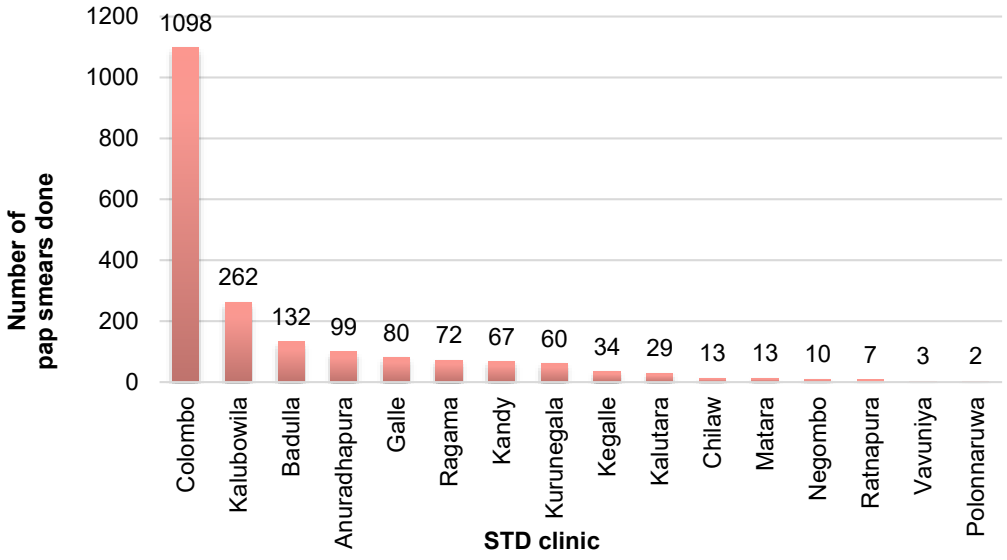
Pap smear (Cervical cytology) screening services in 2015

Pap smear screening services are provided for women to detect potentially pre-cancerous and cancerous lesions in the cervix. Patients with abnormal findings are referred for more sensitive diagnostic procedures and interventions that aim to prevent progression to cervical cancer. According to the National cancer control programme data, the incidence of cervical cancer in Sri Lanka is 8.5/100,000 population. Data on cancer staging was available in 59%, and of them 58.5% were in advanced stages (stage lll and IV) at the time of diagnosis. (Cancer incidence data 2009, NCCP).

Human Papilloma Virus (HPV) has been found to be responsible for 99.7% cases of cervical squamous carcinoma. Pap smear screening is very important for STD clinic attendees as they are more likely to get infected with HPV. Although highly effective HPV vaccines are now available, currently vaccination is not available in the public sector healthcare services. Even for those who get vaccinated, Pap smear screening is still recommended as currently available vaccines do not cover all the HPV types that can cause cervical cancer.

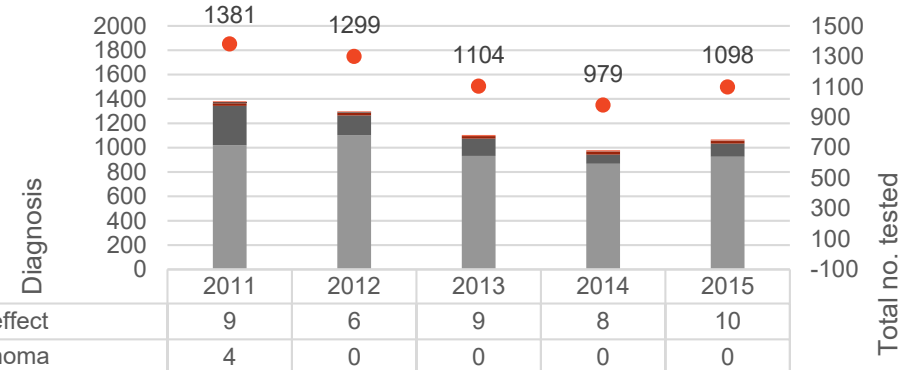
During 2015, the Central STD clinic, Colombo and 15 peripheral STD clinics provided Pap smear screening facilities to female clinic attendees. Of these majority (58 %) of Pap smears were done in Colombo STD clinic. Timely reporting of Pap smear results has been a challenge due to limited resource allocation for this activity.

Figure 38: Number of PAP smear tests done during 2015



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

Figure 39: Results of Pap smear tests done at Colombo STD clinic, 2011-2015



Diagnosis	2011	2012	2013	2014	2015
HPV effect	9	6	9	8	10
Carcinoma	4	0	0	0	0
CINIII/HSIL	3	5	0	2	4
LSIL	22	23	21	26	20
NSI/SI*	323	162	142	75	108
NILM	1020	1103	932	868	926
Total No of Pap done	1381	1299	1104	979	1098

Abbreviations: CIN III-Cervical intraepithelial neoplasia grade 3, HSIL-High grade squamous intraepithelial lesion, NSI/SI- Nonspecific infection/specific infection, NILM-Negative for intra epithelial lesion or malignancy

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.

Summary of quarterly returns received from STD clinics

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

Table 21: Details of clinic attendances in STD clinics during 2015													
Province	STD clinic	New patients			New patients with STIs			Clinic visits by STD patients			Clinic visits by others		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	664	650	1314	290	371	661	1651	2230	3881	3470	7223	10693
	Matale	174	113	287	35	72	107	128	133	261	1468	1841	3309
	Nuwara Eliya	60	86	146	23	35	58	125	181	306	1851	1387	3238
Eastern Province	Ampara	176	203	379	65	115	180	396	428	824	1083	3959	5042
	Batticaloa	183	175	358	61	57	118	600	377	977	1033	2785	3818
	Kalmunai	49	58	107	6	12	18	73	85	158	734	426	1160
	Trincomalee	79	80	159	49	33	82	144	122	266	2443	5622	8065
North Central Province	Anuradhapura	466	295	761	271	184	455	1134	819	1953	3581	4939	8520
	Polonnaruwa	264	216	480	184	156	340	451	379	830	2219	5503	7722
North Western Province	Chilaw	375	455	830	145	342	487	1051	1329	2380	1084	793	1877
	Kurunegala	778	1001	1779	392	753	1145	1449	2194	3643	3320	2612	5932
Northern Province	Jaffna	143	58	201	73	15	88	179	73	252	1213	6654	7867
	Kilinochchi	45	44	89	28	20	48	18	7	25	1000	2723	3723
	Mannar	19	30	49	5	2	7	33	50	83	405	2308	2713
	Vavuniya	144	117	261	90	60	150	333	228	561	1333	3556	4889
Sabaragamuwa Province	Kegalle	350	361	711	131	254	385	1156	1188	2344	1252	1942	3194
	Ratnapura	639	514	1153	172	185	357	331	473	804	2321	2575	4896
Southern Province	Balapitiya	399	205	604	70	91	161	431	328	759	269	1650	1919
	Hambanthota	655	393	1048	202	256	458	1537	1202	2739	1414	1156	2570
	Galle	289	249	538	129	158	287	555	476	1031	2163	10507	12670
	Matara	366	389	755	133	165	298	967	835	1802	1956	8051	10007
Uva Province	Badulla	285	303	588	87	183	270	1286	1375	2661	1817	5089	6906
	Monaragala	120	172	292	20	62	82	134	159	293	2982	3746	6728
Western Province	Colombo	3562	1801	5363	1224	911	2135	10277	7176	17453	7465	4710	12175
	Gampaha	250	301	551	151	259	410	792	864	1656	987	970	1957
	Kalubowila	761	611	1372	349	350	699	4599	3266	7865	1804	1575	3379
	Kalutara	295	309	604	113	229	342	970	1063	2033	2995	3030	6025
	Negombo	369	277	646	151	216	367	816	719	1535	1103	707	1810
	Ragama	706	468	1174	326	288	614	2837	1819	4656	1483	1069	2552
	Wathupitiwala	103	151	254	55	99	154	167	327	494	318	712	1030
Total		**12768**	**10085**	**22853**	**5030**	**5933**	**10963**	**34620**	**29905**	**64525**	**56566**	**99820**	**156386**

Table 22: Details of partner management in 2015										
Province	STD clinic	Contacts of Syphilis treated			Contacts of Gonorrhoea treated			Contacts of Trichomoniasis treated		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	9	0	9	0	0	0	0	0	0
	Matale	1	0	1	0	0	0	0	0	0
	Nuwara Eliya	2	3	5	1	1	2	1	0	1
Eastern Province	Ampara	0	1	1	0	0	0	0	0	0
	Batticaloa	7	7	14	4	4	8	7	3	10
	Kalmunai	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0
North Central province	Anuradhapura	2	2	4	10	4	14	0	0	0
	Polonnaruwa	0	0	0	0	0	0	0	0	0
North Western Province	Chilaw	1	0	1	0	1	1	0	0	0
	Kurunegala	4	8	12	0	5	5	0	0	0
Northern Province	Jaffna	2	2	4	0	0	0	0	0	0
	Kilinochchi	1	0	1	0	0	0	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0
	Vavuniya	1	1	2	0	0	0	0	0	0
Sabaragamuwa Province	Kegalle	3	3	6	1	4	5	5	0	5
	Ratnapura	10	7	17	3	2	5	0	0	0
Southern Province	Balapitiya	4	4	8	1	2	3	0	0	0
	Galle	11	4	15	0	1	1	0	0	0
	Hambanthota	3	3	6	8	2	10	0	0	0
	Matara	0	0	0	0	1	1	0	0	0
Uva Province	Badulla	4	10	14	0	0	0	1	4	5
	Monaragala	4	3	7	4	3	7	0	0	0
Western Province	Colombo	29	27	56	1	6	7	1	1	2
	Gampaha	1	0	1	0	2	2	0	0	0
	Kalubowila	8	8	16	4	11	15	5	1	6
	Kalutara	10	4	14	4	2	6	0	1	1
	Negombo	1	0	1	0	4	4	1	0	1
	Ragama	6	3	9	1	1	2	0	0	0
	Wathupitiwala	1	0	1	0	0	0	0	0	0
Total		**125**	**100**	**225**	**42**	**56**	**98**	**21**	**10**	**31**

Table 23: Blood samples screened for syphilis - 2015																	
Province	STD clinic	Number screened				Number positive				Number confirmed				Number treated			
		STD	ANC	Pre-emp.	Other*	STD	ANC	Pre-emp.	Other*	STD	ANC	Pre-emp.	Other*	STD	ANC	Pre-emp.	Other*
Central Province	Kandy	2739	21794	4974	3251	162	94	8	39	63	7	2	39	38	6	2	24
	Mathale	287	6443	2097	218	4	1	0	5	9	0	0	1	0	0	0	0
	Nuwara Eliya	263	8700	1661	299	1	4	1	0	3	2	1	0	1	0	0	0
Eastern Province	Ampara	546	4096	1347	131	57	8	3	0	8	1	1	0	8	0	1	0
	Batticaloa	358	5733	1551	500	0	25	2	1	1	4	2	2	1	4	0	2
	Kalmunai	144	5432	1164	1165	0	2	0	0	2	0	0	0	0	0	0	0
	Trincomalee	159	6359	1255	767	9	48	11	11	0	0	1	0	0	0	1	0
North Central province	Anuradhapura	1669	16249	4217	3542	36	20	16	3	8	1	1	23	8	1	1	0
	Polonnaruwa	1090	7694	3168	2940	36	32	12	50	19	2	0	24	11	2	0	1
North Western Province	Chilaw	1117	15506	1812	2850	38	5	1	8	19	2	0	2	13	2	0	2
	Kurunegala	1821	25784	5074	993	91	29	1	5	58	0	0	0	45	0	0	0
Northern Province	Jaffna	201	7953	1190	893	9	10	0	0	9	1	0	0	9	1	0	0
	Kilinochchi	89	1800	1554	280	0	1	0	0	0	1	0	0	0	1	0	0
	Mannar	49	1889	639	173	0	0	0	0	1	0	0	0	1	0	0	0
	Vauvniya	694	2711	1442	852	13	5	3	2	15	1	0	2	5	1	0	1
Sabaragamuwa Province	Kegalle	1145	10729	1849	1325	34	36	3	17	39	3	0	4	8	5	0	0
	Ratnapura	2611	21281	4415	3160	90	184	32	87	74	6	1	13	19	6	1	8
Southern Province	Balapitiya	566	5256	400	364	39	13	0	4	33	2	0	6	13	1	0	0
	Galle	2754	9999	1816	1367	259	110	305	31	55	9	2	11	46	9	2	6
	Hambanthota	566	10951	2262	339	8	72	0	7	9	4	0	2	2	2	0	0
	Matara	831	12469	3198	498	10	0	0	1	32	0	0	4	19	0	0	0
Uva Province	Badulla	712	22923	2469	2892	110	333	10	58	60	9	0	16	16	10	1	9
	Monaragala	292	2708	4230	417	40	15	4	0	37	4	0	0	37	3	0	0
Western Province	Colombo	10061	48459	9242	11645	952	416	52	888	641	23	8	607	200	11	0	0
	Gampaha	1084	17318	1874	862	29	80	3	5	47	1	0	34	12	1	0	0
	Kalubowila	3045	590	1303	1569	128	0	1	34	108	0	0	57	70	0	0	22
	Kalutara	597	17505	4611	854	33	28	15	20	27	3	5	18	27	3	4	3
	Negombo	1158	4708	442	703	61	32	3	4	33	5	0	2	20	3	0	0
	Ragama	2646	5804	1773	1527	62	69	6	16	60	2	4	13	38	2	4	11
	Wathupitiwala	357	341	674	101	13	1	0	4	21	1	0	4	7	1	0	0
Total		**39651**	**329184**	**73703**	**46477**	**2324**	**1673**	**492**	**1300**	**1491**	**94**	**28**	**884**	**674**	**75**	**17**	**89**

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

Table 24: Clinic attendance by sex workers in 2015													
Province	STD clinic	New sex workers registered			New sex workers with STI			Total no. of sex workers attended			Total clinic visits by sex workers		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	0	73	73	0	46	46	0	147	147	0	185	185
	Mathale	0	1	1	0	1	1	0	1	1	0	1	1
	Nuwara Eliya	0	0	0	0	0	0	0	17	17	0	17	17
Eastern Province	Ampara	0	3	3	0	0	0	0	0	0	0	3	3
	Batticalo	0	1	1	0	1	1	0	1	1	0	1	1
	Kalmunai	0	0	0	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0	0	0	0
North Central province	Anuradhapura	0	30	30	0	15	15	0	67	67	0	62	62
	Polonnaruwa	0	7	7	0	1	1	0	33	33	0	35	35
North Western Province	Chilaw	0	21	21	0	17	17	0	77	77	0	77	77
	Kurunegala	0	22	22	0	13	13	0	30	30	0	47	47
Northern Province	Jaffna	0	0	0	0	0	0	0	0	0	0	0	0
	Kilinochchi	0	0	0	0	0	0	0	0	0	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0	0	0	0
	Vavuniya	0	0	0	0	0	0	0	0	0	0	0	0
Sabaragamuwa Province	Kegalle	0	8	8	0	7	7	0	24	24	0	27	27
	Ratnapura	2	19	21	0	9	9	7	28	35	9	38	47
Southern Province	Balapitiya	0	36	36	0	3	3	0	29	29	0	47	47
	Galle	0	40	40	0	16	16	0	100	100	0	81	81
	Hambanthota	0	24	24	0	3	3	0	22	22	0	26	26
	Matara	0	17	17	0	2	2	0	44	44	0	31	31
Uva Province	Badulla	0	3	3	0	0	0	0	22	22	0	24	24
	Monaragala	0	0	0	0	0	0	0	4	4	0	12	12
Western Province	Colombo	0	416	416	0	273	273	0	899	899	0	2405	2405
	Gampaha	11	52	63	6	37	43	16	75	91	35	100	135
	Kalubowila	10	74	84	5	65	70	22	212	234	22	272	294
	Kalutara	0	20	20	0	10	10	0	27	27	0	33	33
	Negombo	35	23	58	5	18	23	64	79	143	70	88	158
	Ragama	1	70	71	1	39	40	1	84	85	1	89	90
	Wathupitiwala	4	63	67	2	23	25	4	84	88	4	82	86
Total		**63**	**1023**	**1086**	**19**	**599**	**618**	**114**	**2106**	**2220**	**141**	**3783**	**3924**

Table 25: Civil status of new STD clinic attendees during 2015												
Province	STD clinic	Single/ Never married			Married /Living together			Separated /Divorced			Not known		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	332	216	548	320	371	691	12	59	71	0	4	4
	Mathale	79	9	88	94	104	198	1	0	1	0	0	0
	Nuwaraeliya	18	24	42	42	62	104	0	0	0	0	0	0
Eastern Province	Ampara	77	65	142	99	132	231	0	5	5	0	1	1
	Batticaloa	46	69	115	136	106	242	1	0	1	0	0	0
	Kalmunai	21	24	45	28	34	62	0	0	0	0	0	0
	Trincomalee	25	47	72	51	33	84	3	0	3	0	0	0
North Central province	Anuradhapur	175	34	209	282	239	521	9	22	31	0	0	0
	Polonnaruw	83	58	141	171	150	321	10	8	18	0	0	0
North Western Province	Chilaw	166	227	393	203	185	388	6	43	49	0	0	0
	Kurunegala	241	168	409	515	778	1293	21	55	76	1	0	1
Northern Province	Jaffna	74	38	112	67	19	86	2	1	3	0	0	0
	Kilinochchi	18	18	36	27	26	53	0	0	0	0	0	0
	Mannar	7	18	25	11	12	23	1	0	1	0	0	0
	Vavuniya	53	37	90	85	71	156	6	9	15	0	0	0
Sabaragamuwa Province	Kegalle	95	46	141	254	301	555	1	14	15	0	0	0
	Ratnapura	271	158	429	350	309	659	16	39	55	2	8	10
Southern Province	Balapitiya	262	41	303	135	156	291	1	8	9	1	0	1
	Galle	330	95	425	317	290	607	8	8	16	0	0	0
	Hambanthot	155	98	253	131	144	275	3	7	10	0	0	0
	Matara	177	177	354	183	194	377	6	17	23	0	1	1
Uva Province	Badulla	104	89	193	180	210	390	0	4	4	1	0	1
	Monaragala	51	87	138	69	81	150	0	3	3	0	1	1
Western Province	Colombo	1718	337	2055	1771	994	2765	73	469	542	0	1	1
	Gampaha	135	58	193	103	190	293	12	53	65	0	0	0
	Kalubowila	377	167	544	377	433	810	7	11	18	0	0	0
	Kalutara	184	52	236	91	240	331	10	14	24	10	3	13
	Negombo	181	54	235	174	176	350	14	47	61	0	0	0
	Ragama	377	125	502	303	251	554	25	91	116	1	1	2
	Wathupitiwal	69	27	96	69	136	205	3	54	57	0	0	0
Total		**5901**	**2663**	**8564**	**6638**	**6427**	**13065**	**251**	**1041**	**1292**	**16**	**20**	**36**

Table 26: Reason for attendance among new STD clinic attendees in 2015

Province	STD clinic	Contact of patients			Voluntarily			Referral from magistrate/court			Others*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Kandy	17	39	56	224	67	291	3	10	13	420	534	954
	Mathale	10	2	12	47	31	78	0	1	1	117	79	196
	Nuwara Eliya	8	4	12	13	6	19	0	0	0	39	76	115
Eastern Province	Ampara	17	5	22	80	42	122	38	20	58	41	136	177
	Batticaloa	9	8	17	7	6	13	11	36	47	156	125	281
	Kalmunai	5	3	8	13	4	17	3	2	5	28	49	77
	Trincomalee	2	1	3	17	3	20	9	43	52	51	33	84
North Central province	Anuradhapura	10	14	24	256	108	364	31	11	42	169	162	331
	Polonnaruwa	3	24	27	162	110	272	56	48	104	43	34	77
North Western Province	Chilaw	41	42	83	95	71	166	104	219	323	135	123	258
	Kurunegala	102	66	168	383	316	699	34	93	127	259	526	785
Northern Province	Jaffna	12	5	17	42	13	55	49	31	80	40	9	49
	Kilinochchi	1	0	1	2	0	2	0	0	0	42	44	86
	Mannar	2	0	2	1	0	1	13	26	39	3	4	7
	Vavuniya	14	9	23	19	4	23	13	35	48	98	69	167
Sabaragamuwa Province	Kegalle	115	55	170	143	88	231	7	14	21	85	204	289
	Ratnapura	32	23	55	164	80	244	62	120	182	381	291	672
Southern Province	Balapitiya	21	12	33	70	38	108	0	8	8	308	147	455
	Galle	48	22	70	166	63	229	71	84	155	370	224	594
	Hambanthota	18	22	40	101	43	144	125	40	165	45	77	122
	Matara	34	20	54	115	43	158	98	154	252	119	172	291
Uva Province	Badulla	58	20	78	69	36	105	35	34	69	123	213	336
	Monaragala	8	9	17	22	32	54	22	85	107	68	46	114
Western Province	Colombo	131	116	247	1744	472	2216	53	362	415	1634	851	2485
	Gampaha	12	10	22	86	49	135	29	43	72	123	199	322
	Kalubowila	24	25	49	319	135	454	48	88	136	370	363	733
	Kalutara	15	9	24	128	111	239	31	28	59	121	161	282
	Negombo	39	23	62	95	57	152	25	34	59	210	163	373
	Ragama	56	35	91	196	46	242	25	90	115	429	297	726
	Wathupitiwala	2	0	2	97	132	229	0	7	7	42	78	120
Total		**866**	**623**	**1489**	**4876**	**2206**	**7082**	**995**	**1766**	**2761**	**6069**	**5489**	**11558**

Table 27 . HIV testing and counselling details from STD clinics during 2015											
Province	STD clinics	Sex Workers		MSM		Drug Users		Prisoners		Other*	
		No received HIV testing	No. receive HIV result	No. received HIV testing	No. received HIV result	No. received HIV testing	No. received HIV result	No. received HIV testing	No. received HIV result	No. received HIV Testing	No. received HIV result
Central Province	Kandy	99	82	126	73	116	49	0	0	4438	3780
	Matale	1	1	23	23	38	38	0	0	225	225
	Nuwara Eliya	1	1	0	0	0	0	0	0	299	298
	Ampara	3	3	0	0	0	0	0	0	727	727
Eastern Province	Batticaloa	2	2	2	2	0	0	0	0	479	468
	Kalmunai	0	0	0	0	0	0	0	0	151	151
	Trincomalee	0	0	0	0	0	0	0	0	549	549
North Central province	Anuradhapura	43	43	64	64	0	0	35	35	4405	4405
	Polonnaruwa	23	23	0	0	0	0	38	38	1444	1433
North Western Province	Chilaw	22	22	22	22	41	41	0	0	852	845
	Kurunegala	21	21	1	1	86	86	0	0	1715	1715
Northern Province	Jaffna	0	0	0	0	0	0	16	16	618	618
	Kilinochchi	0	0	0	0	0	0	0	0	89	29
	Mannar	0	0	0	0	0	0	0	0	1539	1483
	Vavuniya	0	0	2	2	0	0		0	3487	3487
Sabaragamuwa Province	Kegalle	15	15	30	30	1	1	8	8	1978	1978
	Ratnapura	35	35	11	11	253	253	61	61	1737	1737
Southern Province	Balapitiya	40	40	103	103	1	1	0	0	647	647
	Galle	79	46	82	18	130	8	80	33	2187	1755
	Hambanthota	26	25	0	0	0	0	0	0	432	414
	Matara	26	26	0	0	0	0	94	90	1831	1666
Uva Province	Badulla	0	0	0	0	0	0	38	38	3126	3126
	Monaragala	4	0	0	0	0	0	1	1	2056	2028
Western Province	Colombo	174	108	498	364	7	1	421	310	4860	3866
	Gampaha	58	32	36	24	0	0	0	0	887	795
	Kalubowila	240	78	333	86	360	63	14	14	2437	1640
	Kalutara	35	35	55	55	3	3	40	40	846	846
	Negombo	92	75	118	81	526	114	18	18	961	750
	Ragama	71	5	176	52	24	1	42	18	1644	806
	Wathupitiwala	63	63	26	26	0	0	0	0	644	644
Total		**1173**	**781**	**1708**	**1037**	**1586**	**659**	**906**	**720**	**47290**	**42911**

Table 28: Details of awareness programmes conducted by STD clinics in 2015									
Province	STD 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	113	10228	2	4500	41	2123	0	0
	Matale	46	3425	0	0	2	32	0	0
	Nuwara Eliya	38	3550	0	0	0	0	1	600
Eastern Province	Ampara	91	4978	6	720	0	0	1	300
	Batticaloa	104	7686	0	0	1	45	1	920
	Kalmunai	44	2800	0	0	0	0	12	360
	Trincomalee	39	3220	0	0	1	40	12	2000
North Central province	Anuradhapura	62	8003	0	0	2	18	0	0
	Polonnaruwa	28	2653	0	0	0	0	0	0
North Western Province	Chilaw	64	5892	1	1500	0	0	0	0
	Kurunegala	63	8435	0	0	18	1170	6	7370
Northern Province	Jaffna	33	1695	0	0	1	35	0	0
	Kilinochchi	20	1056	0	0	0	0	0	0
	Mannar	2	150	0	0	1	104	13	1080
	Vavuniya	174	7665	0	0	0	0	1	450
Sabaragamuwa Province	Kegalle	53	8728	0	0	6	1248	0	0
	Ratnapura	73	7948	1	1074	3	480	3	23738
Southern Province	Balapitiya	12	1098	2	980	3	206	1	150
	Galle	35	3465	0	0	1	35	26	1696
	Hambanthota	14	499	0	0	52	4146	0	0
	Matara	61	3245	1	4000	1	90	24	1300
Uva Province	Badulla	290	14092	0	0	0	0	0	0
	Monaragala	11	1256	25	3760	4	466	1	875
Western Province	Colombo	320	4371	7	12050	14	387	410	763
	Gampaha	96	5863	0	0	0	0	1	450
	Kalubowila	19	645	3	1075	6	189	41	501
	Kalutara	100	7650	2	850	4	620	5	460
	Negombo	1	4	0	0	0	0	1	850
	Ragama	71	5476	0	0	0	0	28	1487
	Wathupitiwala	15	1528	0	0	1	50	7	288
Total		**2092**	**137304**	**50**	**30509**	**162**	**11484**	**595**	**45638**

EMTCT of syphilis and HIV

"The elimination of mother to child transmission (EMTCT) programme for syphilis and HIV was further scaled up during 2015"

Elimination of Mother to Child Transmission (EMTCT) of syphilis and HIV programme in Sri Lanka was further scaled up in 2015. The steering committee regulated and guided the programme through regular reviews. EMTCT programme was officially launched in the North, North Western and North Central provinces during 2015. Other provinces namely Uva, Sabaragamuwa and Eastern provinces too joined the programme by initiating screening pregnant mothers for HIV. With further scaling up, it is expected to cover the whole country by end 2016. During 2015 the EMTCT programme was carried out mainly with government funds while UNICEF assisted in printing leaflets in Tamil and to purchase safe delivery kits.

At the Asia Pacific conference on EMTCT held in September 2015 in Beijing, China, it was decided to work towards validation of the EMTCT programme for syphilis and HIV of Sri Lanka by end 2017. The Global minimum indicators for validation of EMTCT programme for syphilis and HIV are given below.

Table 29: Minimum global indicators for validation of EMTCT

Impact indicators	
a. HIV	Less than 50 new peadiatric infections per 100,000 live births and a transmission rate of either <5% in breastfeeding populations or <2% in non-breastfeeding populations;
b. Syphilis	Less than 50 cases of congenital syphilis per 100,000 live births
Additionally, to accomplish EMTCT of HIV, there are **four process targets** that need to be met. 1. Antenatal care coverage (at least one visit) of more than or equal to 95% 2. Coverage of HIV and/or syphilis testing of pregnant women of more than or equal to 95% 3. Antiretroviral treatment coverage of HIV-positive pregnant women more than or equal to 90% 4. Treatment of syphilis-seropositive pregnant women more than or equal 95%.	

According to reported data, Sri Lanka has achieved the required status in relation to indicators for validation of EMTCT of syphilis. However, Sri Lanka needs to officially apply for validation.

Table 30: Sri Lankan status with regards to EMTCT validation during 2015

a. HIV	New HIV peadiatric infections 1.9 per 100,000 live births
b. Syphilis	Congenital syphilis 3.8 cases per 100,000 live births

Congenital syphilis

A total of 17 cases of congenital syphilis were reported in 2015. Of these 14 were live births and half of them had been diagnosed before the age of 2 years. Most of the live congenital syphilis cases (13) belonged to the 'case definition 3', because they have got infected as a result of inadequate maternal treatment or non-penicillin treatment given to mother due to hypersensitivity. Other three (3) cases were two miscarriages and one intrauterine death (IUD) among women diagnosed as having syphilis during pregnancy.

Table 31: Data related to mother to child transmission of syphilis during 2015

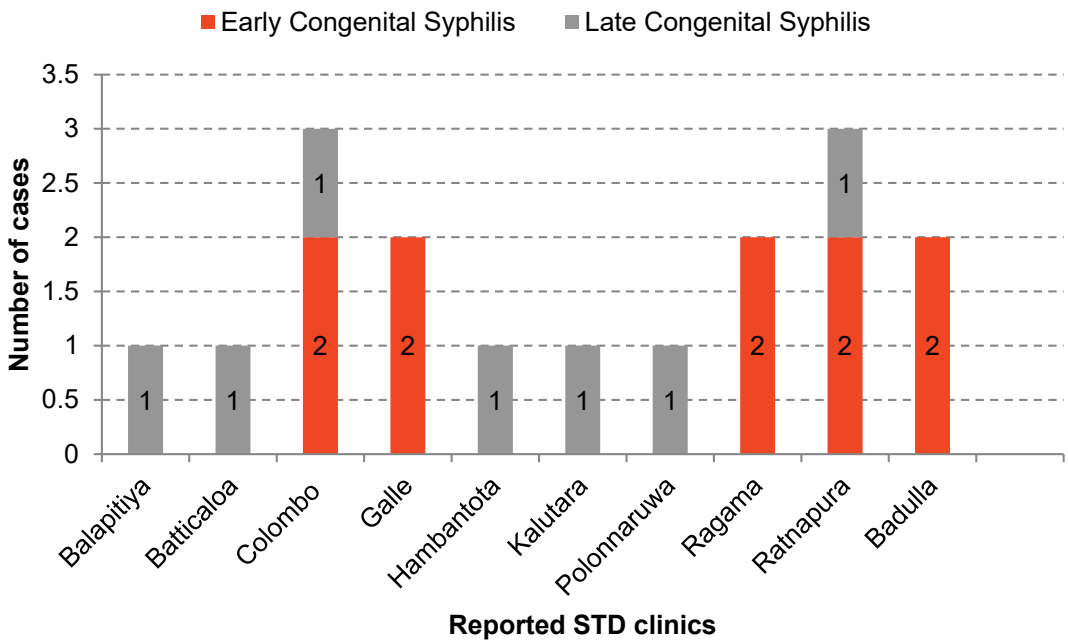
Indicator	Number
1. Number of VDRL tests done among pregnant women in 2015 (by STD clinics)	**326,728**
2. Number of TPPA positive samples detected by antenatal screening in 2015	**87**
3. Number of pregnant women with syphilis who were given treatment	**84**
4. Number of pregnant women provided adequate treatment before 36 weeks of POA	**84**
5. Number of congenital syphilis cases reported during 2015	**17**

Babies born to mothers with any of the following conditions are diagnosed as having congenital syphilis (case definition 3).

"Case definition 3" of congenital syphilis

- **Mother was treated less than 4 weeks prior to delivery**
- **Mother was untreated, treatment status undocumented or unknown**
- **Mother not completed the recommended course of penicillin during pregnancy**
- **Mother treated with non-penicillin antibiotics**

Figure 40: Congenital syphilis cases reported from STD clinics during 2015



Elimination of mother to child transmission of HIV

Number of samples tested for HIV among pregnant women increased from 17,000 in 2012 to 262,047 by the end of 2015. Eleven pregnant women were identified as having HIV infection through antenatal screening for HIV and one pregnant woman was identified due to contact tracing. In addition, four women with HIV who were under HIV care services became pregnant and received EMTCT services in 2015. Appropriate services were provided to all pregnant women with HIV to eliminate mother to child transmission of HIV through STD clinics Colombo, Anuradhapura, Negombo, Kurunegala and Kalutara. STD clinic in Anuradhapura identified 2 women with HIV through ANC screening and one woman in late pregnancy through contact screening.

Since 2011, all pregnant women diagnosed with HIV infection, who received services for EMTCT, delivered HIV uninfected babies. Option B+ with triple ART was provided to all pregnant women diagnosed with HIV which has to be continued for lifetime. The pregnant women were managed by a team including Obstetricians, Venereologists, Pediatricians and Anaesthetists. Mode of delivery was LSCS and all babies were offered ARV prophylaxis with syrup Nevirapine for 6 weeks or when diagnosed in late pregnancy for 12 weeks. Formula milk was provided by an NGO. All babies of mothers who received EMTCT services were negative for DNA PCR. EMTCT services for HIV helps to achieve Millennium Development Goals (MDG) mainly 4, 5 and 6 i.e. reduce child mortality, improve maternal health and combat HIV/AIDS in women and children.

Indicators on EMTCT of HIV

Table 32: Indicators on EMTCT of HIV

Indicators on HIV positive pregnant women and their babies in 2015	Number	Coverage
1. Number of HIV tests done among pregnant women	262,047	71.2%
2. Number of pregnant women with HIV reported {4 known, 12 new cases (11- ANC screening, 1- contact)}	16	-
3. Number of HIV positive women who received EMTCT services	16	-
4. Number of abortions among all pregnant women with HIV	0	-
5. Number of live births among all pregnant women with HIV in 2015 (2014 registered -1, 2015 registered – 8)	9	100%
6. Number of babies born to HIV positive women who received EMTCT services	9	100%
7. Number of babies born to HIV positive women who received EMTCT services on exclusive formula feeding	9	100%
8. Number of babies born to HIV positive mothers who were tested with DNA PCR	10	-

Early infant diagnosis (EID)

As the progression of HIV is rapid in children WHO recommends early diagnosis based on DNA PCR tests. Dried Blood spots are sent to India for testing. All babies exposed to HIV have been tested followed by HIV antibody test at 18 months. All babies born to mothers who received EMTCT services had negative results.

Children living with HIV

NSACP and STD clinics act as the focal points in caring for PLHIV including children. All children identified with HIV are registered at the STD clinics and managed in collaboration with pediatricians. According to the latest ART guidelines of WHO, all children were offered ART during 2015. During 2015, seven children were diagnosed with HIV infection.

There are no special institutions for children affected by HIV/AIDS. Two orphans are cared for by an NGO, all other identified children with HIV are living with their parents or extended families.

Table 33: Children living with HIV in HIV care as of end 2015

ART Centre	Female	Male	Total
Colombo	8	11	19
Kandy	2	5	7
Ragama	3	3	6
Anuradhapura	0	2	2
Galle	0	1	1
Gampaha	1	0	1
IDH	1	0	1
Kalubowila	1	0	1
Kurunegala	1	0	1
Polonnaruwa	1	0	1
Ratnapura	0	1	1
Grand total	**18**	**23**	**41**

A total of 41 children (less than 15 years) were receiving HIV care as of end 2015. Of these nearly 50% were attending Colombo ART center.

Training of health care workers on EMTCT

During the year 2015, the EMTCT programme was scaled up to cover the Northern, North Central and North Western provinces. Two consultative meetings were conducted in Vavuniya and Kurunegala to introduce the programme to provincial authorities, maternal and child health and public health staff. Training programmes for health care workers (HCW) were conducted for staff attached to maternity units of GH Matara, Awissawella and main maternity centres in the country such as the Castle Street Hospital for Women (CSHW), and the De Soysa maternity Home (DMH). These programmes were conducted with the financial support from government of Sri Lanka (GOSL). Information education and communication (IEC) materials were printed in Tamil and safe delivery kits were procured and distributed to all the districts involved in the programme which was funded by UNICEF. The steering committee of EMTCT of HIV and syphilis met regularly to review the programme.

During the year 2015 the EMTCT programme covered more than 2/3 of the pregnant population in the country. The remarkable feature of this programme is the collaboration among several institutions at different levels. At the central level, under the guidance of the Director General of Health Services and Deputy Director General of Public Health Services the unit responsible for maternal and child health in the country; the Family Health Bureau, worked closely with the National STD/ AIDS control programme to give the leadership to this initiative. At the provincial level, Community Physicians and Medical Officers of Maternal and Child Health together with support from the staff of District STD clinics and MOH offices implement the programme in the community. At the grass root level, field health staff from MOH offices conducts awareness programmes and collect blood for testing, while the District STD clinic staff provides testing and treatment facilities. The success of the programme is mainly due to the intra-sectoral collaboration of many organizations within the health sector.

Table 34: Relevant maternal and child health service data

	2013	2014	2015*
Number of pregnancies	383,383	367,528	368,345
Number of deliveries	320,943	320,108	312,897
Still birth/adverse outcome	2,081	1,874	1,974
Abortions	9,856	28,707	30,815
Coverage of antenatal VDRL testing	99.7%	98.1%	99%
Number of MOH units	333	341	338
Number of ANC clinics	3,782	3,832	3,832

*Provisional data Source: Family Health Bureau

Condom promotion

Condom promotion is an important programme area in the National STD/AIDS control programme and carried out by different categories of health care providers such as doctors, public health nursing sisters, nurses and public health inspectors attached to STD clinics. Condoms are provided to needy STD clinic attendees free of charge and also promoted during various awareness programme.

A total of 315,143 condoms were distributed by NSACP through STD clinics. Of these, Colombo, Badulla and Ratnapura STD clinics had distributed over 30,000 condoms each during 2015. More details about the number of condoms distributed by clinics are given in table below.

Condom promotion through peer-led targeted interventions

National STD/AIDS control programme procured 3,550,880 condoms during 2015 and distributed them through STD clinics and Family Planning Association and its sub-recipient NGOs to most at risk population groups & other vulnerable population.

The sexual health services package provided to thousands of FSW, MSM, DU, Beach boys and prison inmates includes condom promotion as one of the three major components i.e. communication, promotion of care seeking behavior and promotion of condoms. Hundreds of thousands of condoms were distributed under this programme in year 2015 by peer-educators among community members.

Table 35: Number of condoms distributed to most-at-risk populations 2013 - 2015

Risk population	Number of condoms distributed		
	2013	2014	2015
Female sex workers (FSW)	566,439	828,460	964,244
Men who have sex with men (MSM)	217,738	402,509	299,127
Beach boys (BB)	52,972	87,845	123,673
Drug users (DU)	27,411	102,142	140,400
Total	**864,560**	**1,420,956**	**1,527,444**

Table 36: Distribution of condoms by STD clinics 2013-2015

Province	STD clinic	2013	2014	2015
Central Province	Kandy	9,659	9,015	10,340
	Matale	0	1200	2600
	Nuwara Eliya	30,540	31,300	29,600
Eastern Province	Ampara	18,787	16,475	17,739
	Batticaloa	2,476	1,300	4,136
	Trincomalee	934	1,570	2,250
	Kalmunai	192	0	110
North Central Province	Anuradhapura	11,020	19,400	20,300
	Polonnaruwa	6,858	8,915	3,520
North Western Province	Chilaw	8,940	13,920	10,270
	Kurunegala	14,180	18,000	16,500
Northern Province	Jaffna	65	2,985	1,220
	Mannar	1,024	1,728	2,950
	Vavuniya	3,000	2,300	3,700
Sabaragamuwa Province	Kegalle	17,370	23,505	22,065
	Ratnapura	51,092	31,336	31,745
Southern Province	Balapitiya	2,500	3,022	3,194
	Galle	10,200	12,387	2,568
	Hambantota	9,881	16,000	11,140
	Matara	9,284	2,800	4,700
Uva Province	Badulla	4,380	7,670	35,507
	Monaragala	1,350	1,350	2,500
Western Province	Colombo	52,720	45,668	46,994
	Gampaha	14,742	15,807	3,665
	Kalubowila	12,102	12,638	13,408
	Kalutara	9,288	8,900	6,000
	Negombo	6,635	6,165	2,900
	Ragama	5,772	7,721	3,249
	Wathupitiwala	236	325	273
All		**315,227**	**323,402**	**315,143**

Assessment of Condom programming - 2015

Situation assessment of condom programming recommended use a unique symbol to point out all condom brands. NSACP developed a common symbol based on a several stakeholder consultations. This symbol will be published with implementation of National Condom Strategy 2016 - 2020.

The first ever comprehensive situation assessment on condom programming in the country was carried out with the support of UNFPA. This assessment addressed the accessibility, availability and usage of condoms in the context of HIV, STI and family planning. It also looked into the factors affecting condom programming in Sri Lanka. Methodology of this assessment included desk reviews, focus group discussions, in-depth interviews and observation assessment of condom demonstrations.

The results revealed that there are no restrictions for accessibility of condoms in Sri Lanka, and they could be purchased over the counter. Still there is a considerable amount of perceived stigma among condom users.

Condoms are listed under the medical device category in the essential drug list, in par with the National Medicines Regulatory Authority ACT, No. 5 of 2015. The main objectives of the condom programming in the National STD/AIDS control programme are prevention of transmission of STI/HIV, provision of family planning services for STD clinic attendees and prevention of transmission of different HIV strains among PLHIV. The main objectives of condom programming in Family Health Bureau are to provide family planning services for eligible couples and prevention of teenage pregnancies through the “cafeteria” method. The government provides condoms free of charge and the commercial sector sells condoms for needy customers. In addition, there are free condoms available for the key populations in the GFATM led interventions operating in districts through peer leaders of key populations.

There are a number of supportive policies, laws, plans, guidelines, strategies and programmes in Sri Lanka which oversee and provide a supportive and conducive environment for the condom programming on the dual protection (prevention of unwanted pregnancies and prevention of HIV/STIs). However, there are few ordinances and articles such as Vagrants ordinance, Brothels ordinance and 365 A of the Penal code which mislead the legal framework for Key populations, which restrict them from using condoms. All legal and other documents support the use of condoms for family planning.

Condoms are not manufactured in Sri Lanka. Registration, sample licensing, manufacturing licensing and condom advertising are prerequisite methodological steps of granting permission for the marketing of condoms in Sri Lanka. There are no quality assurance tests in Sri Lanka after importing condoms, other than document checkups. The Quality assurance tests are not available in Sri Lanka except the elasticity test. There

are no explicit guidelines in the country for the management of condoms, to ensure the quality through the path from the point of importation to the point of user, except storage guidelines issued by the Family Health Bureau. The Family Planning Association of Sri Lanka manages their condom transport and storage according to the Contraceptives Security Guideline. The majority of people are still reluctant to use the word “condom" and use many alternative terms to request condoms from the pharmacies. During Focus Group Discussions, the majority of members revealed the need to improve the knowledge and develop positive perceptions on condoms in the community.

Although key populations had a good knowledge and knew how to use condoms correctly, only the majority of female sex workers used condoms continuously. It was noted that they had good negotiation skills with clients for using condoms. It is noteworthy that the majority of clients of sex workers have used condoms due to enforcement from female sex workers. Cultural barriers and misinterpretation of laws by law enforcement officers led to difficulties for MSM to keep condoms with them. Male sex workers go for unprotected oral sex for higher prices.

The Integrated Biological and Behavioural Survey (IBBS) which was carried out in 2014 showed that the percentage of use of condoms at the last sex encounter with a client was 93%, and an equally high percentage of 90% was revealed with the non-paying partners. The percentage of men who have sex with men (MSM) reporting the use of a condom at last anal sex encounter with a male partner was 58 %, and the percentage of injecting drug users reporting the use of a condom at the last anal sex encounter with a male partner was 25 %. The same study revealed that condom use at last sex among beach boys were 67%.

Figure 41: Publications of condom assessment and condom strategy

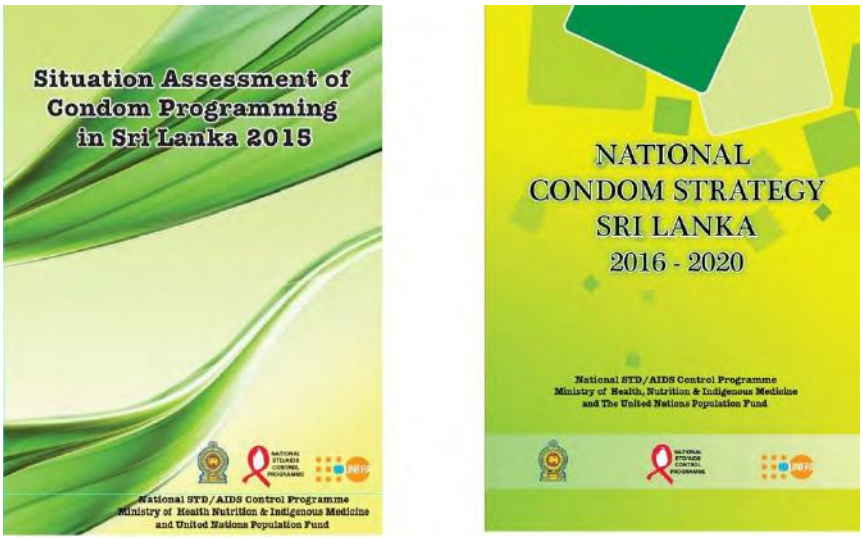


Figure 42: Team who contributed to the condom assessment study

Although university students are a segment of educated youth in the country, they had negative perceptions on condoms. This was seen among Jaffna urban youth as well. Colombo urban youth had good knowledge and positive perceptions on condoms. It was

revealed that estate youth, factory workers and teenage mothers have very low knowledge on condoms. External migrant workers, Armed forces and hospitality sector personnel had good knowledge and perceptions. The society has an impression that the use of condoms gives less sexual pleasure, and condoms are only used by people involved in casual sex, sex workers and people with extramarital relationships.

Law enforcement officers had sound knowledge on vagrant's ordinance and knew that the condom is not an illegal item according to the vagrant's ordinance. It was observed that they had a clear understanding that keeping condoms by sex workers is not an offence. Condom demonstration and communication skills to strengthen the condom use were highest among peer leaders of drug users, sex workers and MSM groups (more than 67%), while it was lowest among Poly clinic service providers (32.5%). Condom demonstration and communication skills percentage was more than 50% among STD clinic service providers.

Figure 43: Dissemination of condom assessment findings

Dr Sarath Amunuama (DDG, PHS-1), Mr. Alain Sibenaler (UNFPA representative), Dr Palitha Mahipala (DGHS) and Dr Sisira Lianage (Director/NSACP) are seen in this picture taken at the dissemination workshop held on 12th of November 2015.

Development of a National Condom Strategy 2016-2020

National STD/AIDS Control Programme developed a national condom strategy based on the key outcomes of the situation assessment of condom programming conducted during 2015. This was developed in line with the National AIDS Policy (2011), the Population and Reproductive Health Policy (1995), the National Maternal and Child Health Policy (2009), the National HIV Strategic Plan (2013-2017) and the National Strategic Plan on Maternal and Newborn Health (2012- 2016). This activity was supported by the UNFPA.

The main aim of the national condom strategy is to ensure the availability of quality condoms of choice, either free of charge or at an affordable price, through an effective and responsive service delivery system, in order to provide quality sexual health services to the entire country. The priority of the national condom strategy is to ensure the availability of quality condoms throughout the country and to enhance the use of condoms among those key populations, vulnerable groups and PLHIV.

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

- Leadership and coordination
- Supply and commodity security
- Support systems (programming)
- Demand, access and utilization

Under each thematic area, several strategies were developed to fulfill the objectives. This will provide a comprehensive plan, in line with the expectations of the stakeholders, to achieve better health status for the Sri Lankan population, by reducing transmission of STIs including HIV infection and preventing unwanted pregnancies.

Following activities related to National Condom strategy were implemented during 2015

- Conducting a dissemination seminar of the first ever condom situation assessment for all stakeholders
- Purchasing 1500 dildos and distribution among different sectors and MO/STDs, for demonstration of correct condom use.
- Development of a unique symbol for all condom brands to indicate condoms when purchasing from outlets. This can be used for all condom brands, including the government sector in the future.
- In addition, a condom leaflet was developed and distributed among different sectors and MO/STDs to educate use of condoms in the correct way.

Laboratory services

The laboratory services of NSACP is provided by the National reference laboratory (NRL) and the peripheral laboratories for HIV and other sexually transmitted infections. NRL is the apex body of the laboratory network. It provides technical guidance for diagnostic laboratory services of the country on HIV and STI and it is the reference centre for those services. The NRL of NSACP is headed by a consultant Microbiologist. The clinical services provided by the medical staff are supported by the medical laboratory technologists.

Laboratory services for sexually transmitted infections

One of the primary roles of the laboratory is to screen, to diagnose and to monitor the patients with sexually transmitted infections. The range of tests provided covers mainly the bacterial and the viral STIs.

HIV Screening and diagnosis

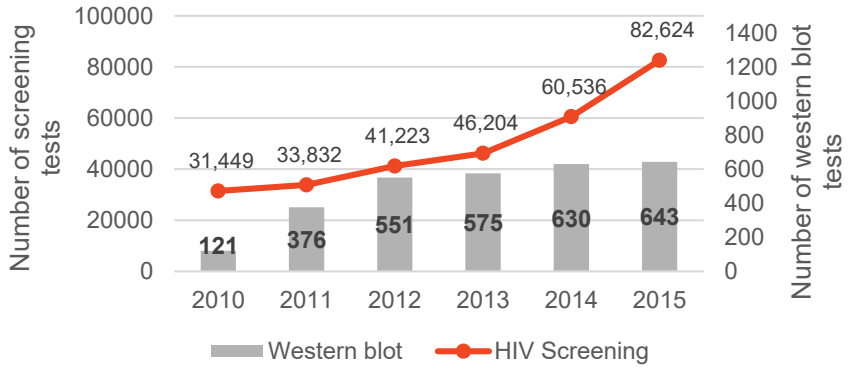
- The diagnostics for HIV includes ELISA, Particle agglutination and rapid strip tests for screening HIV. The testing which support treatment and care for PLHIV is also carried out by the laboratory on routine basis.
- Although most of the peripheral STD laboratories and laboratories of private sector have facilities to perform screening tests for HIV, the confirmatory test for HIV is performed only in the reference laboratory. The National reference laboratory provides HIV confirmation services to the National blood transfusion service and to private sector laboratories free of charge.
- The NRL is the only laboratory in the government sector which provides HIV viral load testing and CD4 testing for the people living with HIV (PLHIV). Viral Load assays are carried out with a highly sensitive real-time PCR, which detects as low as 34 copies/ml of blood enabling the clinician to manage the patient with best therapeutic options.

In addition, the haematological and biochemical investigations for PLHIV are carried out in the National reference laboratory to support their management.

- The NRL of the NSACP facilitates the HIV DNA PCR test for early infant diagnosis of babies exposed to HIV through possible mother to child transmission.
- The recent improvement of services for PLHIV includes HIV drug resistance testing. This new activity was established with National AIDS Research Institute(NARI) of India in year 2015.
- During 2013, NSACP launched a country plan to extend the HIV testing among pregnant women in Sri Lanka to eliminate mother to child transmission of HIV and syphilis (EMTCT). The laboratory support to the EMTCT programme is provided by the NRL and the peripheral STD laboratories. Antenatal syphilis and HIV screening tests of all

mothers attending to the antenatal clinics are performed in the respective district STD laboratories. This has significantly increased the work load of the STD laboratories. Still the human resources for increased work load has not been met and the programme is maintained by the exceptional dedication of the technical staff of the laboratories.

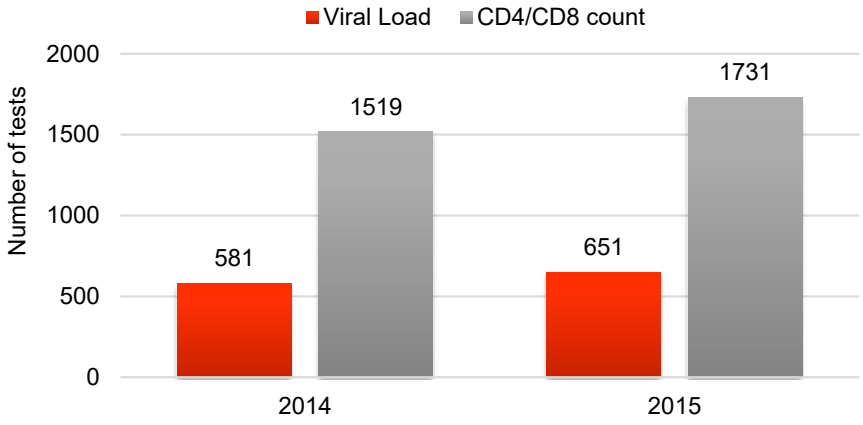
Figure 44: No. HIV screening tests and Western blot tests, 2010-2015



(Source: Lab records – NRL)

Above graph shows the increase of HIV testing at NRL and the testing is almost doubled since 2013.This increase is mainly due to scaling up of the HIV testing among antenatal mothers for the EMTCT programme.

Figure 45: Viral load and CD4 assays in 2014 and 2015



Source: Lab records – NRL-2014 and 2015

HIV Surveillance and Research activities

Other than carrying out routine diagnostic services, the National reference laboratory contributes to HIV surveillance and research activities on a regular basis and performs all HIV testing for HIV sentinel surveillance. It provided all the laboratory back up services to IBBS conducted by the NSACP. The surveillance programme of prison and the drug users is totally supported by the NRL and the district STD laboratories.

Screening and diagnosis of other sexually transmitted diseases

The NRL and the peripheral STD laboratories provide diagnostic and monitoring services to other sexually transmitted diseases as well. The NRL supports the Central clinic and few other district STD clinics where adequate facilities are not available to diagnose sexually transmitted diseases.

The new developments designed in 2015 include the real time PCR test for HSV, GC and Chlamydia. The facility is already installed and the testing will be available in 2016 with the establishment of continuous supply of reagents.

Quality assessment

External quality assessment (EQA) of a laboratory is an essential component in laboratory services. The National reference laboratory participates in the external quality assessment programmes twice every year to maintain the high quality of testing.

- The NRL participates in the EQA for HIV screening and confirmatory testing conducted by the National reference laboratory for HIV of Australia
- Proficiency testing for syphilis serology is under the purview of Center for Disease Control Atlanta, USA and is performed once in every two months.
- The liaison for Gonococcal Anti-Microbial Susceptibility Programme quality assessment is with the WHO collaborative center in Australia.

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

Support for other district clinics

Screening and diagnosis

National reference laboratory has to undertake testing services of peripheral STD laboratories whenever their routine system is disturbed due to lack of Medical laboratory technologists or due to machine breakage. Though this is done to continue the service delivery, such situations lead to major problems in the National reference laboratory as it is also affected by shortages of technical personnel. Though the work load for HIV screening is doubled from 2013, there is no increase in the human resources. This is an area which needs immense support by the Ministry of Health without a delay in order to optimize the services throughout the country.

Distribution of requirements in district STD clinics

Most of the requirements of district STD clinics are supplied by the National reference laboratory. All the reagents and test kits for screening and diagnosis are supplied via the National reference laboratory after assessing the yearly consumption. The essential equipment are purchased and distributed among the district STD clinics to maintain all the district STD laboratories well equipped to cope up the needs of their respective district.

Training of the staff

STD clinic staff

Programmes are organized annually by the National reference laboratory for training and capacity building of the laboratory staff of the district STD laboratories in order to maintain the quality of their service given to the public. In 2015, both MLTs and PHLTs were trained in two programmes which included a sensitization on the laboratory accreditation as well.

Others

Other than the training of own staff of the central and district STD laboratories there are multiple groups of trainees attending to receive training in NRL. These groups include medical students, medical laboratory technology students, PHLT students and postgraduate trainees in venereology, microbiology, health informatics, family medicine, forensic medicine etc.

Collaboration with funding agencies

The NRL has to play a significant role in organizing STD and HIV services to the country in collaboration with various funding agencies. The World bank funds are managed for obtaining

the test kits for EMTCT programme while Global fund supports financially the provision of HIV viral load tests. The World health organization supports the HIV drug resistance testing.

Table 37: Number of microscopic tests carried out in 2015

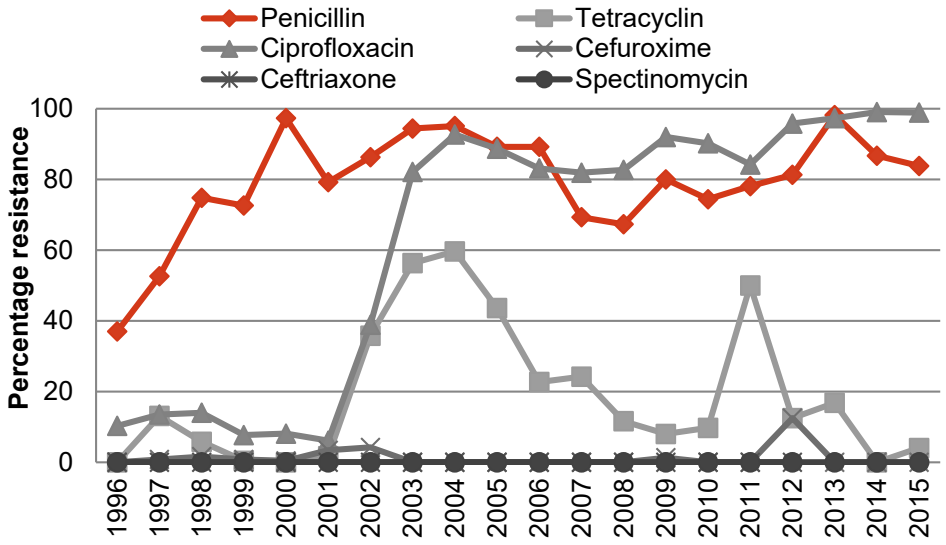
Name of the test	Central clinic laboratory	All district laboratories	Total
Dry smear	9,673	27,074	36,747
Wet smear	5,573	9,485	15,058
Urine Test	1,476	3,754	5,230
EQA smear	4,833	-	4,833
Total	21,555	40,313	61,868

Table 38: Number of laboratory tests carried out at NRL during 2015

Name of the test	Number of tests	Name of the test	Number of tests
HIV screening	82709	Serum amylase	50
Western Blot	642	Blood sugar	295
HIV Viral load	651	Lipid profile	264
CD4/CD8 count	1731	Blood urea	315
VDRL	79407	Serum creatinine	509
TPPA	10074	SGOT	556
GC culture	7531	SGPT	549
GC ABST	99	Alkaline phosphate.	481
Chlamydia PCR	2688	Serum bilirubin	490
Cervical cytology	1458	Total protein	176
Full blood count	1298	Serum albumin	155
ESR	125	Serum globulin	155
HBs Ag	779	Direct bilirubin	404

Figure 46: Gonococcal culture section at the National reference laboratory

Figure 47: Gonococcal antibiotic resistance pattern 1996-2015



(test for cefuroxime was not done after 2012)

Above graph shows the antibiotic resistance pattern of N. gonorrhoea detected at the National reference laboratory. Gonococci are notorious to develop resistance to antibiotics and therefore, monitoring resistance is an important function of the NRL. It is not recommended to use any antibiotic which has more than 5% resistance. Usage of cefuroxime was stopped in 2012 due to development of resistance well over 5%. Currently, cefixime 400 mg single dose is used as the first line treatment for uncomplicated gonococcal infections. However, NRL is unable to perform antibiotic resistance to this drug due to non-availability of antibiotic discs.

Multi-sectoral collaboration

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

Prison sector- HIV prevention programme ("Light for life" programme)

Prevention interventions on STIs and HIV in the prison sector have been conducted since 2005. The objective of the prison sector programme is to prevent HIV/AIDS and other sexually transmitted infections among the prison community in Sri Lanka, through life skills based education and health promotion in prisons. Island-wide prison intervention programmes were conducted during 2011-15 under the theme of "Light for life", with funding support from the Global Fund (Round 9). The interventions were based on a communication strategy developed for the prison sector. These interventions were overseen by a steering committee consisting of members of the Prison department and the National STD/AIDS control programme (NSACP). Four committee meetings were held during 2015. The activities included advocacy for prison authorities, skills-building sessions for rehabilitation officers and sexual health promotion training for medical staff. Selected prison inmates were trained as peer educators (PE) by trained rehabilitation officers. The PE conducted both formal and informal sessions for fellow inmates, using audio-visual communication methods.

Island-wide prison intervention programmes were conducted during 2011-15 under the theme of "Light for life", with funding support from the Global Fund (Round 9).

HIV testing promotion in the prison sector

Prison inmates volunteered for HIV testing after the formal and informal discussions carried out by PEs. Testing was done according to the "HIV testing guidelines for the prison setup". This guideline was circulated among both STD and relevant prison staff. During 2015, thirty mobile HIV testing clinics were held for prisoners. The confirmed positive cases were referred for treatment and care services at the STD clinics. Same blood samples were used to test for syphilis. Group counseling method was used prior to drawing of blood for HIV testing. Negative test results were conveyed to the prisoners by the prison medical officer after providing post-test counseling. Positive results were conveyed by a trained medical officer of the relevant STD clinic. During 2015, a total of 11,382 inmates underwent voluntary HIV testing and counseling in the prisons situated island-wide. Of them, four (4) were HIV positive. The sero-positive rate among the prison inmates in 2015 was 0.03%.

Life skill based peer educator training in prison sector

Two-day life skill based Peer Educator Training was given to inmates of the 30 prisons situated island-wide, at which 1200 peer educators were trained. The peer educators have developed leadership qualities for prevention of HIV among the inmates. They have provided peer education to 24,037 fellow inmates during 2015, as confirmed by the prison authority. This was reflected by the increased demand for voluntary blood testing in the prison settings.

An attractive communication card was developed and distributed among inmates of all the prisons to promote HIV testing. This helped the peer educator activities during the informal sessions. Two consultative workshops on behaviour change communication were carried out for the medical officers and staff members in the prison sector for promotion of safe sex & HIV testing. These workshops helped to update their knowledge on HIV prevention. All officers recruited to the prison department in 2015 were given skills based HIV prevention training with emphasis on proper handling of HIV positive prison inmates.

A special life skill development programme was conducted for young prison offenders at the 'Watareka' prison on the 28th of December 2015. Soft skill development, decision making, problem solving and critical thinking skills were enhanced at this Programme. An interactive session was conducted at which real life case histories were discussed with reference to promotion of sexual and reproductive health. At the end of the programme, young offenders were given presents as an encouragement for their life skills.

Armed forces - HIV prevention programmes

The activities of the armed forces were based on the National Strategic Plan for 2013-2017. The objective of the armed forces training was to achieve positive behaviour change, improve knowledge on HIV and safe sexual behaviours. The programme resulted in promoting HIV testing among them. Training of trainers programmes using the training module was carried out for selected health and other relevant staff of the armed forces across the country. These trainers were given 3 days training, and were provided with all necessary communication materials to carry out programmes in their respective duty stations using formal and informal communication methods. Their performance was monitored and evaluated by officials of the respective forces, based on guidelines provided by the NSACP. Four training of trainers programmes were conducted at which 196 armed forces personnel were trained as trainers. In addition, training was given to 80 air force officers and other rankers, who were appointed to work in the South Sudan health sector.

All three armed forces carried out activities to commemorate the World AIDS Day 2015. The NSACP facilitated these initiatives by providing communication materials (posters, banners and leaflets).

Drama competition among Navy personnel on the World AIDS Day 2015

To mark the “World AIDS Day - 2015” the National STD/AIDS Control Programme requested all multi-sectoral stakeholders to conduct innovative public health programmes to prevent Sexually Transmitted Diseases including HIV, Director/Medical Services of the Sri Lanka Navy organized a drama competition on HIV prevention to promote sexual health among young navy personnel at the Eastern Navy Command, Trincomalee.

All sectors/branches within the Eastern Navy Command camp contributed immensely to develop colourful, aesthetically appropriate and professional dramas. Health messages related to sexually transmitted infections and HIV prevention were highlighted in almost all the dramas. These included the importance of HIV testing, condom promotion for dual protection, high risk behaviours among navy personnel and prevention of mother to child transmission.

A large number of staff members have got involved in several stages of this activity, such as script writing, directing, decorating, singing, dancing and acting. Thus, the health messages have been conveyed to a larger group of navy officers and other staff categories.

Awareness programmes among Navy officers on STI/HIV prevention

Several awareness programmes on STI/HIV prevention were conducted in the following navy commands with technical support of the staff of STD clinics in the area.

Table 39: Awareness programmes conducted by Navy and STD clinics

Navy Command	Peripheral STD clinic
Western naval area – Navy Hospital Complex, Welisara	STD clinic - Ragama
Eastern naval area – Navy Hospital, Trincomalee	STD clinic - Trincomalee
Southern naval area – Navy Hospital, Boossa	STD clinic – Galle
North Central naval area, Poonawa, Madawachchiya	STD clinic – Anuradhapura
North Western naval area – Mollikulama	STD clinic – Kurunegala
Northern naval area – Kareinagar	STD clinic - Jaffna
South Eastern naval area – Pothuvil	STD clinic - Ampara

Youth sector- HIV prevention programmes

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

Figure 48: Training of Trainers (TOT) programme for youth officials

Training of trainers was commenced in 2014 with funds allocated by the government of Sri Lanka. These activities were based on the three-day life skill based participatory training module, and activities were continued during 2015.

Training of trainers programmes based on the training module were conducted for island-wide Youth Council officers and Youth Corps officers. A total of 47 Youth Corps trainers and 145 Youth Council officers were trained during 2015 as trainers.

These officers from the Youth Corps and the Youth Council were given 3 days of training and all necessary communication materials were provided to carry out programmes at the peripheral level. These trainers were instructed to implement HIV/STD programmes in their respective areas, using both formal and informal methods.

In addition, 37 healthcare providers from various parts of the country were given three-day participatory life skill based training as trainers. They were supposed to carry out both formal and informal training for youth at the district level.

There are 35 Youth Corps centers island-wide, and 12000 youth get trained each year for career guidance under the Youth Ministry. The selected officers were trained as trainers under the Multi Sectoral unit, based on the training module. Sexual health has been incorporated in to their regular training curriculum. In addition, the Multi sectoral unit facilitated special awareness programmes in all the Youth Corp centers with the support of the respective MO/STDs.
All these youths were given communication materials on HIV prevention and leaflets on condoms.

Youth programmes at island wide vocational training centers

The partnership between the National STD/AIDS Control Programme and the Vocational Training Authority had created an opportunity to disseminate knowledge on Sexually Transmitted Diseases including HIV among the youth. A strong collaboration was established between the regional/ divisional vocational training centers and the Medical officers in the peripheral STD clinics. These peripheral STD clinics were given the responsibility to conduct awareness programmes at the local vocational training centers. The Multi sectoral unit conducted six programmes in Dehiwala, Kaduwela, Colombo Central, Homagama, Ratmalana and Maharagama. The rest of the programmes were conducted by the respective MO/STDs. In addition, two awareness programmes were conducted for youth who are studying at the Technical Colleges in Colombo. The main aim was to make them aware on the matters related to sexual health and well-being.

Figure 49: Awareness programme conducted in a technical college

Training of university students from other countries on STD/ HIV

AIESEC (Association Internationale des Étudiants en Sciences Économiques et Commerciales) is the world's largest student run organization focused on providing a platform for youth leadership development. "Heal a nation" project is an initiative of the AIESEC at the university of Moratuwa, mainly focused upon creating awareness on sexually transmitted diseases among school and university students. The Multi-sectoral unit of the National STD/AIDS Control Programme provided technical guidance and support, focusing on prevention and control of HIV/AIDS. This training consisted of epidemiology on HIV/AIDS, life skill development for sexual health promotion, prevention of HIV/AIDS, prevention of sexually transmitted infections and HIV testing. In addition, video clips and documentaries on HIV prevention presentations were included. Three workshops were conducted in 2015 for students from China, Philippines, Africa, Canada, France, Netherlands, Indonesia, Malaysia and India.

Education sector programmes

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

National Institute of Education conducted training for the Directors of Health and Physical Education, who are attached to educational zones in each district. The Multi-sectoral unit was

involved in 6 training workshops to train on sexual education, emphasizing on life skill based education. In addition to that, skill based training was given at two teacher training programmes in Kelaniya and Akurassa areas.

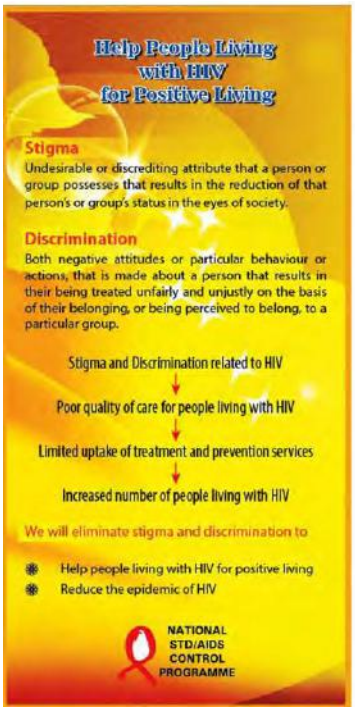
The National STD/AIDS control programme has initiated school awareness programmes to educate school children on sexually transmitted diseases, HIV and life skill development for sexual health promotion through the MO/STDs. Relevant communication materials were developed and distributed among the MO/STDs.

Awareness programmes for students of Ananda College (Colombo10), D.S. Senanayake College (Colombo 8), Mahanama College (Colombo 3) and Anula Vidyalaya (Nugegoda) were conducted during 2015.

Programmes for reduction of stigma and discrimination among healthcare providers

A one-day training programme was conducted among health care workers including nursing sisters, nursing tutors and nursing officers, to reduce stigma and discrimination related to PLHIV.

Figure 50: Communication cards for healthcare providers on stigma and discrimination



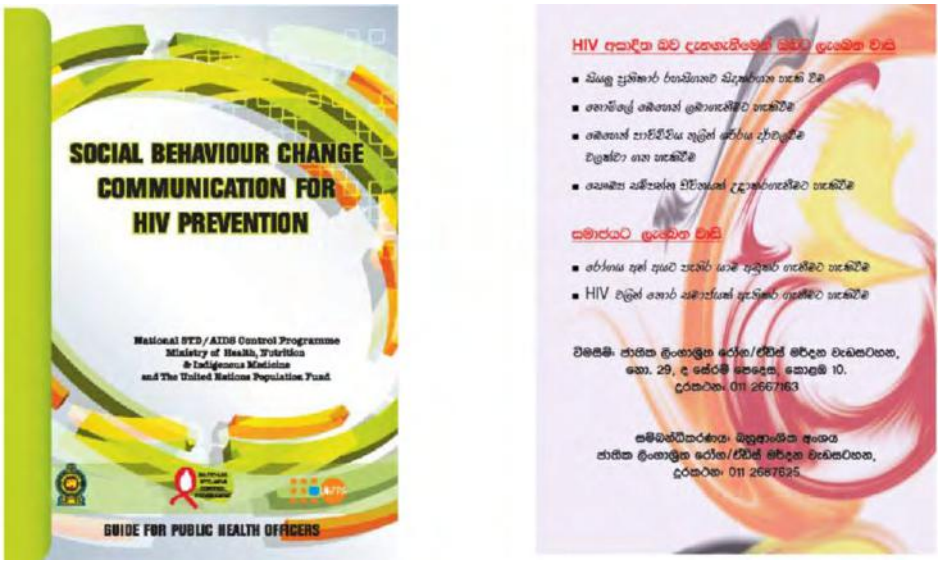
Knowledge on HIV infection, prevention of stigma related to HIV and improvement of the living standards of people living with HIV by reducing discrimination related to HIV were shared with the healthcare workers at the workshop. Two programmes were conducted during 2015, and 80 healthcare providers were trained.

A communication card was developed in two languages (English and Sinhala) for healthcare providers. The facts included in the leaflets were aimed at increasing the knowledge on stigma and discrimination related to HIV infection and inculcating positive attitudes towards the people living with HIV, among healthcare workers.

Handbook on social behaviour change communication for HIV prevention

A book titled “Social behavioural change communication for HIV prevention was published in 2015. Some theories for prevention of HIV were described at individual level of health belief model, reasoned action, stages of change and fear management, interpersonal level of social learning theory and community level of theory of gender and power, diffusion of innovations and ecological model were included in the book. Overview of HIV infection, behaviour change and sexual health of a person, definitions and application of social behaviour change communication were described under social behaviour change communication section.

Figure 51: Handbook on BCC and a leaflet on promotion of HIV testing



North and East provincial reviews - 2015

"Provincial reviews are joint efforts by the staff of National STD/AIDS Control Programme and members of provincial health services and other provincial stakeholders to improve STI and HIV services in the province"

The National STD/AIDS Control Programme commenced provincial reviews in 2015. The STI/HIV provincial reviews are organized to improve participation and involvement of provincial health authorities and provincial stakeholders in improving STI/HIV services in the provinces. These provincial review are joint efforts of the staff of National STD/AIDS Control Programme as technical partners and members of provincial directors of health services and provincial stakeholders as administrative and implementing partners.

Following officers actively participated in these reviews.

- The Director and Consultants from National STD/AIDS control programme
- Provincial Directors of Health Services
- Regional Directors of Health Service
- Deputy Regional Directors of Health Services
- Major staff of STD clinics
- Medical Officer-Planning
- Regional Epidemiologist
- Medical Officer-Maternal and Child Health
- Consultants/Medical Officers of TB clinics and blood banks
- Directors of hospitals in the province

Team work of each district was presented by the MO/STD of the respective districts. Strategic, administrative and technical decisions were taken based on comments and recommendations that were made at these meetings and timely follow-up was carried out.

One important recommendation of the administrative and technical review panel was to estimate key and vulnerable populations in each district in order to provide targeted, measurable STI/HIV prevention and curative services.

Eastern province STI/HIV review

The first STI/HIV Provincial review for the Eastern province was held at RDHS office, Batticaloa on 3rd of March 2015 with the participation of STI/HIV stakeholders from public and curative health services in all four districts in the Eastern Province i.e. Ampara, Batticaloa, Kalmunai and Trincomalee.

Figure 52: Participants of the Eastern province review meeting

Northern province STI/HIV review

The Northern Province STI/HIV review was held on the 8th May 2015 at the RDHS office Vavuniya with the participation of relevant stakeholders from Jaffna, Kilinochchi, Mannar, Mullaitivu, and Vavuniya districts.

Figure 53: Participants of the Northern province review meeting

Global Fund supported activities in 2015

The Global Fund supported activities during 2015 were conducted as the continuation of the phase 2 of the Global Fund grant planned for 2013-2015. The grant activities were implemented by the National STD/AIDS control programme (Principal recipient-1) and the Family Planning Association (Principal recipient-2).

Three principal objectives of the GF project activities were to increase the scale and quality of comprehensive interventions for most-at-risk populations (MARPs), to provide care, treatment and support for people living with HIV and to generate and use the strategic information.

Figure 54: A teleconference among NSACP, GF country team and LFA

Regular teleconferences with the Global Fund country team in Geneva and Local funding agent in Colombo has become a routine feature at NSACP.

Table 40: Description of Global Fund expenditure in 2015

Cost Category	Budget Allocation (USD)	Expenditure (USD)	Difference (USD)
Human resources	69,836	65,985	3,851
Technical assistance (IBBS etc.)	857	176,110	(175,252)*
Training and capacity building	64,525	30,102	34,424
Health products and equipment	442,419	198,116	244,304
Pharmaceutical Products	376,785	211,060	165,725
Procurement and supply manage.	55,630	-	55,630
Infrastructure and other equipment	152	12,263	(12,111)*
Communications materials	4,331	3,948	383
Monitoring and evaluation (M&E)	19,951	1,993	17,958
Support to target populations	197	-	197
Planning and administration	866	888	(21)
Overheads	4,630	767	3,863
Total	**1,040,180**	**701,230**	**338,950**

** These negative differences are mainly due to the money being allocated to 2014 and the activities conducted in 2015.*

Prevention interventions for most at risk and vulnerable populations

Prevention activities for MARPs by the NSACP were mainly carried out through community outreach activities by district STD clinic staff. Awareness and Behavioural Change Communication (BCC) on sexual health STI/HIV, condom education and distribution, screening for syphilis and HIV were conducted during outreach programmes by STD clinics in Kalubowila, Ragama, Chilaw, Kalutara, Ratnapura, Kurunegala, Anuradhapura and Galle during 2015. Total of 75 community outreach programmes were conducted and these improved relationships between MARPs, implementing NGOs and STD clinics which will lead to utilization of STD clinics by MARPs on their own.

Prison prevention interventions were conducted through training of peers in island wide prisons in Sri Lanka. In 2015, a total of 30 peer educator training programs were conducted and each training consisted of 40 peers. These trained peers provide awareness to prison inmates. In addition, the district STD clinic staff conducted outreach to HIV testing in island wide prisons (more details of the prison interventions are given in the multi-sectoral section).

Care and support for PLHIV and capacity building

Global Fund support has been a major boost to ART programme in Sri Lanka. Support to procurement of health products (ART, HIV rapid test kits, Viral Load kits, CD4 reagents, condoms and lubricants) and non-health products, venereologists' visits to branch ART centers to provide care and treatment, training of health care workers on HIV care are important in scale up of HIV services throughout the country.

Consultant Venereologists made a total of 24 monthly ART visits during 2015 to Polonnaruwa and Jaffna STD clinics. These visits not only provided care for PLHIV in their own location but also facilitated capacity building of MO/STDs in these clinics.

Eleven (11) healthcare worker training programmes spanning over 2 days were conducted in Western, North Central, North Western, Central and Sabaragamuwa provinces in 2015. These trainings targeted on comprehensive care for management of PLHIV and to address issues related to stigma and discrimination.

Capacity building programmes were conducted for Medical laboratory technologists, Public health laboratory technicians, Medical officers during 2015 under the Global Fund grant.

Table 41: Achievements of NSACP with Global Fund support in 2015

Indicator	Target	Result achieved	
		Number	Percent
Number and percentage of prisoners reached through peer education with behaviour change communication (BCC) for sexual health and HIV prevention	21,000	24,037	114%
Number of prisoners tested and counselled for HIV who received their test results	16,888	11,378	67%
Number of most-at-risk populations (sex workers, clients of sex workers, male STI clinic attendees, people who use and/or inject drugs, men who have sex with men, beach boys) tested and counselled for HIV who received their test results	27,071	28,963	107%
Number of medical doctors, nurses and laboratory staff trained in HIV and AIDS care relevant to their duties	240	315	131%

Global Fund activities of the Family Planning Association

Being the Principal recipient-2, the Family Planning Association (FPA), directly receives funding from GF. The FPA plays a supportive role to achieve national targets in HIV prevention, especially activities linked to key populations by helping to minimize risky sexual behaviors.

The minimum sexual health/HIV prevention service package of the FPA includes peer education on sexual health/HIV prevention, behavior change communication through distribution of IEC materials, condom demonstration and distribution. Moreover, additional services are provided according to the individual needs of the clients including referral for HIV counselling and testing and STI case management.

Table 42: HIV prevention activities conducted by FPA supported by GF in 2015

Indicator	Target	Results achieved	
		Number	Percentage
Number and percentage of female sex workers reached with HIV prevention programs	4,800	4,603	96%
Number of condoms distributed to female sex workers	1,563,302	960,039	61%
Number and percentage of MSM reached with HIV prevention programs	6,000	3,638	61%
Number of condoms distributed to MSM	658,536	299,147	45%
Number of beach boys reached with HIV prevention programs	1,600	1,727	108%
Number of condoms distributed to beach boys	150,000	123,716	82%
Number and percentage of drug users reached with HIV prevention programs	8,000	7,679	96%
Number of condoms distributed to drug users	156,352	140,389	90%
Number of adults and children living with HIV who receive care and support services	360	491	136%

Preparation of the NFM proposal for 2016-18

"One of the major achievements of NSACP during 2015 was to successfully develop a GF proposal to get a grant of US$ 10,765,843 for the national response to HIV in Sri Lanka. This amount is allocated for a period of 3 years, 2016-2018"

The Global Fund (GF) is a financing institution with the vision of achieving a world free of the burden of HIV/AIDS, TB and malaria. The Global Fund introduced a new mechanism, New Funding Model (NFM) to prepare grant applications. The NFM approach is based on country fund allocation and the cycle covers a period of three years. It is designed to assist countries in achieving maximum impact with active involvement of all stakeholders.

National STD/AIDS control programme was successful in submitting a New Funding Model (NFM)proposal and obtaining a Global Fund grant of US $ 10,765,843, for a period of 3 years from 2016-2018. Of this US $ 5,323,102 is allocated for the Ministry of Health (NSACP) and US $ 5,442,741 for the NGO Principal recipient (Family Planning Association). All stakeholders including donor agencies, community organizations and multiple government sectors supported NSACP to achieve this challenging task.

Figure 55*:* **Development of the concept note with stakeholder involvement**

The development of the concept note itself commenced in February 2015. An international technical consultant and an in country financial consultant provided technical support to finalize the grant proposal.

Figure 56: Development of M&E module of the concept note

The concept note focused on innovative, high impact activities with goals, strategies & activities guided by the strategic directions of the National HIV Strategic Plan 2013-2017. In addition, findings of multiple reviews which were conducted during the country dialog provided inputs to the concept note.

This Global Fund HIV grant will be implemented with below mentioned goals, strategies and activities during 2016-2018 by the National STD/AIDS Control Programme of the Ministry of Health and by the Family Planning Association which will perform activities independently with the technical coordination from NSACP.

Goals

1. Preventing new HIV infections in key populations and vulnerable groups.
2. Ensuring high quality treatment and care services to all populations in need.

Strategies

1. Improved coverage of key affected and underserved groups through community based interventions.
2. Strengthened linkages with the private sector to expand HIV and STI prevention, treatment and care services to all populations in need.
3. Better targeted testing of at risk groups to identify PLHIV.
4. Increased and faster initiation of identified PLHIV into the HIV Continuum of Care.

5 Robust treatment monitoring for improved PLHIV outcome.

6 Improved M&E and surveillance systems and capacity to analyze and use data.

Planned activities during 2016 - 2018 by NSACP

1 Prevention programs for key populations and other vulnerable groups

I. Provide HIV testing to key populations and targeted vulnerable populations.

II. Provide rapid HIV testing in prisons, including training of prison health staff.

III. Procurement of rapid test kits, condoms and lubricants for the needs of key populations and other vulnerable groups.

IV. Conduct training and refresher training of trainers (ToT) for peer educators in prisons for provision of prevention services.

V. Strengthen national coordination and cooperation and develop an action plan for tailored harm reduction interventions and service package for PWUD/PWID.

VI. Conduct prison sector advocacy and sensitization.

VII. Implement advocacy and training of trainers (ToT) for migrants and tourism professionals.

VIII. Creating enabling environment through advocacy and training of police officers, and legal literacy training for key populations.

IX. Learning best practices concerning PWUD/PWID in the region.

2 Treatment, care and support:

I. Quality assurance and quality control (QA/QC) of ARV drugs procured by the government of Sri Lanka.

II. Increase the coverage of TB screening to all PLHIV.

III. Train STI clinics staff and laboratory technologists to perform rapid testing.

IV. Send samples abroad for DNA PCR testing and HIV genotypic testing.

V. Conduct basic HIV clinical training to private and public sector health care personnel.

VI. Conduct refresher training for STI clinic health providers.

VII. Increase access to and strengthen provision of HIV/STI services in Northern and Eastern Provinces.

VIII. Improve laboratory facilities in STI clinics.

IX. Procurement of 6 CD4 machines, 10 ELISA machines, viral load test kits, RDTs and RNA PCR machine.

X. Increase referral and linkages with private sector including QC of HIV testing.

3 Health Information System and M&E:

I. Development and roll out of an electronic patient database in central and district levels in line with the National strategic plan for the national health information system.

II. Conduct operations research on cases of lost to follow-up among PLHIV along the testing, treatment and care cascades.

III. Conduct size estimates for key populations to support national and local programming and target setting

IV. Conduct an Integrated Biological and Behavioral Surveillance (IBBS) survey

V. Conduct a rapid assessment of drug use patterns in order to inform risk reduction and harm reduction interventions among PWUD/PWID in Sri Lanka

VI. Develop data quality assessment (DQA) guidelines, conduct training and implement routine DQA as well as ad hoc data quality/verification visits to STI clinics.

VII. Improve routine reporting from private sector

4 Programme Management

I. Development of a National HIV/STI prevention strategy for Key populations.

II. Development of a National HIV testing policy

III. Development of a Prison HIV/AIDSpPolicy

IV. Conduct regular supervisory visits to STI clinics

V. Multi-sectoral coordination meetings (Subcommittee and National AIDS Committee)

VI. Advocacy for legal personnel to reform punitive laws

Training and capacity building

"Training and capacity building of healthcare workers and other staff is an important activity of the National STD/AIDS Control Programme (NSACP). The NSACP provide both preventive and clinical training in these capacity building programmes"

Training and capacity building of healthcare workers and other staff is an important programme area of the National STD/AIDS Control Programme (NSACP). The training includes both preventive and clinical training. Undergraduate and postgraduate medical training is one of the most important activities conducted by the NSACP and other STD clinics located in teaching hospitals. In recent years, the NSACP has been providing such services increasingly for other groups / stakeholders as well.

Pre-service training

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

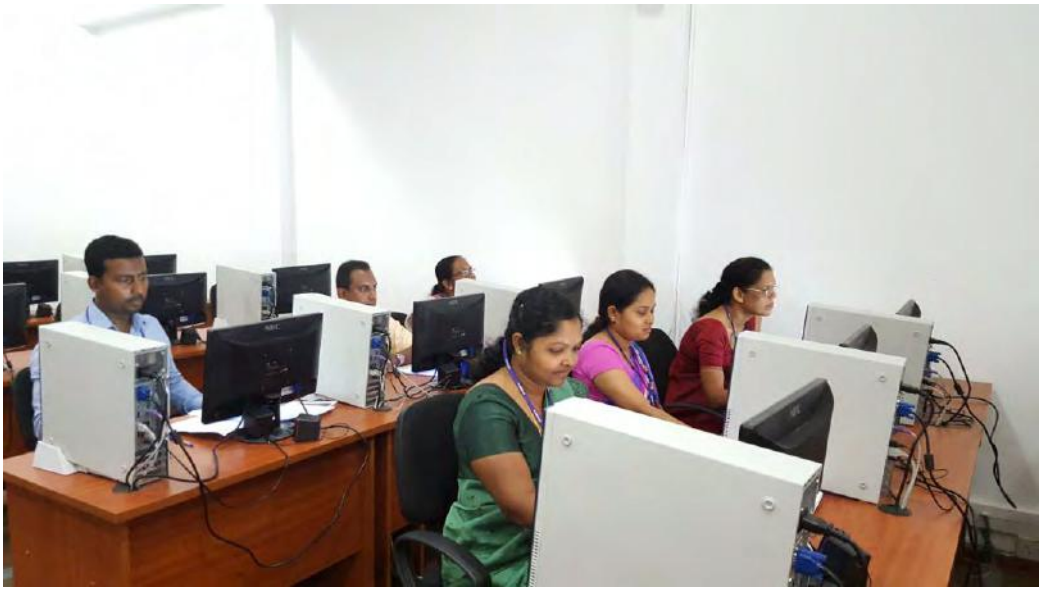
Refresher training

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

Figure 57: A refresher training on ART monitoring

Figure 58: A refresher training on ART monitoring

Figure 59: In service computer training of NSACP staff on use of MS Excel



Undergraduate medical training

Training and capacity building of medical students in treatment, care, control and prevention of STIs and HIV/AIDS is essential parts in medical curricula. Each year, medical students from

the University of Colombo and Kotalawala Defense University (KDU) attend the Central clinic for their clinical appointments. Medical students of other universities such as Sri Jayawardenapura, Kelaniya, Ruhuna and Rajarata receive training from the relevant STD clinics situated close to these universities.

Nursing and other university students

Nursing students in different training schools also undergo training in STD and HIV. They either receive only lectures or lectures and visits to relevant clinics. There is a growing interest in this subject area among other groups of students in university level studies. One recent example is the visit by the entire batch of students from the National Institute of Social Development, who had received lectures on STD and HIV to familiarize themselves with the services provided by the Central clinic.

Postgraduate medical training

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

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

Medical officers of health (MOH) trainees

The Medical Officers who undergo training at the National Institute of Health Sciences follow a short training course at the NSACP.

Targeted interventions related capacity building

Scaling up of intervention programmes targeting most-at risk population (MARPs) groups (female sex workers, men who have sex with men, drug users, beach boys and prisoners) were started in 2011. Capacity building such as training of trainers and peer-educator training

are two important components of these intervention programmes. The NSACP provides necessary technical support for these training activities on an ongoing basis.

Table 43: Training and capacity building carried out by the Central clinic, Colombo

Category	Number trained
Training of major staff on prevention, EMTCT, treatment and care	2098
Other training	
MO - STD	15
Other MOO	46
PHLT	30
HCW minor staff	33
PG Trainees	
MD venereology trainees	6
Diploma venereology trainees	8
DFM trainees	19
DCH trainees	102
MD Dermatology trainees	3
MD Virology trainees	2
MD Microbiology trainees	36
MD Com. Med trainees	36
Medical Students	
University of Colombo	234
Kotalawala defense university	87
Nurses and Nursing students	754
Students of MSc in Social studies	100
Total	**3609**

IEC and Advocacy programmes

Information, Education and Communication (IEC) on STIs and HIV/AIDS is an important programme area of the National STD/AIDS control programme (NSACP). This work is carried out every day at different levels.

Several hundreds of patients with STIs and HIV related issues are seen at STD clinics all over the country. Persons attending STI/HIV AIDS services at STD clinics are provided extensive awareness on related STI and HIV issues. These services are provided by different categories of healthcare providers such as doctors, public health nursing sisters, nursing officers and public health inspectors attached to services.

In addition, NSACP carry out awareness programmes on STIs and HIV in different situations. Different organizations (schools, NGOs, armed forces, department of Police, government institutions etc.) request lectures/lecture discussions on STI and HIV from NSACP and other peripheral STD clinics. All these requests are attended without hesitation by different health care providers as appropriate.

The NSACP pay special attention to raise awareness among general public on STI and HIV through mass media. At times lectures given on these topics are published in print and electronic media.

Targeted interventions

Providing sexual health services for most-at risk population (MARP) groups is a major area of interventions adopted in the country as a national programme. Under this programme female sex workers (FSW), men who have sex with men (MSM), drug users (DU), beach boys and prison inmates are covered in selected districts of the country. IEC is one major component of the sexual health services package provided to them. Hundreds of peer educators from the above categories of MARP were engaged in raising awareness on STI and HIV among fellow community members during last year.

Table 44: Type of IEC activities carried out by the Central STD clinic, Colombo

Type of activity	Target group	No. of programmes	No. of attendees
Awareness programmes	Youth	4	725
	School children	3	750
	University students	2	460
	PLHIV	2	NA
	Drug users	4	384
	Factory workers	4	3450
	Tri-forces	3	850
	Public - TV programmes	5	NA
	Public - radio programmes	2	NA
	Public - exhibitions	5	7,700
	Public - lectures	51	5600
	Public - musical programmes	1	Public
	Public - bicycle ride + walk	1	Public
	Media conferences	2	175
	Newspaper articles	2	Public
	Patient awareness	743	743
Advocacy programmes	Ministry	3	NA
	Provincial authorities	5	NA
	Condom strategy development	3	NA
	IEC subcommittee	1	35

Table 45: Details of IEC Programmes conducted by STD clinics

Type of Participants	Number of programmes	Approximate number of participants
Female Sex Workers	90	1,347
MSM	17	445
Drug Users	39	1,462
Prisoners	164	10,802
Youth (out of school)	277	23,338
School children	322	46,172
General public/mixed group	632	54,042
Other	699	75,408
Total	**2148**	**207,364**

World AIDS Day 2015

"World AIDS Day is held on the 1st of December each year. This is an opportunity for people worldwide to unite to acquire knowledge, good behaviours and promote positive attitudes towards People Living with HIV (PLHIV)"

National Event in Batticaloa

The National STD/AIDS Control programme in collaboration with the Provincial Director of Health services of the Eastern Province and Regional Director of Health Services of Batticaloa, organized the World AIDS Day national event in Batticaloa. This area is popularly known as "land of singing fish" because of its aquatic environment and the city's scenic beauty with many lagoons.

Figure 60: Religious leaders' participation in the World AIDS Day - 2015

The event was held on December 1st 2015. The theme "Test Today" was continued for the second year to strengthen the efforts to improve HIV diagnosis and treatment. The objectives of commemorating this event were to make a greater impact through advocating key leaders in the Eastern Province, improving awareness among the general and vulnerable populations, improving HIV diagnosis and condom use for HIV prevention.

Figure 61: The world AIDS Day walk in Batticaloa

Figure 62: The world AIDS Day walk in Batticaloa

Two media conferences were organized prior to the main event in Colombo and in Kalmunai. Television programs organized in all three languages further improved public awareness and the impact of this national event.

Figure 63: The world AIDS Day walk in Batticaloa

Figure 64: The meeting held at public hall of municipal council, Batticaloa

The main event comprised of a walk starting from the Mahatma Gandhi Park at the Batticaloa city which proceeded through many populated locations such as the main town, bus stands, schools, government and private offices, banks and finally reached the public hall at the Batticaloa municipal council. At the public hall the event was commemorated with cultural

events, awareness programs and key note addresses. Religious leaders, tri forces and school children actively participated in the walk. Rapid HIV testing and condoms were made available at the conference venue. Staff of NSACP central and district clinics, representatives from governmental, non-governmental organizations and representative from Global Fund Country Coordinating Mechanism (CCM) participated at the event. Approximately 100 participants voluntarily underwent rapid HIV testing and about 3000 condoms were distributed from the condom booth. Hatton National Back (HNB) PLC was the principal sponsor of this event. In addition, Population Services Lanka (PSL), World Vision and Singing Fish organization financially supported this event.

World AIDS Day activities conducted by prisons

Similar to previous years, multi-sectoral unit organized various events for World AIDS Day 2015. A variety of communication materials were distributed among the 30 prisons in the country to carry out interventions parallel to the World AIDS Day 2015. All 30 prisons participated in the World AIDS Day 2015 commemoration with the prisoners in order to develop their skills and awareness. They organized a World AIDS Day walk, art competitions and other relevant activities. Five hundred (500) prisoners from the main four prisons in Colombo (Colombo Remand, Colombo Magazine, Welikada-male and Welikada-female prisons) participated in the World AIDS Day Walk, which helped to increase HIV/AIDS awareness among the general public in the area. Posters, banners and decorated vehicles were used to display HIV prevention messages and the theme for the event was “Test today”.

Figure 65: Health minister participating in the World AIDS Day walk at Borella

Figure 66: The world AIDS Day walk at Borella

Figure 67: NSACP staff participating in the World AIDS Day walk at Borella

Figure 68: Prisoners participating in the World AIDS day walk at Borella

Table 46: World AIDS Day activities for 2015 in the island-wide prisons

Prison	Programmes conducted in the prison
Anuradhapura	Development of posters and banners. Awareness programme for inmates
Ambepussa	Awareness programme for inmates
Badulla	AIDS Day walk at Mahiyangana town area. Poster, essay and oratory competitions among inmates, awareness programme for inmates
Batticaloa	AIDS Day walk from the prison to the Batticaloa hospital. Poster competition among inmates performed an AIDS day drama.
Galle	AIDS Day walk inside the prison, video show, awareness programme for inmates.
Jaffna	AIDS Day walk and awareness programme for inmates
Kalutara	AIDS Day walk from the prison to Kalutara town, essay and oratory competitions for male and female sections
Kilinochchi	AIDS Day conference at Nelum Piyasa army conference hall to 400 army personnel and 200 people from general population.
Bogambara	AIDS Day walk from the prison to Pallekele town. Debate competition among inmates, poster, essay and poem competitions among inmates, awareness programme for inmates and HIV blood testing campaign.
Kandawaththa	Awareness programme for inmates
Kegalle	Awareness programme for inmates, poster, essay, and short drama competitions among inmates.
Kuruwita	AIDS Day walk with inmates, poster exhibition, awareness programme for inmates and HIV blood testing campaign.
Mahara	AIDS Day walk from the prison to the town. Drama on HIV and awareness programme for inmates
Matara	Poster, essay and poem competitions among inmates, awareness programme for inmates
Monaragala	AIDS Day walk from the prison to the Monaragala town. Drama on HIV and awareness programme for inmates
Negombo	Open poster competition among inmates and awareness programme for inmates
Dalupotha, Pallansena	Drama, poster and essay competitions among inmates, awareness programme for inmates
Pallekele	Poster, essay and poem competitions among inmates, awareness programme for inmates
Boossa	AIDS day walk from the prison to Galle road, Boossa junction. Posters and banners on HIV were displayed.
Polonnaruwa	Poster and singing competitions among inmates, awareness programme for inmates
Thaldena	AIDS day walk at Mahiyangana town, Performed a street drama, Poster, Essay and poem competitions among inmates
Tangalle	Poster competition among inmates, Competition on HIV knowledge. Awareness programme for inmates
Kadurugasara	Awareness programme for inmates
Trincomalee	AIDS day walk with the assistance of the police sector. Poster, essay and oratory competitions among inmates. Awareness programme for inmates
Vavuniya	Awareness programme for inmates
Wariyapola	AIDS day walk from Wariyapola Sri Visuddharama temple to Wariyapola town. Posters and banners made by inmates.
Watareka	Essay competitions among inmates, Awareness programme for young offenders and teachers of “Suneetha” school.
Weerawila	AIDS day walk from Debarawewa to Tissamaharama town. Poster and Essay competitions among inmates, Awareness programme for inmates

Events in pictures

Sinhalese and Tamil New Year

A ceremony was organized by the welfare society of the NSACP to celebrate the Sinhalese and Tamil New Year. A large number of staff members participated at this event. Singing, dancing and acting sessions were held with full of joy and enthusiasm.

Figure 69: NSACP staff celebrating Sinhalese and Tamil New Year

Figure 70: NSACP staff celebrating Sinhalese and Tamil New Year

Figure 71: NSACP staff celebrating Sinhalese and Tamil New Year

Vesak celebration

A dharma sermon was held at NSACP to commemorate “Vesak” festival, organized by the welfare society. Creative and attractive “Vesak” decorations were designed and demonstrated at the NSACP premises. All staff members gave their fullest support for this event.

Figure 72: Preparation of Vesak lanterns at SIM unit of NSACP

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)-India delegation's visit to Sri Lanka

An interagency PEPFAR-India delegation visited Sri Lanka from September 21-25, 2015, to explore the opportunities for PEPFAR-India to provide technical assistance to HIV response in Sri Lanka. The interagency team consisted of Dr Pauline Harvey, Mr. Xerses Sidwa, Mr. David Nelson, and Mr. Lokesh Upadhyaya. Dr Ilanchezhian Thangaraj and Mr Pramod K from the Voluntary Health Services in Chennai also accompanied the team.

Figure 73: PEPFAR-India delegation with NSACP staff

Figure 74: PEPFAR-India delegation with staff of Mahamodara STD clinic

Figure 75: PEPFAR-India delegation discussing with Beach boys

Figure 76 : At the debriefing meeting with DGHS Dr Palitha Mahepala

Sports day events at Borella Prison Grounds

A “Sports Day” was organized to uplift the unity, team spirit and entertainment among staff members. This was held on 29th August 2015 at prison grounds, Colombo.

Figure 77: The sports event organized by NSACP staff

Retirement of NSACP staff

Retirement of Dr Chandrika Wickreamsuriya and Dr Neelamani Punchihewa took place in 2015. Both of them have served the NSACP for more than 20 years. Dr Wickramasuriya looked after the duties of the deputy director during last few years prior to her retirement. Dr Punchihewa coordinated the Global Fund project activities of round 9.

Figure 78: Dr Punchihewa’s farewell ceremony

Figure 79: Dr Wickramasuriya's farewell ceremony

Online course on "Principles of STD and HIV Research"

Some of the medical staff of the NSACP successfully completed an online course on the Principles of STD and HIV research conducted by the University of Washington, USA. This e-course was conducted for a period of 12 weeks starting from 14th of September 2015. WHO provided funding support for this activity.

Figure 80: Online course participants with WHO representative Dr. Jacob Kumaresan

Quality improvement activities

Various activities were conducted in NSACP to improve the productivity and efficiency within the institution to provide quality health care service during 2015. They were carried out with the objective of utilizing the available resources efficiently and productively by establishing the 5 S concepts within the institution.

Seven 5-S productivity circles were established within the institution and a responsible team leader was nominated for each team. Four productivity and quality improvement meetings were held during 2015.

Activities carried out include:

- Formulation of an annual action plan for the institution to improve the productivity and quality.
- A lecture discussion was organized to improve the knowledge on “productivity” among staff members of NSACP. This was conducted by a resource person from “National Quality Secretariat”.
- A “cleaning day” was organized within the institution to discard all the unnecessary items in their respective units.
- Two “shramadana” campaigns were conducted to clean the surrounding environment of the institution. Painting of the parapet wall, arranging flower pots/vases and gardening were done on these days.

Figure 81: A Shramadana campaign at NSACP

Figure 82: A Shramadana campaign at NSACP

- One-day workshop on “Healthcare quality and safety improvement” was conducted among staff members to update their current knowledge on healthcare quality and safety. Quality improvement concepts, healthcare management concepts (KAIZEN) and facts regarding responsiveness were discussed extensively.
- Essential items were purchased to improve the quality and standard of healthcare delivery within the institution. Items such as pedal dustbins, wall clocks, plastic racks and other necessary equipment’s were distributed among units within the institution.

Figure 83: Results of Shramadana campaigns at NSACP

Financial summary - 2015

Table 47:Summary of financial details for 2015

Financial Sources	Description	Fund Allocation (LKR)	Fund Utilization (LKR)
1. Capital Expenditure			
Ministry of Health	Building construction	2,934,249.00	1,694,016.91
	World AIDS Day activity	1,000,000.00	917,663.00
	Service training programmes	853,715.00	762,487.14
	Purchase office equipment	10,000,000.00	10,625,800.05
	Purchase of laboratory equipment	10,939,530.00	11,122,808.30
	Purchase of ELISA machines	1,900,000.00	1,900,000.00
	Repair of the machines	1,328,300.00	1,328,300.00
	Repair of cool room	860,472.00	860,472.00
	Total	**29,816,266.00**	**29,211,547.40**
UNFPA	Consultative workshops, advocacy programmes, printing of publication	4,000,000.00	3,666,000.00
WHO	Consultative workshops, review meetings. training module development	1,600,000.00	369,985.43
World Bank	Prevention of mother to child transmission.	11,231,299.00	9,100,000.00
Global Fund	Human resources	8,869,153.00	9,145,493.00
	Technical and management assistance	108,900.00	24,408,788.00
	Training	8,194,694.00	4,172,079.00
	Health products and health equipment	56,187,260.00	27,458,846.00
	Pharmaceutical products	47,851,677.00	29,252,937.00
	Procurement supply and management cost	7,065,000.00	0.00
	Infrastructure and other equipment	19,350.00	1,699,675.00
	Communication materials	550,000.00	547,133.00
	Monitoring and evaluation	2,533,800.00	276,246.00
	Living support to clients/target population	25,000.00	0.00
	Planning and administration	110,000.00	123,027.00
	Overheads	588,000.00	106,166.00
	Sub total	**132,102,834.00**	**97,190,390.00**
Total Capital Expenditure		***178,750,399.00***	***139,537,922.83***
2. Recurrent Expenditure			
Ministry of Health	Personal emoluments (salaries etc.)	98,700,000.00	106,006,374.54
	Travelling expenses	300,000.00	316,041.42
	Stationary and office requisites	700,000.00	485,844.47
	Fuel supplies	700,000.00	722,848.19
	Waste management and other	500,000.00	181,451.72
	Maintenance expenditure (vehicles etc.)	2,800,000.00	3,000,593.34
	Postal communication	1,000,000.00	1,279,131.25
	Electricity and water	5,800,000.00	5,083,996.93
	Security, cleaning service and other	4,700,000.00	5,300,552.10
	Loan interest/transfers	810,000.00	846,728.99
	Medical supplies	500,000.00	498,419.72
Total Recurrent Expenditure		***116,510,000.00***	***123,721,982.67***
Grand Total (LKR)		**295,260,399.00**	**263,259,905,50**

Contact information - 2015

1	Ampara District	
	1. STD clinic – Ampara	
	Address	STD clinic, General Hospital, Ampara
	Email:	stdclinic.ampara@gmail.com
	Telephone	063-3636301, 063-2224239
	Fax	063-2222988
	Contact person: Dr Sakunthala de Soyza (Medical officer in charge)	
	2. STD clinic – Kalmunai	
	Address	STD clinic, Base Hospital, Kalmunai.
	Email:	stdclinic.kalmunai@gmail.com
	Telephone	067-2223660
	Fax	067-2223660
	Contact person: Dr A.R.M Faris (Medical officer in charge)	

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

3	Badulla District	
	4. STD clinic – Badulla	
	Address	STD clinic, Room No 73, Provincial General Hospital, Badulla.
	Email:	stdclinic.badulla@gmail.com
	Telephone	055-2222578
	Fax	055-2222578
	Contact person:	Dr H.G.C. Vethanayagam (Medical officer in charge)

4	**Batticaloa District**	
	5. STD clinic – Batticaloa	
	Address	STD Clinic, Teaching Hospital, Batticaloa.
	Email:	stdclinic.batticaloa@gmail.com
	Telephone	065-2222261
	Fax	065-2224401
	Contact person: Dr S. Anusha (Medical officer in charge)	
5	**Colombo District**	
	6. STD clinic - Colombo	
	Address	National STD/AIDS Control Programme, 29, De Saram Place, Colombo 10
	Email	stdclinic.colombo@gmail.com
	Telephone	011-2667163
	Hot lines	011-2695420 (Female), 011-2-695430(Male)
	Fax	011-5336873
	Contact persons:	
	Dr S. Liyanage	Director
	Dr L.I. Rajapakse	Venereologist
	Dr K.A.M. Ariyaratne	Venereologist
	Dr G. Weerasinghe	Venereologist
	Dr S. Benaragama	Epidemiologist
	Dr J.P. Alwitigala	Microbiologist
	Dr J. Vidanapathirana	Community Physician
	Dr S. Herath	Community Physician
	7. STD clinic -Kalubowila	
	Address	STD Clinic, Room 43, Sunandarama Rd, Kalubowila.
	Email:	stdclinic.kalubowila@gmail.com
	Telephone	011-4891055
	Fax	011-4891055
	Contact persons:	Dr Nalaka Abeygunasekara (Venereologist), Dr Sumudu Perera (Medical officer in charge)

6	**Galle District**	
	8. STD clinic – Balapitiya	
	Address	STD Clinic, Base Hospital, Balapitiya.
	Email:	stdclinic.balapitiya@gmail.com
	Telephone	091-3094667
	Contact person:	
	Dr S. Krishanth Witharana	(Medical officer in charge)
	9. STD clinic - Mahamodara	
	Address	STD clinic, Teaching Hospital, Mahamodara, Galle
	Email:	stdclinic.mahamodara@gmail.com
	Telephone	091-2245998
	Fax	091-2232088
	Contact persons:	Dr Darshani Wijewickrema (Venereologist) Dr R.M.S. Ratnayake (Medical officer in charge)
7	**Gampaha District**	
	10. STD clinic – Gampaha	
	Address	STD Clinic, District General Hospital, Gampaha
	Email:	stdclinic.gampaha@gmail.com
	Telephone	033-2234383, 031-2224156
	Fax	033-2222179
	Contact Person:	Dr S. B. S. Gamage (Medical officer in charge)
	11. STD clinic - Negombo	
	Address	STD clinic, District General Hospital, Negombo
	Email:	stdclinic.negombo@gmail.com
	Telephone	031-2224156
	Contact persons:	Dr Himali Perera (Venereologist) Dr Lionel Halahakoon (Medical officer in charge)

	12. STD clinic - Ragama	
	Address	STD clinic, Room 70, Teaching Hospital, Ragama
	Email:	stdclinic.ragama@gmail.com
	Telephone	011-2960224
	Fax	011-2960224
	Contact persons:	
	Dr R.G.J.D. Ranatunga	(Venereologist)
	Dr Anjana Rajapaksha	(Medical officer in charge)
	13. STD clinic - Wathupitiwala	
	Address	STD Clinic, Base Hospital, Wathupitiwala
	Email:	
	Telephone	033-2280261
	Fax	033-2280927
	Contact person:	
	Dr D.P.G.N. Dhanuska	(Medical officer in charge)
8	**Hambantota District**	
	14. STD clinic - Hambantota	
	Address	STD clinic, General Hospital, Hambantota
	Email:	stdclinic.hambantota@gmail.com
	Telephone	047-2222247
	Fax	047-2222409
	Contact person:	
	Dr A.L. Nalin Chaminda Geeganage	(Medical officer in charge)
9	**Jaffna District**	
	15. STD clinic – Jaffna	
	Address	STD Clinic, Teaching Hospital, Jaffna
	Email:	stdclinic.jaffna@gmail.com
	Telephone	021-2222261, 021-2217756
	Fax	021-2222262
	Contact person:	
	Dr Tharanee Guruparan	(Medical officer in charge)

10	Kalutara District	
	16. STD clinic – Kalutara	
	Address	STD Clinic, General Hospital, Kalutara
	Email:	stdclinic.kalutara@gmail.com
	Telephone	034-2236937
	Fax	034-2236937
	Contact person:	
	Dr C.Jayakody	(Acting Venereologist)
	Dr S.A.P Nishanthi	(Medical officer in charge)

11	Kandy District	
	17. STD clinic – Kandy	
	Address	STD clinic, P.O. Box 207, Kandy
	Email:	stdclinic.kandy@gmail.com
	Telephone	081-2203622
	Fax	081-2203622
	Contact Persons:	
	Dr Ganga Pathirana	Venereologist /General Hospital, Kandy
	Dr S.R.K.T. Gamage	Medical officer in charge

12	Kegalle District	
	18. STD clinic – Kegalle	
	Address	STD clinic, District General Hospital, Kegalle
	Email:	stdclinic.kegalle@gmail.com
	Telephone	035-2231222
	Fax	035-2231222
	Contact person:	
	Dr Geethani Samaraweera	(Acting Venereologist)
	Dr M.A. Sunethra Buddhadasa	(Medical officer in charge)

Contact information - 2015

13	District Kurunegala	
	19. STD clinic- Kurunegala	
	Address	STD Clinic, Teaching Hospital, Kurunegala
	Email:	stdclinic.kurunegala@gmail.com
	Telephone	037-2224339
	Fax	037-2224339
	Contact person:	
	Dr Nihal Edirisinghe	(Medical officer in charge)
14	**District Kilinochchi**	
	20. STD clinic- Klinochchi	
	Address	STD Clinic, Base Hospital, Kilinochchi
	Telephone	021-2285327, 021-2285329
	Contact person:	
	Dr Venuri Fernando	(Medical Officer)
15	**Mannar District**	
	21. STD clinic – Mannar	
	Address	STD clinic, District General, Hospital Mannar
	Email:	stdclinic.mannar@gmail.com
	Telephone	023-2250573
	Fax	023-2250573, 023-2250748
	Contact person:	
	Dr Anton Sisil Rajani	(Medical officer in charge)
16	**Matale District**	
	22. STD clinic- Matale	
	Address	STD clinic, District General Hospital, Matale
	Email:	stdclinic.matale@gmail.com
	Telephone	066-2222261-extention 146, 066-3664387
	Fax	066-2224202
	Contact person:	
	Dr A. Sherifdeen	(Medical officer in charge)

17	**Matara District**	
	23. STD clinic – Matara	
	Address	STD clinic, No 43, General Hospital, Matara
	Email:	stdclinic.matara@gmail.com
	Telephone	041-2232302
	Fax	041-2232302
	Contact person:	
	Dr Roshan Jayaweera	(Medical officer in charge)
18	**Monaragala District**	
	24. STD clinic – Monaragala	
	Address	STD clinic, District General Hospital, Monaragala
	Email:	stdclinic.monaragala@gmail.com
	Telephone	055-2276261, 055-2276826
	Fax	055-2276700
	Contact person:	
	Dr B.F.A.F. Pradeep	(Medical officer in charge)
19	**Nuwara Eliya District**	
	25. STD clinic – Nuwara Eliya	
	Address	STD clinic, General Hospital, Nuwara Eliya
	Email:	stdclinic.nuwaraeliya@gmail.com
	Telephone	052-2223210
	Fax	052-2223476
	Contact person:	
	Dr Tissa Seneviratne	(Medical officer in charge)
20	**Polonnaruwa District**	
	26. STD clinic – Polonnaruwa	
	Address	STD clinic, General Hospital, Polonnaruwa
	Email:	sticlinic.polonnaruwa@gmail.com
	Telephone	027-2225787
	Fax	027-2223253
	Contact Person: Dr Indrani Peris **(**Medical officer in charge)	

21	**Puttalam District**	
	27. STD clinic – Chilaw	
	Address	STD clinic, General Hospital, Chilaw
	Email:	stdclinic.chilaw@gmail.com
	Telephone	032-2220750
	Fax	032-2223200
	Contact person:	
	Dr N. R. Amarajeewa	(Medical officer in charge)
22	**Ratnapura District**	
	28. STD clinic – Ratnapura	
	Address	STD clinic, Provincial General Hospital Complex, Ratnapura
	Email:	stdclinic.ratnapura@gmail.com
	Telephone	045-2226561
	Fax	045-2224761
	Contact person:	Dr Darshani Mallikarachchi (Venereologist), Dr Kanchana Upasena (Medical officer in charge)
23	**Trincomalee District**	
	29. STD clinic – Trincomalee	
	Address	STD clinic, General Hospital, Trincomalee
	Email:	stdclinic.trincomalee@gmail.com
	Telephone	026-2222261, 026-2222563
	Contact person:	
	Dr V. Srigawriesvaran	(Medical officer in charge)
24	**Vavuniya District**	
	30. STD clinic – Vavuniya	
	Address	STD clinic, General Hospital, Vavuniya
	Email:	stdclinic.vavuniya@gmail.com
	Telephone	024-2224575
	Fax	024-2224575, 024-2222892
	Contact person:	
	Dr G. Nandakumar	(Medical officer in charge)

For more information, contact;

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