Ministry of Health & Mass Media
Sri Lanka

NATIONAL STD AIDS CONTROL PROGRAMME



National STD/AIDS
Control Programme
SRI LANKA

ANNUAL REPORT

2025

Annual Report
2025

National STD/AIDS Control Programme,



Ministry of Health & Mass Media
Sri Lanka

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FOREWORD

It is with great pleasure and a profound sense of responsibility that I present the Annual Report of the National STD/AIDS Control Programme (NSACP) for the year 2025. This report encapsulates our collective achievements, operational challenges, and strategic milestones over the past year as we continue our dedicated path towards ending AIDS by 2030 and sexually transmitted infections (STIs) as public health threats in Sri Lanka.

Throughout 2025, the NSACP has remained steadfast in implementing the National HIV/STI Strategic Plan (2023–2027). Sri Lanka continues to maintain a low-level HIV epidemic, with an adult prevalence remaining below 0.1%. This achievement is a direct testament to the efficacy of our evidence-based, decentralized healthcare model, and the resilient commitment of our healthcare workers.

The year 2025 marked critical advancements in our biomedical and structural interventions. We successfully scaled up the delivery of condom and lubricants, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) to populations at higher risk, reinforcing our prevention toolkit. Concurrently, our commitment to dual elimination sustaining the Elimination of Mother-to-Child Transmission (EMTCT) of HIV and syphilis, alongside advancing our strategy for Triple elimination for mother to child transmission of HIV, Syphilis and Hepatitis B remains a cornerstone of our maternal and child health priorities. Furthermore, the initiation of the 2025 Integrated Biological and Behavioral Survey (IBBS) and Population Size Estimation (PSE) supports our reliance on high-quality strategic information to drive targeted, data-backed policy formulations.

As we look toward the future, we must acknowledge the challenges that remain. Reaching hidden key populations, addressing the social stigma that hinders early testing, and combating the global threat of antimicrobial resistance (AMR) in STIs require adaptive, innovative, and empathetic responses. Our newly introduced National Communication Strategy (2026–2030) will be instrumental in modernizing our public health messaging and leveraging virtual combination prevention services to close these gaps.

I extend my deepest gratitude to the all national and provincial level health staff, multi-sectoral state partners, civil society organizations, community-based networks, and international development partners, including the Global Fund and all United Nations Agencies. Most importantly, I thank the dedicated clinical, laboratory, and administrative staff of the NSACP.

As we move forward, let this report serve not only as a record of our accountability, but also as an evidence-based document that supports accelerated action. Together, we will continue to strengthen universal health coverage in comprehensive sexual health services, while ensuring a stigma-free environment for every citizen of Sri Lanka.

Dr. JCM Tennekoon

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

ACKNOWLEDGEMENT

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ABBREVIATIONS

ABC	abacavir
Ab	Antibody
AIDS	Acquired immunodeficiency syndrome
ANC	antenatal clinic
ART	antiretroviral treatment
ARV	antiretrovirals
ATV/r	atazanavir boosted with ritonavir
AZT	zidovudine
BB	Beach boys
BCC	Behavior Change Communication
BH	Base Hospital
CBO	Community Based Organization
CD4	Cluster of differentiation
CMV	Cytomegalovirus
DGH	District General Hospital
DGHS	Director General of Health Services
DOT	Directly Observed Therapy
DQA	Data Quality Assessment
DRV	darunavir
DTG	dolutegravir
DU	Drug User
DUO	Dual testing
EFV	Efavirenz
EIMS	Electronic Information Management System
ELISA	Enzyme Linked Immunosorbent Assay
EMTCT	Elimination of Mother to Child Transmission
EPTB	Extrapulmonary TB
FHB	Family Health Bureau
FPA	Family Planning Association
FSW	Female Sex Worker
FTC	emtricitabine
GFATM	Global Fund to fight AIDS, TB and Malaria
GC	Gonococcal
GH	General Hospital
GoSL	Government of Sri Lanka
GVAC	Global Validation Advisory Committee
H2H	Heart to Heart
HBsAg	Hepatitis B Surface Antigen
HCW	Health Care Worker

- HCG Human Chorionic Gonadotropin
- HCV Hepatitis C Virus
- HIV Human Immunodeficiency Virus
- HIVST HIV Self-Test
- HPV Human Papillomavirus
- HPE Health Products Equipment
- HR Human Resources
- HSS Health System Strengthening
- ICTA Information and Communication Technology Agency
- IEC Information Education and Communication
- KP Key population
- LFU Loss to follow up
- LPV/r Lopinavir /ritonavir
- MSM Men who have sex with men
- M&E Monitoring and Evaluvation
- NAC National AIDS Committee
- NBTS; National Blood Transfusion Service
- NCD non-communicable diseases
- NDDCB; National Dangerous Drug Control Board
- NGO non-governmental organization
- NRL National Reference Laboratory
- NSP National Strategic Plan
- OI Opportunistic Infections
- o-PEP Occupational Post Exposure Prophylaxsis
- PEP Post Exposure Prophylaxis
- PEPSE Post Exposure Prophylaxis following sexual exposure
- PrEP Pre Exposure prophylaxis
- PWID People who Inject Drugs
- SOP Standard Operational Procedures
- STD Sexually Transmitted Infections
- TAF Tenofovir alafenamide
- TDF Tenofovir disoproxil fumarate
- TPPA Treponema pallidum particle agglutination)
- UNFPA United Nations Population Fund
- VDRL Venereal Disease Research Laboratory
- WAD World AIDS Day
- WHO World Health Organization

Senior Management Team of the National STD/AIDS Control Programme (NSACP)



2nd row from left to right : Dr. Umedha Jayasinghe, Mr. Samantha Liyanage, Dr. Iruka Rajapaksha, Dr. Gayan Ariyadasa, Mr. Chandana Senaviratne, Dr. Pageeth Premadasa, Dr. Nimali Jayasuriya, Dr. Bandula Mayadunne, Dr. S. Muraliharan.

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Absent : Dr. Janaka Weragoda, Dr. Madhavi Gunathilaka

01 INTRODUCTION

The National STD/AIDS Control Programme (NSACP) of the Ministry of Health leads the national response to HIV and sexually transmitted infections (STIs) in Sri Lanka. The programme is responsible for the coordination, planning, and implementation of the National Strategic Plan for HIV, in alignment with the national AIDS policy. NSACP collaborates closely with a wide range of national and international stakeholders to ensure an effective and sustainable response.

The headquarters of NSACP is located at No. 29, De Saram Place, Colombo 10, Sri Lanka. A network of 40 full-time Sexual Health Clinics, supported by several branch and community clinics, serves as the primary service delivery platform of NSACP. These clinics are strategically distributed across all 25 districts of the country and provide comprehensive STI and HIV prevention, treatment, care, and support services.

Figure 1.1: Sexual Health clinics in Sri Lanka-2025



Table 1.1. Island wide Network of Sexual health Clinics , ART clinics and branch clinics

Province	District	ART clinic	Sexual health clinic	Branch clinic
Western province	**Colombo**	Colombo	Colombo	Prison clinic in Welikada
		Kalubowila	Kalubowilla	
		Awissawella	Awissawella	
		NIID	-	
		Homagama	Homagama	
	Gampaha	Ragama	Ragama	
		Gampaha	Gampaha	
		Negambo	Negombo	
		Wathupitiwala	Wathupitiwela	
	Kalutara	Kalutara	Kalutara	Horana, Pimbura
		Panadura	Panadura	
North western Province	**Kurunegala**	Kurunegala	Kurunegala	Nikaweratiya
		Kuliyapitiya	Kuliyapitiya	
	Puttalam	Chillow	Chilaw	
		Puttlam	Puttalam	
Northern Province	**Jaffna**	Jaffna	Jaffna	
	Mannar	-	Mannar	
	Kilinochchi	Kilinochchi	Kilinochchi	
	Mullaitivu	-	Mullaitivu	
	Vavuniya	Vavuniya	Vavuniya	
Eastern Province	**Batticaloa**	Batticaloa	Batticaloa	BH Walachchenei, BH Kalawanchikudi Kanthankudi
	Ampara	Ampara	Ampara	Mahaoya, Dehiaththakandiya
	Trincomalee	Trincomalee	Trincomalee	
	Kalmunai	Kalmunai	Kalmunai	BH Kalmunai North, BH Pottuvil
Uva Province	**Badulla**	Badulla	Badulla	
		-	Mahiyanganaya	
	Monaragala	Monaragala	Monaragala	
Southern Province	**Galle**	Galle (Mahamoidara)	Galle (Mahamodara)	
		Balapitiya	Balapitiya	
	Matara	Matara	Matara	
	Hambantota	Hambantota	Hambantota	
		Tangalle	Tangalle	

Sabaragamuwa Province	**Ratnapura**	Rathnapura	Ratnapura	BH Balangoda
		Embilipiya	Embilipitiya	
	Kegalle	Kegalle	Kegalle	Warakapola, Mawanella
Central Province	**Kandy**	Kandy	Kandy	Dumbara Prison clinic Nawalapitiya
	Matale	Matale	Matale	Wilgamuwa
		Dambulla	Dambulla	
	Nuwara Eliya	Nuwaraeliya	Nuwara Eliya	
North Central	**Anuradhapura**	Anuradhapura	Anuradhapura	
	Polonnaruwa	Polonnaruwa	Polonnaruwa	

Table 1.2. Community clinics in Colombo and Gampaha districts (Conducted by NSACP KP unit in 2025)

District	Location	KP Category served
Colombo	Al Akbar Mosque, Slave Island	People Who Use/ Inject Drugs PWUD/PWID
Colombo	Community centre, Mihindusenpura Flats, Dematagoda	People Who Use/ Inject Drugs PWUD/PWID
Colombo	Heart to Heart centre at Pagoda Road, Nugegoda	Men having sex with men (MSM)
Colombo	Community centre, by Mithuru Mithuro, Kollonnawa	Female sex workers (FSW)
Colombo	Community centre, Muvadhora Uyana Flats, Thotalanga, Grandpass	People Who Use/ Inject Drugs PWUD/PWID
Colombo	Silencer Waththa, Community Centre, Kirulapone	People Who Use/ Inject Drugs PWUD/PWID
Colombo	Community centre, Magazine Road, Borella	People Who Use/ Inject Drugs PWUD/PWID
Gampaha	SARD Community clinic, Nittabuwa, Wathupitiwala	Men having sex with Men (MSM)
Gampaha	Community Cenetre, by Mithuru Mithuro, & H2H Kandy Road, Kealaniya	Female Sex workers and Transgender(TG) community

Preventive services include a range of biomedical interventions such as condom promotion and distribution, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis following sexual exposure (PEPSE) and providing antiretroviral therapy for all people living with HIV(PLHIV). All services are provided free of charge, ensuring accessibility, availability, and equity in care. NSACP also delivers high-quality STI and HIV laboratory services through a well-established national laboratory network. The programme has further

strengthened its strategic information systems and digital health solutions to support data-driven decision-making. Sri Lanka remains firmly committed to achieving global HIV targets, including the UNAIDS 95–95–95 targets, and to ending AIDS as a public health threat by 2030. Significant progress has been made towards the elimination of mother-to-child transmission (EMTCT) of HIV and syphilis, supported by strong integration with maternal and child health services and effective inter-programme collaboration.

Vision

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

Mission

Quality sexual health services for a healthier nation.

Objectives

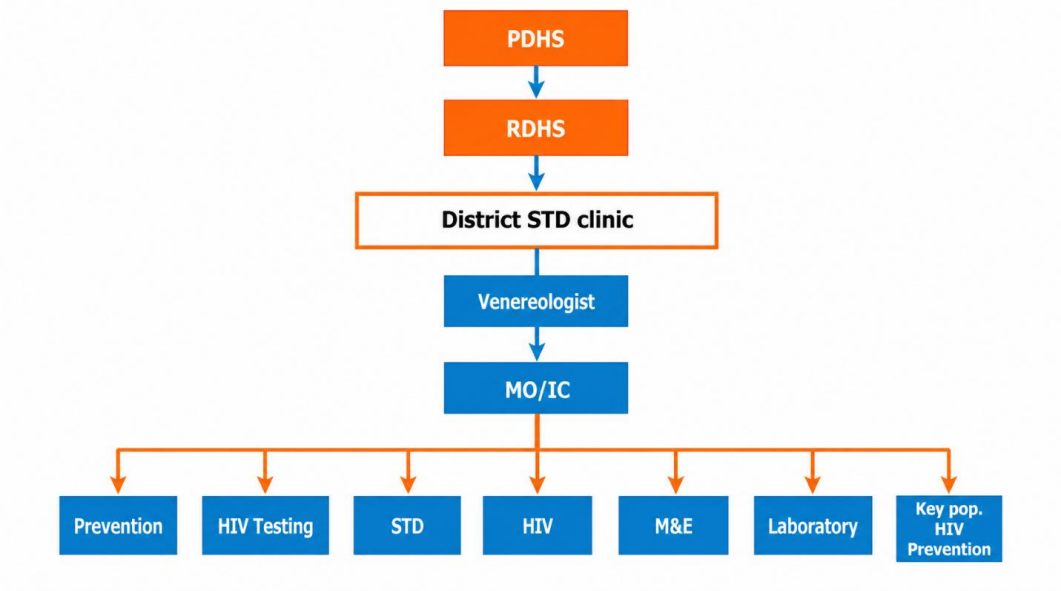
1. To prevent new HIV/STI infections among key populations, vulnerable populations, and the general population.
2. To ensure universal access to HIV/STI diagnosis, treatment, care, and support services.
3. To strengthen strategic information systems and knowledge management for an evidence-based response.
4. To strengthen health systems and ensure an effective multi-sectoral HIV/STI response.

Programme Structure and Service Delivery

Administratively, NSACP functions under the Ministry of Health, while most district-level Sexual Health Clinics operate under provincial health authorities. Together, they deliver comprehensive preventive, clinical, and laboratory services targeting both key populations and the general population.

A substantial proportion of preventive interventions is implemented at the district level, with active engagement of civil society organizations, community-based organizations, and affected communities. These efforts align with the national policy of a decentralized, rights-based HIV programme that promotes multi-sectoral collaboration and meaningful community participation.

Figure 1.2: Organigramme of sexual health clinic

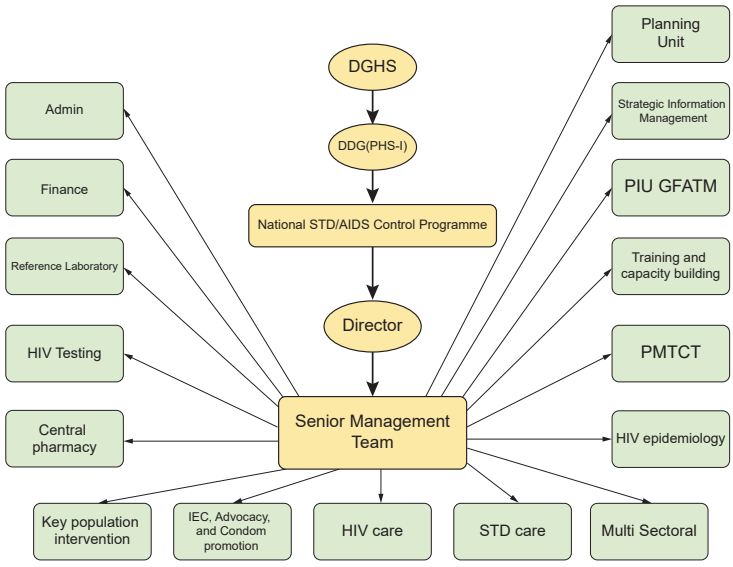


At the central level, NSACP is responsible for overall programme coordination, technical guidance, and monitoring and evaluation. Key functions include:

- Development of national guidelines and strategic plans
- Procurement of antiretroviral medicines and essential commodities
- Generation and management of strategic information
- Conducting surveillance and research activities
- Management of Global Fund/ government grants in collaboration with district clinics
- Capacity building and training of healthcare staff

These functions ensure the effective implementation and sustainability of the national HIV and STI response.

Figure 1.3: Organigramme of the National STD/AIDS Control Programme



National programme areas and coordinators of NSACP

	National programme area	Name of the coordinator
01	Administration	Dr. J.C.M. Tennekoon, Director, NSACP S. K. Liyanage, Administrative officer, NSACP
02	Strategic Information Management	Dr. K.A.M Ariyaratne, Consultant Venereologist
03	HIV Epidemiology	Dr. Madhavi Gunathilaka, Consultant Community Physician
04	HIV treatment and care	Dr. Umedha Jayasinghe, Consultant Venereologist
05	STD care and EMTCT programme	Dr. Nimali Jayasuriya, Consultant Venereologist
06	Laboratory services	Dr. Jayanthi Elwitigala, Consultant Microbiologist, Dr. Buddini Samaraweera, Consultant Virologist
07	Key population programme	Dr. Sathya Herath, Consultant Community Physician
08	Multisectoral Collaboration	Dr. Janaka Weragoda, Consultant Community Physician
09	IEC, Advocacy and Condom promotion	Dr. Vino Dharmakulasinghe, Consultant Venereologist
10	Training and Capacity building	Dr. Iruka Rajapakse, Consultant Venereologist
11	HIV testing	Dr. Waruni Pannala, Consultant Venereologist
12	Planning and implementation of Global fund project	Dr. Gayan Ariyadasa, Consultant Community Physician
13	Central Pharmacy	G.A.S.Madushani, Chief Pharmacist
14	Finance	Roshika Samankumari (Accountant NSACP) Chandana Senaviratne (GF Project Accountant)

NSACP continues to work in close collaboration with government institutions, civil society organizations, international development partners, and key population groups to ensure equitable access to high-quality, stigma-free services. The programme remains committed to expanding access to HIV testing and antiretroviral therapy (ART), Strengthening surveillance systems including community-based monitoring, integrating STI services within the broader health system aligning with global targets such as the UNAIDS 95–95–95 goals and the Sustainable Development Goals. Through these efforts, NSACP continues to adapt to emerging public health challenges while sustaining progress towards ending AIDS as a public health threat in Sri Lanka.

02 Epidemiology of HIV in Sri Lanka

MADHAVI GUNATHILAKA [2], ARIYARATNE MANATHUNGE [1]

According to the latest UNAIDS estimates, the global HIV epidemic continued to show substantial progress in 2025; however, significant gaps remained in HIV prevention, testing, treatment, and access to services. Globally, an estimated 41 million people were living with HIV in 2025. Approximately 1.2 million people [950,000–1.7 million] newly acquired HIV, representing a 42% decline compared with 2010 and demonstrating considerable progress in the global HIV response. This highlights the continued need to strengthen HIV prevention, testing, early diagnosis, treatment, and access to comprehensive HIV services. An estimated 570,000 people [430,000–780,000] died from AIDS-related illnesses during the same year.

According to UNAIDS, the risk of acquiring HIV is approximately 18 times higher among gay men and other men who have sex with men (MSM), 17 times higher among sex workers, 34 times higher among people who inject drugs, and 17 times higher among transgender women compared with the general adult population. In addition, HIV prevalence among people in prisons and other closed settings is approximately twice as high as in the general adult population. These disparities highlight the importance of addressing structural barriers, stigma, and discrimination while ensuring equitable access to comprehensive HIV prevention, testing, treatment, and care services for key populations.

Overview

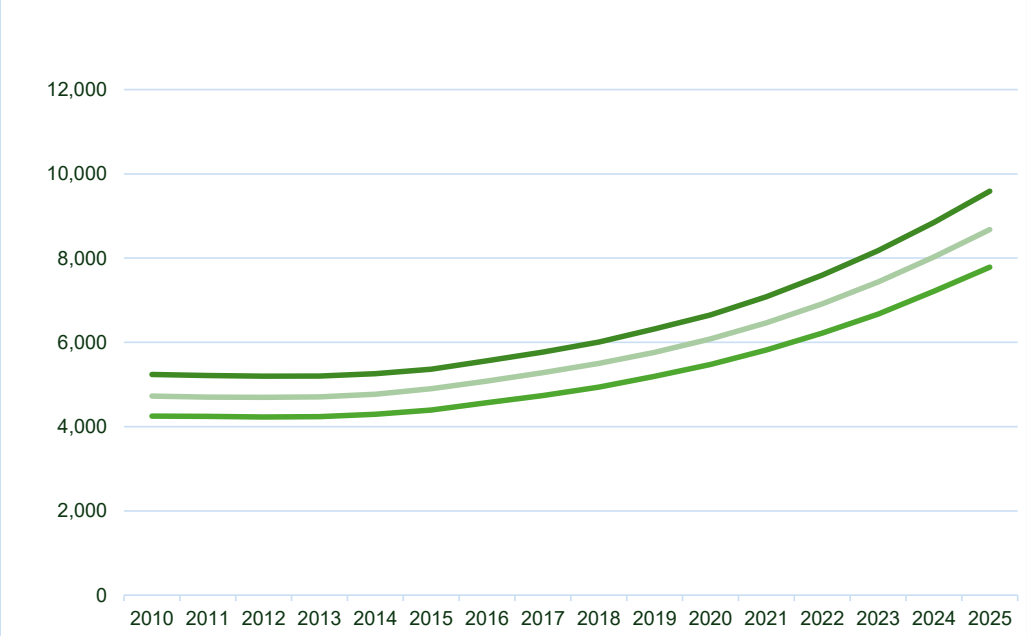
Sri Lanka has historically been classified as a low-prevalence country for HIV, with a concentrated epidemic primarily affecting key populations. However, surveillance data and modeled estimates over the past decade indicate a significant shift in the epidemiological landscape, characterized by accelerating transmission, a growing burden among young people, and an increasing concentration of new infections among men who have sex with men (MSM). Against this evolving backdrop, the Annual Health Report on HIV provides a comprehensive overview of the country's epidemiological situation, programmatic response, and emerging trends in HIV transmission, treatment, and care over the reporting year. It synthesizes surveillance data, including new infections, people living with HIV, AIDS-related mortality, and key population trends, to inform evidence-based decision-making for the national HIV response. By documenting both progress achieved and challenges that remain, the report aims to guide stakeholders in strengthening prevention, testing, and treatment services, bringing Sri Lanka closer to ending HIV as a public health threat.

HIV Estimates

People Living with HIV

The estimated number of people living with HIV (PLHIV) in Sri Lanka has grown steadily over the reporting period, rising from under 200 in early years to approximately 8,700 (range: 7,800–9,600) in 2025. Growth was particularly rapid through the early-to-mid period, after which the estimate plateaued around 4,700 for several consecutive years (remaining relatively stable between 2010 and 2013). From 2014 onwards, a gradual rise resumed, with the increase becoming more pronounced after 2020. Overall, PLHIV estimates increased by roughly 85% over the last decade, reaching current levels. This sustained increase reflects both ongoing new infections and the cumulative effect of improved survival due to ART, resulting in a growing number of people living with HIV who require continued care and treatment services.

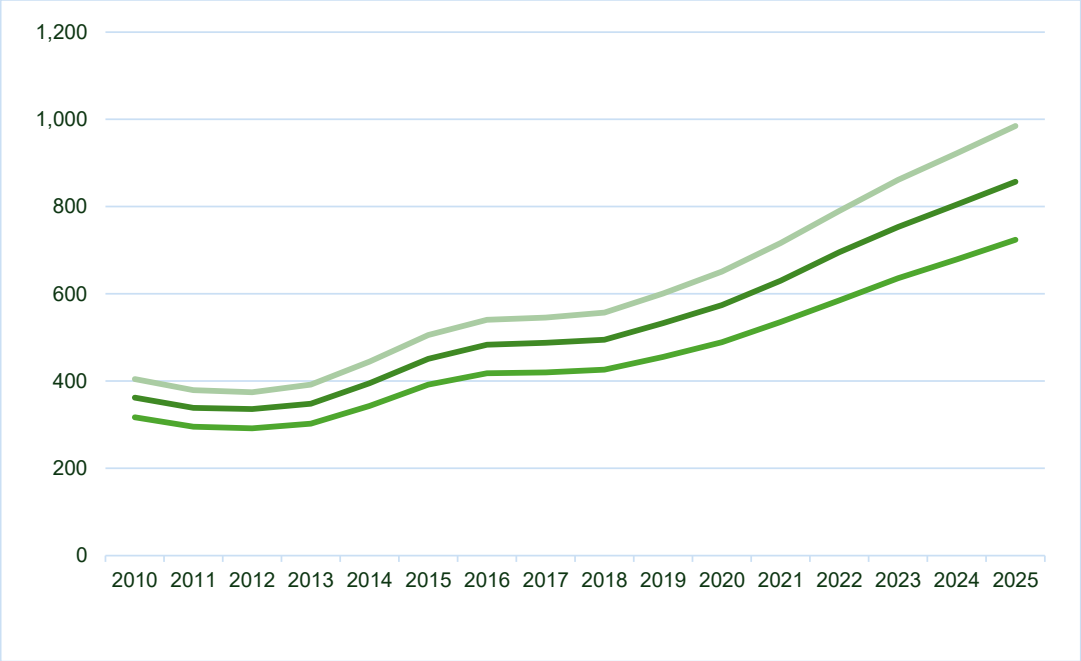
Figure 2.1: The estimated number of people living with HIV (PLHIV) in Sri Lanka (2025)



New HIV Infections

Sri Lanka's HIV epidemic has historically remained at low levels, with estimated new infections under 500 per year for most of the reporting period. From a slight decline between 2010 and 2012, new infections began rising steadily from 2013 onwards, increasing from approximately 360 cases in 2010 to about 860 cases in 2025. The increase became more pronounced after 2020, with new infections rising rapidly each year to reach approximately 800–980 by 2025 — more than double the level observed in 2010. This clear upward trend indicates a growing epidemic that warrants increased prevention efforts, particularly among key populations such as MSM.

Figure 2.2: New HIV Infections in Sri Lanka (2025)



HIV treatment cascade and progress towards the 95-95-95 targets (2025)

The 2025 HIV treatment cascade and progress towards the 95-95-95 targets demonstrate important gaps across the HIV care continuum. Overall, 66% of people living with HIV knew their HIV status. Among those who knew their status, 79% were receiving antiretroviral treatment (ART), and 89% of people receiving ART had achieved viral suppression. When considered among all people living with HIV, this corresponds to 52% receiving ART and 46% having a suppressed viral load.

The largest gap is at the first stage HIV diagnosis, with only 66% of people living with HIV aware of their status, indicating the need to strengthen HIV testing and case-finding strategies. Although treatment coverage among those diagnosed is relatively high, it remains below the 95% target, highlighting the need for prompt linkage to care and timely ART initiation. The relatively high level of viral suppression among those on ART (89%) is encouraging; however, the overall proportion with viral suppression remains low because of gaps in diagnosis and treatment coverage. Overall, these findings emphasize the need to strengthen HIV testing, early diagnosis, linkage to care, rapid ART initiation, retention in treatment, and adherence support to improve the HIV cascade and move towards the 95-95-95 targets.

Figure 2.3: HIV treatment cascade (2025)

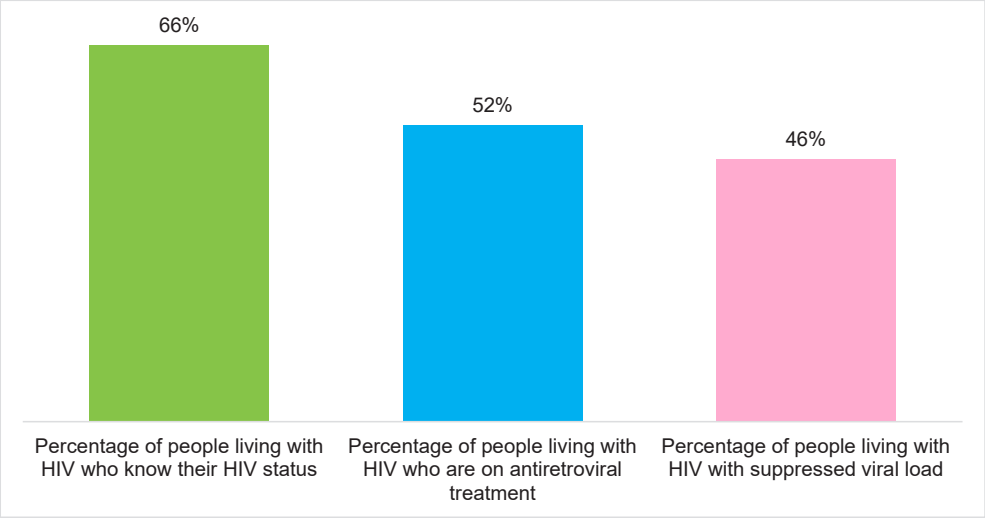
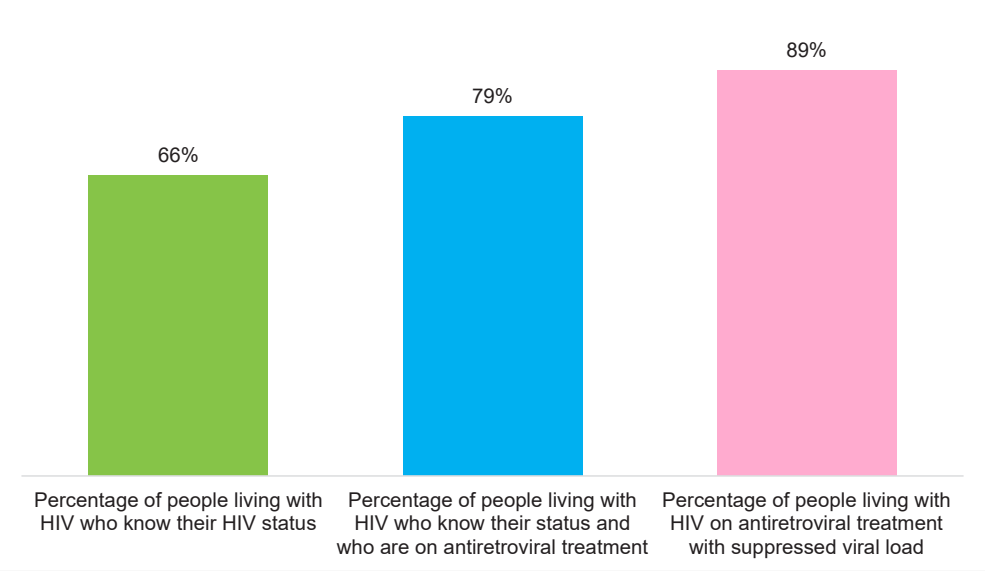


Figure 2.4: Progress towards the 95-95-95 targets (2025)



AIDS-Related Deaths

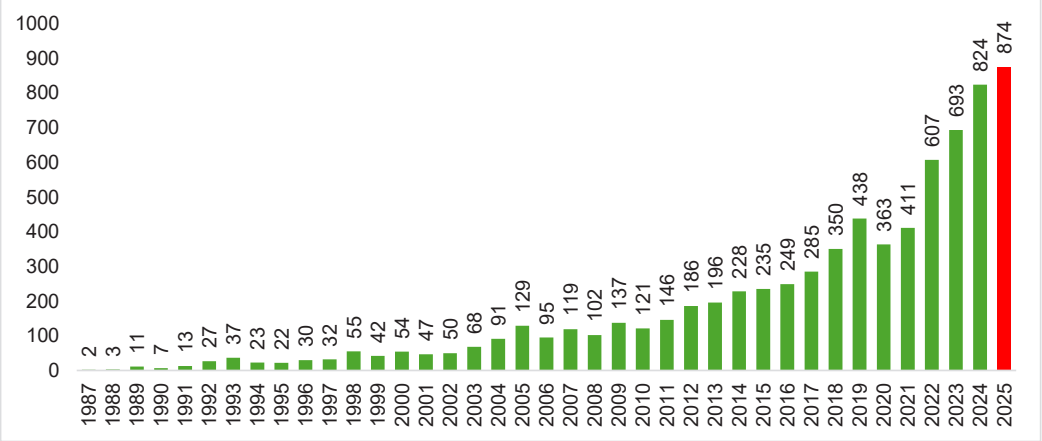
In contrast to the rising trends in new infections and PLHIV, AIDS-related deaths in Sri Lanka have remained consistently low, staying under 500 annually, with most years recording fewer than 100–200 deaths. The 2025 estimate remains below 500 (low: <200), reflecting sustained low mortality likely attributable to effective ART coverage and treatment access. This sustained low mortality, despite rising case numbers, underscores the success of Sri Lanka's treatment programs even as prevention challenges grow.

Trends in Reported Cases

Since the first case was reported in 1987, the cumulative number of reported HIV cases in Sri Lanka has grown steadily, with a marked acceleration evident from 2017 onwards.

Annual reported reached 874 in 2025, the highest annual figure on record. This represents more than a three-fold increase within less than a decade, signaling either a genuine expansion of the epidemic, substantial improvements in case detection through expanded testing services, or, more likely, a combination of both. These programmatic data align closely with the rising trend observed in HIV estimates, reinforcing the picture of an epidemic in transition from a low-level to a growing concentrated epidemic.

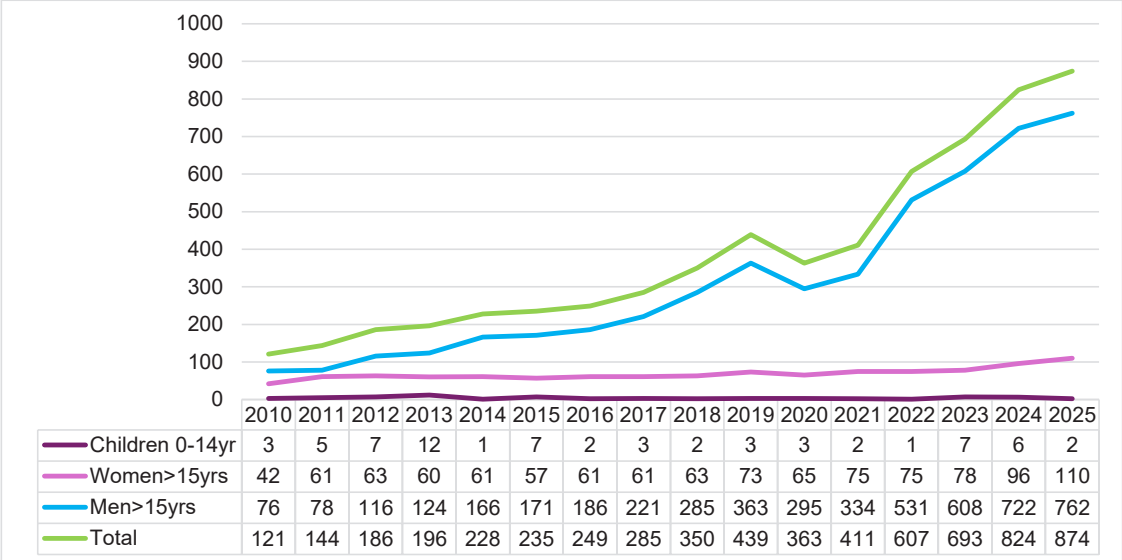
Figure 2.5: Trends in reported cases from 1987-2025



The cumulative number of reported HIV cases in Sri Lanka has risen steadily since the first case was recorded in 1987, reaching a total of 7,403 cases by 2025. Growth remained gradual and relatively flat through the 1990s and 2000s, before accelerating noticeably from around 2015 onwards. This exponential rise in recent years reflects the compounding effect of increasing annual case detection, underscoring the growing scale of Sri Lanka's HIV epidemic over time.

Reporting of HIV cases by age and sex

Figure 2.6: Reporting of HIV Cases by Age and Sex



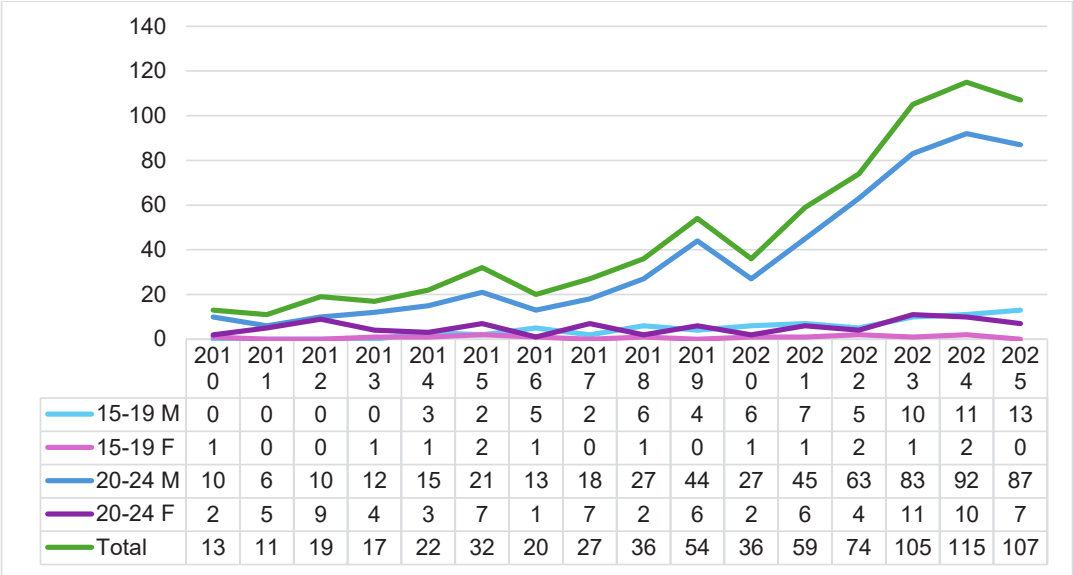
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Children 0-14yr	3	5	7	12	1	7	2	3	2	3	3	2	1	7	6	2
Women>15yrs	42	61	63	60	61	57	61	61	63	73	65	75	75	78	96	110
Men>15yrs	76	78	116	124	166	171	186	221	285	363	295	334	531	608	722	762
Total	121	144	186	196	228	235	249	285	350	439	363	411	607	693	824	874

Reported HIV cases in Sri Lanka by age and sex show a clear and growing male predominance, with cases among men over 15 years rising sharply from 76 in 2010 to 762 in 2025, far outpacing the more modest increase among women over 15 years (42 to 110 over the same period). Cases among children aged 0-14 years have remained low and stable throughout, never exceeding 12 annually, indicating limited mother-to-child transmission. The total case count, which closely tracks the male trend line, rose from 121 in 2010 to a record 874 in 2025, with a particularly steep acceleration after 2020, underscoring that the recent surge in Sri Lanka's HIV epidemic is being driven predominantly by adult men.

Reporting of HIV cases among 15-24 age group

HIV cases among the 15-24 age group in Sri Lanka have risen sharply since 2010, increasing from 13 cases to a peak of 115 in 2024, before slightly declining to 107 in 2025. The 20-24 male age group has consistently driven this trend, growing from just 10 cases in 2010 to 87-92 in recent years, accounting for the majority of cases in this cohort. The 15-19 male group also shows a steady increase, particularly from 2018 onwards, reaching 13 cases in 2025. In contrast, both female sub-groups (15-19 F and 20-24 F) have remained low and relatively stable throughout the period, rarely exceeding single digits. This pattern indicates that the rising HIV burden among youth is overwhelmingly concentrated among young males, particularly those aged 20-24, likely reflecting transmission dynamics linked to the MSM epidemic.

Figure 2.7: Reporting of HIV cases among 15-24 age group



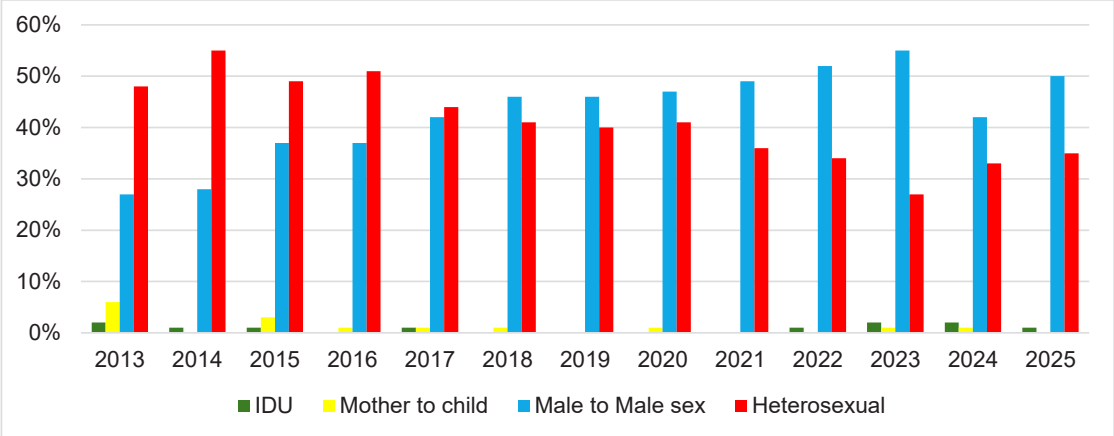
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
15-19 M	0	0	0	0	3	2	5	2	6	4	6	7	5	10	11	13
15-19 F	1	0	0	1	1	2	1	0	1	0	1	1	2	1	2	0
20-24 M	10	6	10	12	15	21	13	18	27	44	27	45	63	83	92	87
20-24 F	2	5	9	4	3	7	1	7	2	6	2	6	4	11	10	7
Total	13	11	19	17	22	32	20	27	36	54	36	59	74	105	115	107

Mode of transmission

The probable mode of HIV transmission in Sri Lanka has shifted markedly since 2013, with heterosexual transmission initially dominant (peaking near 55% in 2014) before declining steadily over the following decade to around 33-35% by 2024-2025. In contrast, male-to-male sex has shown a consistent upward trend, overtaking heterosexual transmission

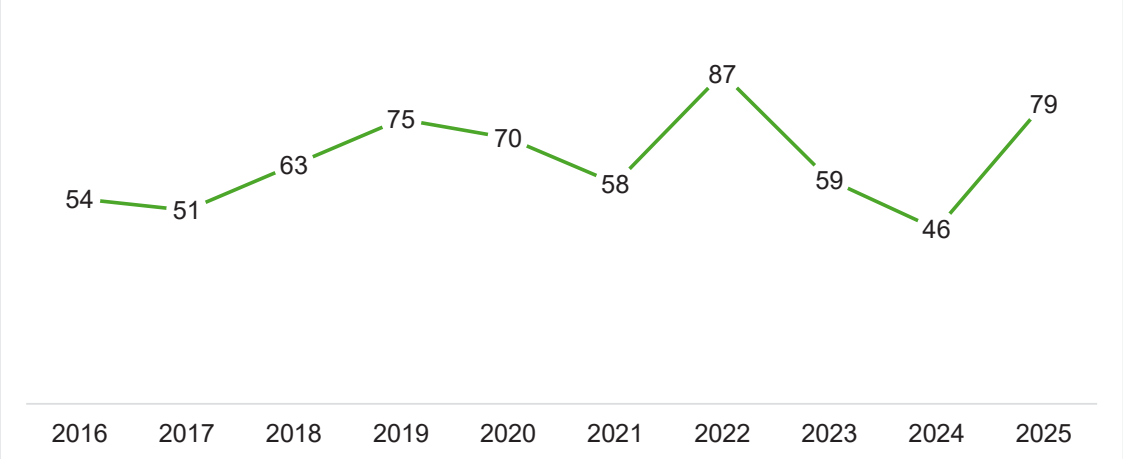
as the leading mode from around 2018 onwards, and reaching approximately 50-55% in recent years (2022-2025). Meanwhile, transmission via injecting drug use (IDU) and mother-to-child transmission (MTCT) have remained consistently low, each under 5% throughout the period. This crossover pattern highlights an epidemic increasingly driven by sexual transmission among MSM, reinforcing the need for targeted prevention efforts for this key population.

Figure 2.8: Mode of transmission among reported cases from 2013-2025



Deaths in HIV patients

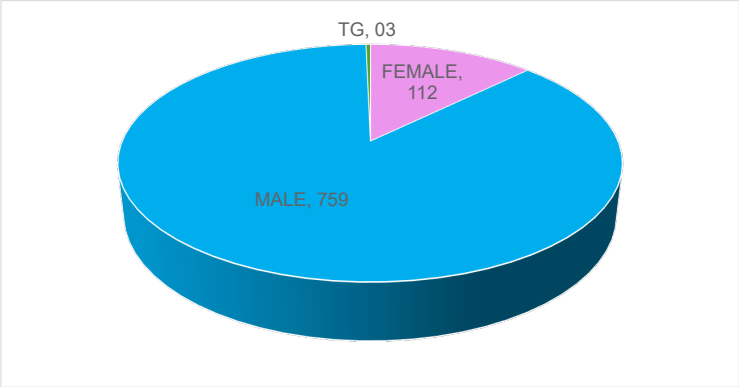
Figure 2.9: Reporting of deaths in HIV patients



Deaths among HIV patients in Sri Lanka have fluctuated over the past decade without a clear sustained trend, starting at 54 in 2016 and dipping slightly to 51 in 2017, before rising steadily to a peak of 87 in 2022. Following this peak, deaths declined to 46 in 2024, with a slight uptick to 79 in 2025. Overall, annual deaths have remained within a relatively narrow range of roughly 46-87 throughout the period, suggesting relatively stable mortality despite the rising trend in new HIV diagnoses over the same timeframe.

Reported data in 2025

Figure 2.10: Gender distribution in reported HIV cases

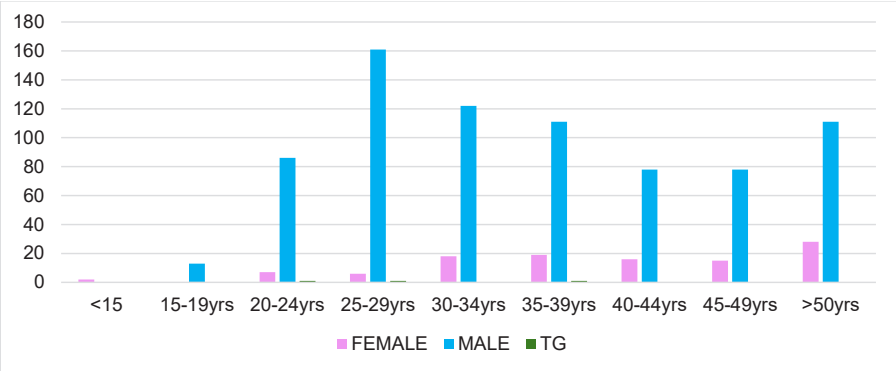


In 2025, the gender distribution of reported HIV cases in Sri Lanka shows a strong male predominance, with men accounting for 759 cases (87%) compared to 112 females (13%) and just 3 transgender individuals. This stark imbalance reflects the increasingly male-concentrated nature of the epidemic, consistent with the rising contribution of male-to-male transmission observed in recent years.

Age distribution of reported HIV cases

The age distribution of HIV cases in Sri Lanka in 2025 shows a clear concentration among males, with the highest burden in the 25-29 year age group (over 160 cases), followed by substantial numbers in the 30-34, 35-39, and over-50 age groups (110-125 cases each). Female cases remain comparatively low across all age groups, generally under 20, with a slightly higher count in the over-50 category (around 28 cases). Transgender cases are minimal across all age groups, while cases under 15 years are negligible, reinforcing that the epidemic is predominantly affecting young to middle-aged adult males.

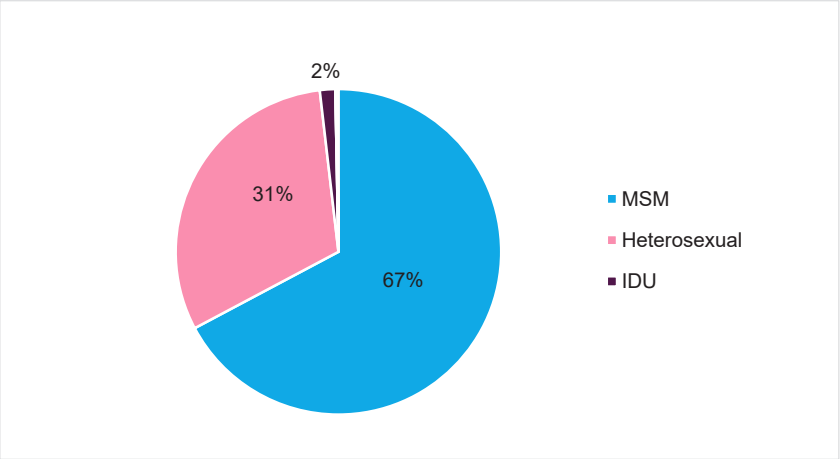
Figure 2.11: Age distribution of reported HIV cases



Mode of transmission in males in 2025

Among males with a declared mode of transmission, male-to-male sex (MSM) accounts for the majority at 67%, followed by heterosexual transmission at 31%, with injecting drug use (IDU) and other routes contributing minimally (around 2%). Notably, 113 male cases did not declare their mode of transmission, but among those who did, the data clearly confirm MSM as the predominant transmission route driving the male HIV burden in Sri Lanka.

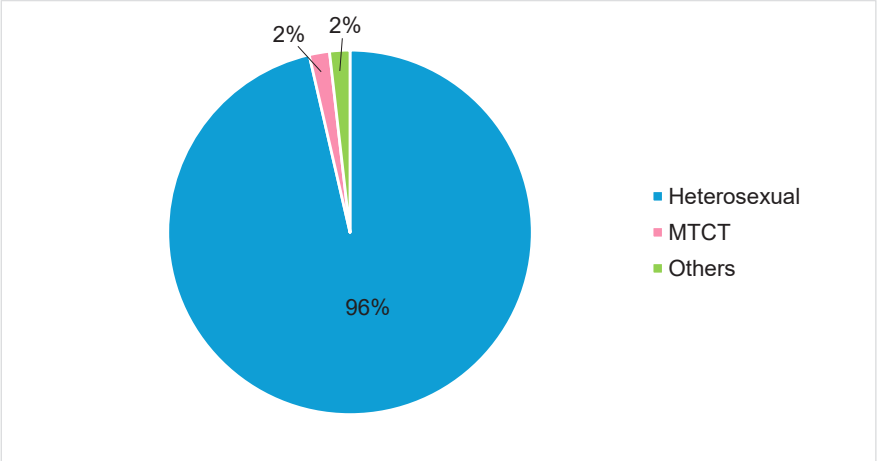
Figure 2.12: Mode of transmission in males



Mode of transmission in females in 2025

Among females, heterosexual transmission overwhelmingly accounts for the mode of HIV transmission at 96%, with the remaining small fractions attributed to mother-to-child transmission. This pattern contrasts sharply with the male transmission profile, confirming that heterosexual contact remains the near-exclusive route of infection among women in Sri Lanka.

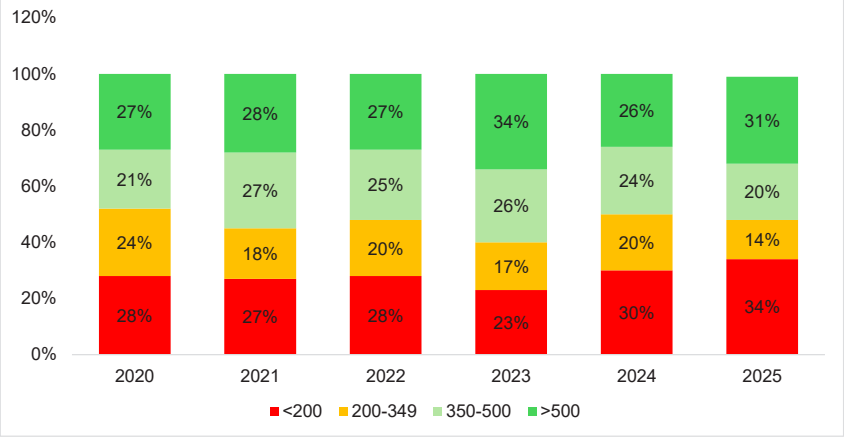
Figure 2.13: Mode of transmission in females



Baseline CD4 counts in patients dignosed withHIV

The stacked bar chart illustrates the percentage distribution of CD4 count categories among a patient population over a six-year period (2020–2025). CD4 counts are a critical marker of immune health in HIV-positive individuals, and the data is segmented into four clinically meaningful categories. CD4 count indicates the level of immune function: <200 cells/mm³ – severe immunosuppression; 200–349 – moderate; 350–500 – mild; >500 – normal/healthy immune function.

Figure 2.14: Percentage distribution of CD4 count categories



Over the five-year period, the data reveals a complex and mixed picture of immune health. While there is a commendable increase in the proportion of patients achieving healthy CD4 counts (>500), this progress is overshadowed by an alarming rise in severe immunosuppression (<200) by 2024–2025. The declining middle categories further suggest a bifurcation of outcomes within the patient population.

Implications for the National Response

These trends collectively indicate that Sri Lanka's HIV epidemic is shifting from a historically low and stable pattern to one characterized by accelerating transmission, particularly among MSM and younger age groups. While the treatment cascade appears robust as evidenced by low and stable mortality prevention efforts have not kept pace with the changing transmission dynamics. This underscores the urgent need for:

- Scaled-up, targeted prevention programs for MSM, including expanded access to PrEP, condoms, and lubricants
- Enhanced case-finding through community-based and self-testing approaches tailored to young MSM
- Strengthened behavioral surveillance, such as the IBBS survey, to better understand risk behaviors and inform targeted interventions
- Youth-friendly, stigma-free health services that address the specific needs of young MSM entering the epidemic
- Continued investment in ART scale-up to maintain low mortality as the PLHIV population grows
- addressing the rising proportion of patients with CD4 counts below 200, including strengthening treatment adherence programs, improving early diagnosis, and reducing loss to follow-up

Without intensified and targeted prevention efforts focused on MSM and youth, Sri Lanka risks a continued escalation of its HIV epidemic, threatening to reverse decades of progress in maintaining a low-prevalence status.

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03 EPIDEMIOLOGY OF SEXUALLY TRANSMITTED INFECTIONS-2025

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Sexually transmitted infections (STIs) continue to represent a significant and evolving public health challenge globally and within Sri Lanka. Despite substantial progress in diagnostics, treatment, and prevention strategies, STIs remain a major contributor to morbidity, adverse reproductive health outcomes, and increased susceptibility to human immunodeficiency virus (HIV) infection. Understanding the epidemiological patterns of STIs is therefore essential for guiding effective prevention, surveillance, and control strategies.

The global response to STIs is currently aligned with the Global Health Sector Strategies on HIV, Viral Hepatitis and STIs (2022–2030) led by the World Health Organization, which aims to eliminate STIs as public health concerns by 2030. The persistence and resurgence of STIs highlight several underlying challenges, including asymptomatic infections, stigma and discrimination, gaps in health-seeking behavior, and inequities in access to care.

Table 3.1: Number of STIs reported by age and sex- 2025

No.	STI diagnosis	Men <25 years	Women <25 years	Men ≥25 years	Women ≥25 years	Total	%
1	Early syphilis	117	51	391	124	683	6.0%
2	Late syphilis	55	24	359	157	595	5.2%
3	Early Congenital Syphilis	3	3	1	2	9	0.1%
4	Late Congenital Syphilis	1	-	-	1	2	0.0%
5	Hepatitis B	7	-	42	12	61	0.5%
6	Hepatitis C	39	7	70	9	125	1.1%
7	Gonorrhoea and presumptive GC	149	24	445	74	692	6.1%
8	Ophthalmia neonatorum	-	3	5	15	23	0.2%
9	NGU/NGC	143	293	573	1,838	2,847	25.1%
10	Mycoplasma genitalium	3	4	11	25	43	0.4%
11	1st episode genital herpes	140	343	761	1,132	2,376	20.9%
12	Recurrent genital herpes	34	54	230	226	544	4.8%
13	1st episode genital warts	224	178	899	756	2,057	18.1%
14	Recurrent genital warts	18	11	140	58	227	2.0%
15	Pelvic inflammatory disease	-	8	-	61	69	0.6%
16	Trichomoniasis	5	3	21	43	72	0.6%
17	Epididymo-orchitis	15	-	55	-	70	0.6%
18	Scabies	90	5	163	14	272	2.4%
19	Pthirus pubis infection (lice/crabs)	1	-	3	1	5	0.0%
20	Genital molluscum contagiosum	14	6	59	21	100	0.9%
21	Other STIs	51	40	205	188	484	4.3%
	Total	**1,109**	**1,057**	**4,433**	**4,757**	**11,356**	**100.0%**

A total of 11,356 of various sexually transmitted infections (STIs) diagnosed among patients attending STD clinics island wide, with a higher STIs reporting from women: 5,542 men (48.8%) and 5,814 women (51.2%).

Figure 3.1: STIs reported from STD clinics by sex during 2025

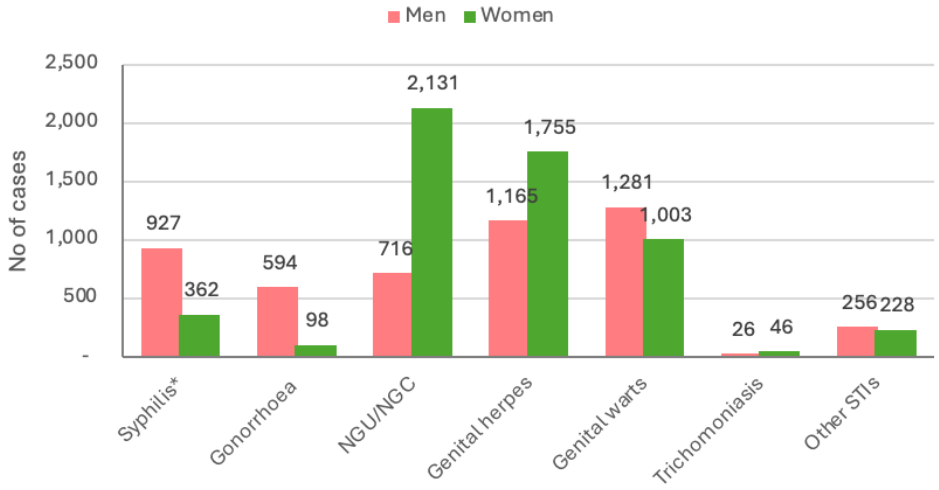
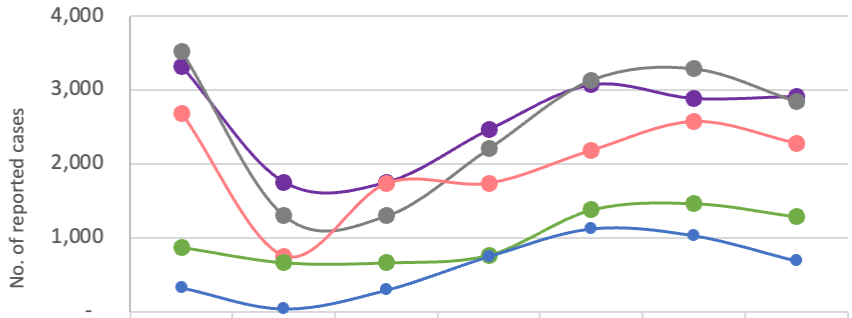


Figure 3.1 shows the STIs reported from STD clinics by sex during 2025. Genital herpes and non-gonococcal infections and trichomoniasis have reported more among women.

Figure 3.2. Trend of number of reported STIs, 2019-2025



	2019	2020	2021	2022	2023	2024	2025
Genital herpes	3,326	1,753	1,753	2,469	3,077	2,891	2,920
Non-gono. infections	3,527	1,302	1,302	2,213	3,139	3,292	2,847
Genital warts	2,687	757	1,741	1,743	2,189	2,579	2,284
Syphilis*	876	666	666	770	1,383	1,469	1,289
Gonorrhoea	331	46	301	754	1,128	1,035	692

* All forms of syphilis

Figure 3.2 illustrates the temporal trends in selected sexually transmitted infections (STIs) reported from 2019 to 2025. Overall, a marked decline in reported cases was observed in 2020 across all STI categories, likely reflecting disruptions to healthcare services during the COVID-19 pandemic. This was followed by a steady upward trend from 2021 onwards. Non-gonococcal infections and genital herpes consistently accounted for the highest number of reported cases throughout the period. Non-gonococcal infections peaked in 2024 (3,292 cases) before showing a slight decline in 2025 (2,847 cases). Similarly, genital herpes increased from 1,753 cases in 2021 to a peak of 3,077 cases in 2023, followed by a modest decline thereafter. Gonorrhoea exhibited the most pronounced fluctuation, with a sharp drop in 2020, a rapid increase to 1,128 cases in 2023, and a notable decline to 692 cases in 2025. These trends highlight the ongoing need for strengthened STI prevention, screening, and treatment services.

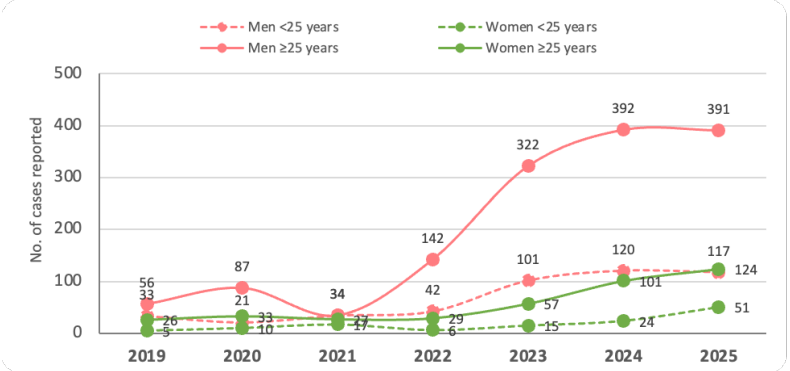
Syphilis

Syphilis is a sexually transmitted infection caused by a spirochete named Treponema pallidum. It can progress through several stages, namely primary, secondary and tertiary, if not treated adequately. Apart from that, syphilis can cause congenital infection due to mother-to-child transmission.

Early Syphilis

Early syphilis is a highly contagious stage of syphilis. This stage can be further divided into primary, secondary and early latent stages. Without appropriate treatment, the disease can progress into late stages affecting multiple organ systems. Early diagnosis and proper treatment are the corner stones in preventing complications and onward transmission.

Figure 3.3: Early syphilis cases by age and sex - 2019-2025

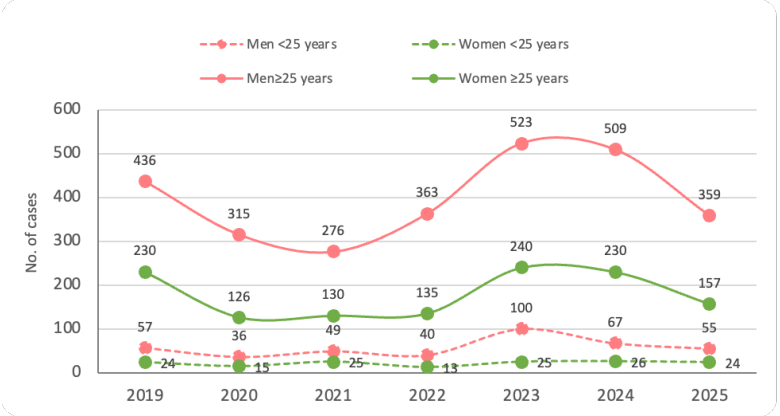


In 2025, 683 early syphilis cases were reported—508 men (74.3%) and 175 women (25.5%)—accounting for 6 % of all STI diagnoses. This continues the upward trend observed in previous years, particularly among men aged 25 years and older, who showed a sharp increase from 56 cases in 2019 to 392 in 2024, while 2025 showed almost the same number of cases. Younger men also showed increasing numbers, while cases women remained lower with modest changes.

This trend highlights a growing burden among men, indicating the need for targeted screening, early diagnosis, and treatment strategies.

Late Syphilis

Figure 3.4: Number of late syphilis cases reported from STD clinics by age and sex -2019-2025



In 2025, altogether 595 cases of late syphilis were recorded—414 men (69.5%) and 181 women (30.4%)—making up 5.2% of all STI cases. This shows a declining trend following a peak in 2023 where there were 623 cases among men and 265 cases among women. Since then, numbers of reported late syphilis cases among all age and sex groups show a downward trend.

Congenital Syphilis, 2019 – 2025

Figure 3.5: Trend of congenital syphilis rate per 100,000 live births, 2019-2025

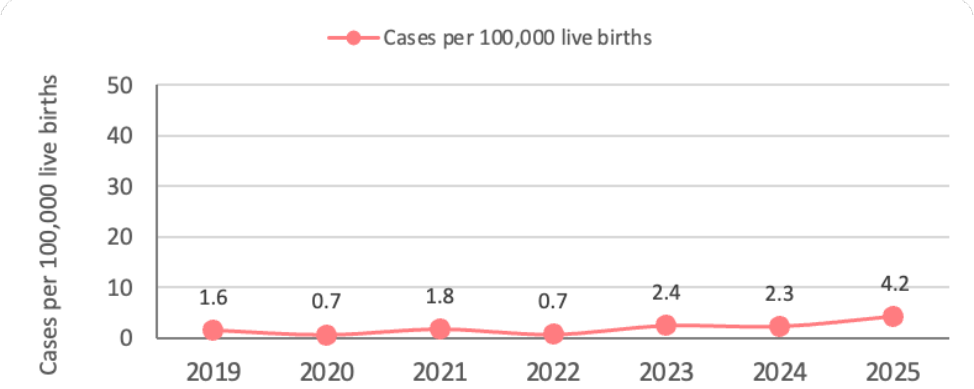
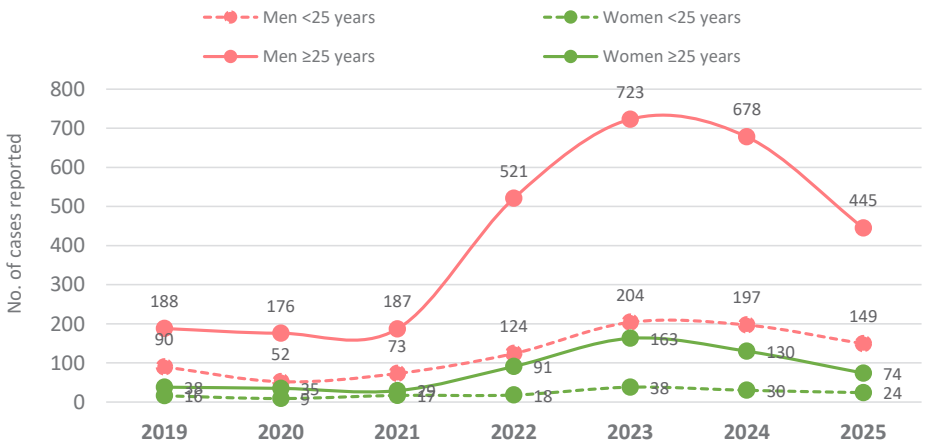


Figure 3.5 shows the rate of congenital syphilis cases per 100,000 live births. Although congenital syphilis case rates are much lower than the target given by the World Health Organization for EMTCT validation purpose of less than 50 per 100,000 live births, Sri Lanka's congenital syphilis case rate shows an upward trend over this period.

Gonorrhoea

Gonorrhoea is a common sexually transmitted infection caused by Neisseria gonorrhoeae, affecting the urethra, cervix, rectum, pharynx, and conjunctiva. A substantial proportion of infections—particularly among women—are asymptomatic, contributing to ongoing transmission and delayed diagnosis. When present, symptoms may include urethral or vaginal discharge and dysuria. Untreated infection can lead to serious complications such as pelvic inflammatory disease, infertility, ectopic pregnancy, and increased risk of HIV acquisition and transmission.

Figure 3.6: Gonorrhoea cases by age and sex - 2019-2025

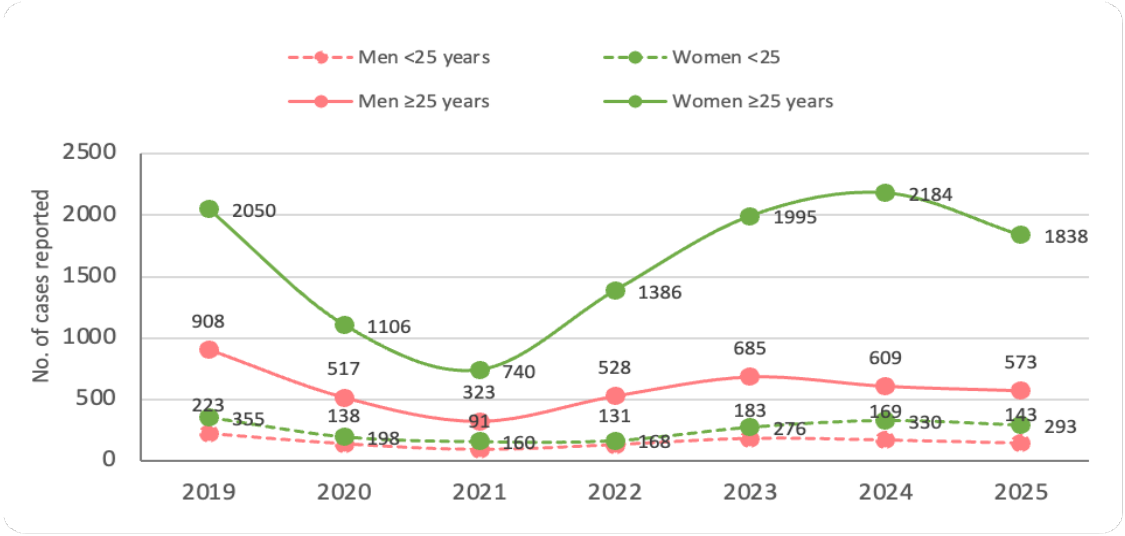


The figure demonstrates that gonorrhoea cases are consistently higher among men, particularly those aged ≥25 years, who account for most reported infections throughout the period. A sharp decline is observed in 2020 across all groups, followed by a marked increase from 2021, peaking in 2023. Although cases declined in 2024 and further in 2025, levels remain higher than pre-pandemic figures. Women show comparatively lower-case numbers, with a modest rise among those aged ≥25 years after 2021, while cases among younger women (<25 years) remain consistently low.

Non-gonococcal infections

Non-gonococcal infections, most caused by Chlamydia trachomatis, Mycoplasma genitalium, and Ureaplasma urealyticum, are among the most frequently reported sexually transmitted infections. They often present with urethritis or cervicitis, though a large proportion—especially in women—remain asymptomatic, contributing to ongoing transmission. If left untreated, non-gonococcal infections can lead to complications such as pelvic inflammatory disease, infertility and adverse pregnancy outcomes.

Figure 3.7: Non-gonococcal infection cases by age and sex - 2019-2025



In 2025, 2,847 cases of non-gonococcal infections were reported from STD clinics, comprising 2,131 women (74.9%) and 716 men (25.1%), making up 25.1% of all STI diagnoses. This condition was the second most reported STI among women.

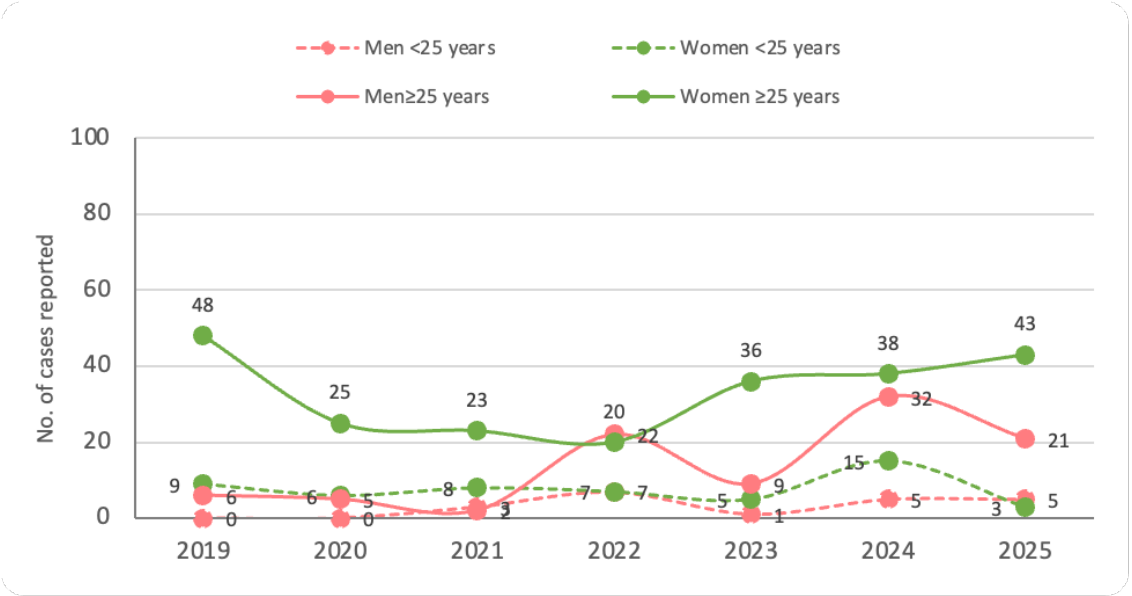
Non-gonococcal infections show a marked decline across all groups in 2020–2021, followed by a steady increase from 2022 onwards. Women aged ≥25 years consistently account for the highest number of cases, with a pronounced rise peaking in 2024 before a slight decline in 2025.

Trichomoniasis

Trichomonas vaginalis is a protozoan parasite that causes trichomoniasis, a common sexually transmitted infection affecting both men and women. Infection is often asymptomatic, particularly in men, but in women it may present with vaginal discharge,

itching, and dysuria. It is clinically important due to its association with adverse reproductive outcomes and increased susceptibility to HIV infection.

Figure 3.8: Trichomoniasis in all STD Clinics end of 2025



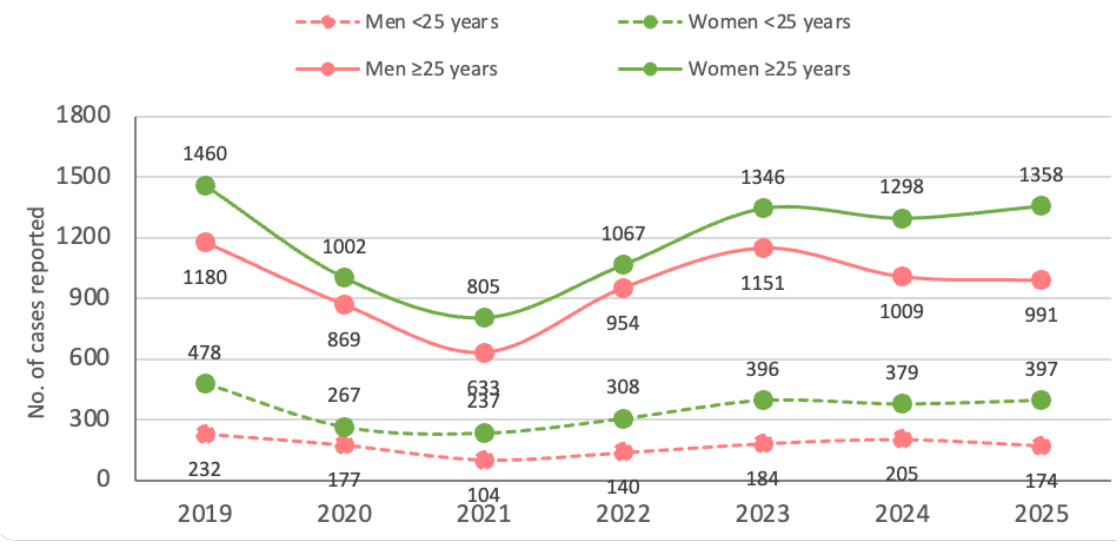
In 2025, 72 cases of trichomoniasis were reported from STD clinics across Sri Lanka, with 46 women and 26 men affected. Trends from 2019 to 2024 showed that women aged 25 years and older consistently had the highest number of cases, rising from 25 in 2020 to 38 in 2024. A change in the trend can be observed in 2025 with a marked decline in cases among men >25 and a slight decline is observed among women >25.

Genital herpes

Herpes simplex virus (HSV) is a common viral cause of sexually transmitted infections, primarily due to HSV-2, although HSV-1 is increasingly recognized in genital infections. It typically presents with painful vesicular lesions or ulcers in the genital and perianal regions, often accompanied by recurrent episodes due to viral latency in sensory nerve ganglia. A significant proportion of infections are asymptomatic or unrecognized, allowing continued transmission through asymptomatic viral shedding.

HSV infection is lifelong and has important public health implications. It is associated with an increased risk of HIV acquisition and transmission, and in pregnancy, primary infection—especially in late gestation—can result in severe neonatal herpes. While there is no cure, antiviral therapy such as acyclovir effectively reduces symptom severity, duration, and frequency of recurrences, as well as viral shedding.

Figure 3.9: Number of genital herpes cases by age and sex, 2019 - 2025



In 2025, a total of 2,920 genital herpes cases were reported from STD clinics across Sri Lanka, with women accounting for 1,755 cases (60.1%) and men for 1,165 cases (39.8%). Genital herpes represented approximately 25% of all reported STI diagnoses, making it one of the most observed infections during the year.

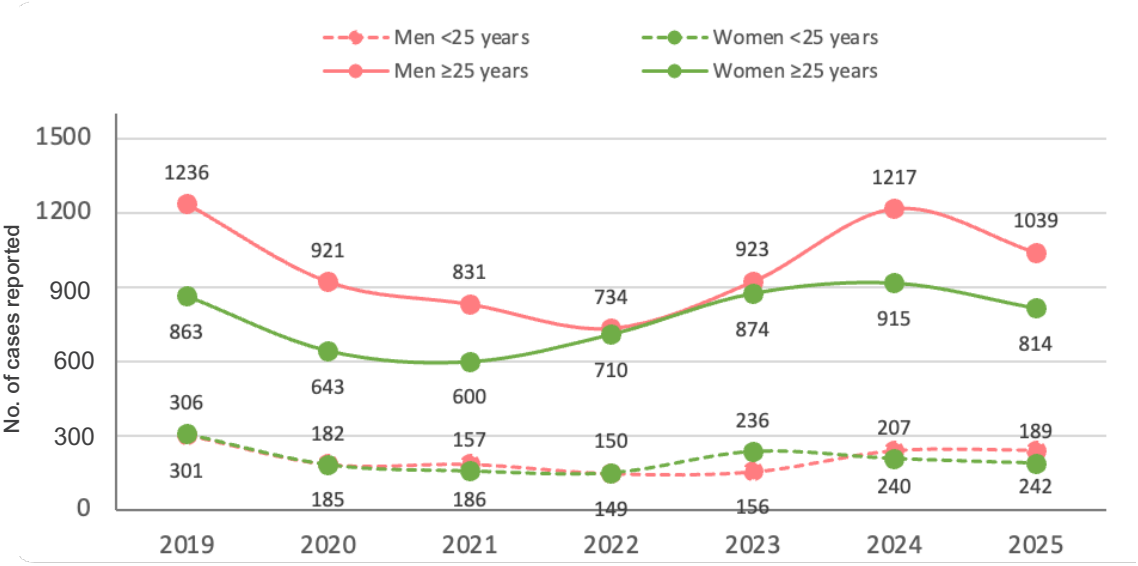
Although a slight decline is noted thereafter, case numbers remain relatively high in 2024 and 2025, with women ≥25 years reporting 1,298 and 1,358 cases, respectively, and men ≥25 years 1,009 and 991 cases. Younger age groups (<25 years) consistently report lower case numbers, though they follow a similar trend, with men cases rising from 104 in 2021 to 205 in 2024 before declining to 174 in 2025, and women cases increasing from 237 in 2021 to 396 in 2023, stabilizing thereafter.

Genital warts

Genital warts are a common sexually transmitted infection caused by low-risk types of human papillomavirus (HPV), most commonly types 6 and 11. They present as soft, flesh-colored growths in the genital or anal region and are transmitted through sexual contact. Genital warts can cause significant physical discomfort and psychosocial distress. Management focuses on removal of visible lesions and reducing transmission, while HPV vaccination remains an effective preventive strategy.

In 2025, 2,284 cases were reported from STD clinics—1,281 men (56.1%) and 1,003 women (43.9%)—accounting for 20% of all STI diagnoses.

Figure 3.10: **Number of genital wart cases by age and sex, 2019 - 2025**



The figure shows that genital warts are consistently more common among individuals aged ≥25 years in both sexes, with men contributing the highest number of cases throughout the period. After a dip in case number during pandemic era, a gradual increase can be observed from 2022, peaking in 2024 with 1,217 cases among men ≥25 years and 915 among women ≥25 years, before declining in 2025.

The continued burden reinforces the importance of HPV vaccination, public awareness, and prompt treatment to control transmission.

The observed trends highlight the need for sustained strengthening of prevention strategies, including health education, promotion of safer sexual practices, and expanded screening services. Ensuring timely diagnosis, effective treatment, partner management remains essential. Continued surveillance and targeted interventions for high-risk groups will be critical to reducing transmission and achieving national and global STI control targets.

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04 SEXUAL HEALTH CLINIC SERVICES IN SRI LANKA

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Sexual Health Clinics in Sri Lanka form the backbone of the national Sexually Transmitted Infection (STI) and Human Immunodeficiency Virus (HIV) prevention and control programme. These specialized clinics provide comprehensive sexual health services, including prevention, diagnosis, treatment, counselling, and follow-up care for STIs, HIV, viral hepatitis, and other sexual health conditions. Currently, a network of 40 main clinics and 20 branch clinics operates across the country, ensuring equitable access to high-quality sexual health services for all populations.

All services are provided under the supervision of Consultant Venereologists and trained Medical Officers of STD (MO/STDs), ensuring evidence-based, confidential, and client-centered care. In addition to managing infectious diseases, sexual health clinics address broader sexual and reproductive health needs, including sexual dysfunctions, contraception, health promotion, and community outreach. Through a combination of clinical services, preventive interventions, and public health activities, these clinics play a pivotal role in safeguarding sexual health, reducing the burden of STIs and HIV, and improving the overall wellbeing of individuals and communities in Sri Lanka.

Functions of Sexual Health Clinics in Sri Lanka

- Diagnosis, testing, treatment, and follow-up care for sexually transmitted infections (STIs).
- HIV testing, counselling, diagnosis, treatment initiation, and long-term care.
- Provision of hepatitis B and hepatitis C screening, treatment, prevention, and follow-up services.
- Administration of hepatitis B vaccination for high-risk populations.
- Management of male and female sexual health problems, including sexual dysfunctions.
- Provision of Pre-Exposure Prophylaxis (PrEP) services for HIV prevention.
- Provision of Post-Exposure Prophylaxis (PEP) services following occupational and non-occupational HIV exposure.
- Condom promotion, distribution, and education on correct and consistent use.
- Partner notification and contact tracing services for STI and HIV prevention.
- Defaulter tracing and retention-in-care activities to improve treatment adherence and follow-up.

- Specialized services for key populations, including men who have sex with men (MSM), female sex workers (FSW), transgender persons, and people who inject drugs (PWID).
- Screening of antenatal women for HIV, syphilis, and hepatitis B as part of the National Elimination of Mother-to-Child Transmission (EMTCT) Programme, aimed at maintaining dual elimination of HIV and syphilis and progressing towards triple elimination.
- Provision of contraception and sexual and reproductive health counselling.
- Delivery of Information, Education, and Communication (IEC) programmes on sexual health and disease prevention.
- Conducting community outreach programmes and awareness campaigns.
- Community-based HIV and STI testing services for key, vulnerable, and general populations.
- HIV and STI screening programmes in prisons and other institutional settings.
- Blood surveys and behavioural surveillance activities among priority populations.
- Pre-employment and foreign employment medical assessments related to HIV and STI screening.
- Training and capacity building of healthcare workers and community-based personnel.
- Collection, monitoring, and reporting of STI, HIV, and viral hepatitis surveillance data.
- Establishment and maintenance of referral networks for specialized medical, psychosocial, and community support services.
- Health promotion activities aimed at reducing stigma, discrimination, and risky sexual behaviours.
- Supporting national public health programmes related to HIV, STIs, viral hepatitis, and sexual health promotion.

Hepatitis B and C Services Provided by Sexual Health (STD) Clinics in Sri Lanka

The Sexual Health (STD) Clinics in Sri Lanka play an important role in the prevention, diagnosis, treatment, surveillance, and control of hepatitis B and hepatitis C infections. Since 2024, hepatitis B and C services have been integrated into the routine activities of all STD clinics, ensuring island-wide access to comprehensive viral hepatitis services.

Screening and Early Detection

All STD clinics provide screening services for hepatitis B and hepatitis C, particularly targeting populations at increased risk of infection. These include:

- Individuals are diagnosed with sexually transmitted infections.
- People living with HIV.
- Men who have sex with men (MSM).
- Female sex workers (FSW).
- People who inject drugs (PWID).
- Sexual and household contacts of patients diagnosed with hepatitis B or hepatitis C.
- Individuals with a history of high-risk sexual behaviours.
- Patients referred from blood banks and blood donor screening programmes.
- Individuals identified through foreign employment medical screening programmes.
- Patients referred from hospitals and specialist clinics, including gastroenterology, hepatology, medical, surgical, and other outpatient clinics.
- Pregnant women identified through antenatal screening programmes.
- Individuals with abnormal liver function tests or clinical suspicion of viral hepatitis.

Diagnosis and Confirmation

STD clinics perform initial screening and facilitate confirmatory testing for hepatitis B and hepatitis C. Patients with positive screening results undergo further clinical and laboratory evaluation to confirm the diagnosis, assess disease stage, and determine treatment eligibility.

Clinical Management and Treatment

All STD clinics provide clinical assessment, counselling, follow-up, and treatment services for hepatitis B and hepatitis C. Patients are managed according to WHO treatment guidelines and receive regular monitoring of treatment response and disease progression. Management is carried out in close collaboration with gastroenterologists and other relevant specialists when necessary. Patients requiring advanced investigations or specialist interventions are referred appropriately while maintaining continuity of care through the STD clinic network.

Contact Tracing and Partner Services

Contact tracing is routinely conducted for patients diagnosed with hepatitis B and hepatitis

Hepatitis B Vaccination

STD clinics provide hepatitis B vaccination to eligible individuals who are susceptible to infection. Priority groups include:

- Sexual partners and household contacts of individuals diagnosed with hepatitis B
- People living with HIV

- Men who have sex with men (MSM)
- People who inject drugs (PWID)
- Health care workers in STD clinics
- Non-governmental organization (NGO) workers working with high-risk populations

Vaccination services form a key component of the national hepatitis prevention strategy.

Integrated STI Services

As hepatitis B and hepatitis C share common routes of transmission with other sexually transmitted infections, all patients diagnosed with viral hepatitis are assessed and screened for HIV infection, syphilis. And other sexually transmitted infections as clinically indicated.
This integrated approach ensures comprehensive sexual health care and facilitates early detection of co-infections.

Counselling and Health Education

Comprehensive counselling services are provided to all patients and their contacts. Counselling includes:

Surveillance and Data Reporting

STD clinics contribute to the national surveillance system for viral hepatitis. Data on hepatitis B and hepatitis C screening, diagnosis, treatment, follow-up, and outcomes are routinely collected and reported. Surveillance data are shared with the Epidemiology Unit and other relevant stakeholders to support national monitoring, planning, and disease control activities.

National Role of STD Clinics

The integration of hepatitis B and hepatitis C services into the STD clinic network has strengthened Sri Lanka's response to viral hepatitis. Through comprehensive screening, diagnosis, treatment, contact tracing, vaccination, counselling, surveillance, and collaboration with specialist services, STD clinics play a vital role in reducing transmission, improving patient outcomes, and advancing national and global hepatitis elimination goals.

Number of Hepatitis B and c cases report to STD clinic in 2025.

Hepatitis B/C	Hepatitis B	Hepatitis C
Number	65	137

CONSULTANT VENEREOLOGIST [1]

05 HIV TESTING SERVICES

WARUNI PANNALA [1], GEETHANI SAMARAWEERA [1]

HIV testing remains the essential gateway to HIV prevention, treatment and care services and is a cornerstone of the global effort to end AIDS as a public health threat. Achieving the UNAIDS 95:95:95 targets depends on the timely identification of people living with HIV and their linkage to treatment and care services. Early diagnosis not only improves individual health outcomes but also contributes to reducing onward HIV transmission through treatment as prevention.

Sri Lanka continues to implement a differentiated HIV testing services to reach populations with different levels of risk and healthcare access. HIV testing services are provided through multiple modalities, including STD clinics, hospital-based testing, antenatal screening, tuberculosis clinics, blood donor screening, prison health services, private-sector testing, community outreach programmes, online outreach testing, and HIV self-testing. Particular emphasis is placed on expanding access among key populations through community-based and peer-led approaches.

The National STD/AIDS Control Programme (NSACP) continues to strengthen the quality, coverage, and effectiveness of HIV testing services through capacity building, implementation of innovative testing approaches, quality assurance systems, and enhanced partner notification through index case testing activities. These efforts aim to maximize case finding, facilitate early linkage to care, and contribute to the national goal of ending AIDS while maintaining high standards of testing quality and client confidentiality.

Table 5.1: HIV testing services in 2025.

Catregory of the samples tested for HIV	Number tested	Number positive	% of HIV positive rate
STD clinic samples*	73607	423	0.575
HIV rapid tests done in government hospitals	11825	53	0.448
Key population intervention programmes	31797	88	0.277
TB clinic screening	8630	22	0.255
Prison inmates	21468	22	0.102
Private hospitals, visa screening laboratories and SJGH**	189103	146	0.046
Screening at public and private sector blood banks	467199	90	0.019
Other ***	181980	21	0.012
Pre-employment screening	16929	1	0.006
Antenatal mothers	214881	8	0.004
Total	1217419	874	0.072

* STD samples include clinic attendees, hospital referrals, and testing of contacts

** SJGH – Sri Jawardenapura General Hospital,

*** Other = Pre-conceptional, screening before procedures, know4sure,legal and insurance purposes, tri-forces screening

A total of 1,217,419 HIV tests were performed in 2025 compared with 1,244,143 in 2024, representing a 2.1% decrease in overall testing volume. Despite the lower number of tests, 874 HIV-positive individuals were identified in 2025 compared with 824 in 2024, resulting in an increase in overall positivity from 0.066% to 0.07%. STD clinics remained the largest contributor to HIV case detection, identifying 423 cases (48% of all diagnoses) in 2025, while maintaining the highest positivity rat (0.57%). HIV rapid testing in government hospitals showed a substantial increase in testing volume with 7469 in 2024 to 11828 in 2025 with positivity rate only less than STD clinic samples. Testing through private hospitals, laboratories and SJGH contributed 146 diagnosis. (out of those 59 were from screening for foreign employment visa) Key population intervention programmes and TB clinic screening continued to demonstrate relatively high positivity rates compared with routine screening programmes, underscoring the value of targeted testing approaches. Antenatal screening and blood bank screening maintained very high coverage with consistently low positivity rates, reflecting the low prevalence of HIV in these populations. Overall, the findings indicate improved efficiency of HIV testing services in identifying HIV-positive individuals, despite a modest reduction in total testing volume.

Testing in STD clinics

STD clinic-based HIV testing remains one of the most important HIV testing strategies in Sri Lanka, with services available in all 25 districts. It consistently yields the highest number of HIV diagnoses and among the highest positivity rates compared with other testing modalities. HIV testing at STD clinics includes individuals seeking care for symptoms suggestive of sexually transmitted infections, clients requesting voluntary HIV testing and screening, key population members presenting directly to clinics or referred through community outreach programmes, referrals from other healthcare facilities, and individuals undergoing testing for medico-legal purposes. To improve access to services for key populations, the Colombo STD Clinic operates dedicated key population clinics that provide a more accessible and client-friendly environment for HIV and STI prevention, testing, and treatment services.

Hospital-Based HIV Testing

Hospital-based HIV testing expanded substantially in 2025, with the number of HIV rapid tests performed in government hospitals increasing from 7,469 in 2024 to 11,828 in 2025. The positivity rate of this group is the second-highest yielding testing group after STD clinic testing. This reflects the importance of strengthening hospital-based,

indicator condition driven HIV testing in low-prevalence settings like Sri Lanka. To further support this effort, the NSACP developed a poster highlighting HIV indicator conditions and shared the electronic version with STD clinics for dissemination within hospitals end this year. Plans are underway to print and distribute the poster to hospitals islandwide in the coming year.

HIV screening among TB patients

HIV screening among patients with tuberculosis (TB) remains a key component of collaborative TB/HIV activities in Sri Lanka. Almost all patients diagnosed with TB are screened for HIV soon after diagnosis or registration at TB clinics. While a few clinics, provide on-site HIV rapid testing, most TB clinics refer blood samples to the nearest STD clinic for testing. In 2025, both the number of tests performed and the positivity rate remained comparable to those reported in 2024, indicating continued high coverage and stable HIV case detection among TB patients

Private sector HIV testing

Private sector HIV testing, including testing conducted through private hospitals, laboratories, and the SJGH, continues to play an important role in Sri Lanka's HIV testing programme. In 2025, 189,103 HIV tests were performed through the private sector, identifying 146 HIV-positive individuals with a positivity rate of 0.05%. Following reactive screening results, either patients or their blood samples are referred to government STD clinics for confirmatory testing. Private sector thus provides an additional testing pathway, and continued collaboration with private healthcare providers is essential to ensure timely diagnosis, linkage to care, and strengthened national surveillance.

Blood donor screening

The National Blood Transfusion Service conducts routine HIV testing on all donated blood samples. The number of HIV-positive detections showed a noticeable increase in 2024 compared to the previous year, and this rise remained relatively stable in 2025. This trend may indicate a true rise in HIV positivity among donors, highlighting the need to further strengthen pre-donation counselling and mass education to prevent individuals with recent high-risk exposures from donating blood, thereby ensuring continued blood safety.

HIV testing by Tri Forces.

Army, Navy, and Air Force personnel undergo regular HIV screening, both periodically and prior to as well as upon completion of foreign missions. HIV test kits are procured by the Ministry of Defence, while testing is conducted by healthcare personnel within the tri-forces medical services.

HIV testing in prisons

HIV testing in prisons remains a key component of HIV prevention and care services. In 2025, a total of 21,468 HIV tests were conducted among inmates through district STD clinics and prison health services. The number of HIV-positive cases remained at 22 in both 2024 and 2025. These figures are significantly higher than in 2023, when only 9 positives were identified despite a comparable number of tests being conducted. These data highlight prisons as a continuing high-yield setting for HIV screening and prevention interventions.

HIV testing among key populations in 2025

Key populations are tested for HIV in STD clinics and also through community-based outreach services. STD clinics provide HIV testing for key populations who attend for STI screening, PrEP and PEP services, or present with STI-related symptoms. In addition community outreach for key populations is conducted either by STD clinic staff or by NGO/CBO partners working in the district.

NGO-supported peer-led key population interventions are implemented in 15 districts by designated NGO/CBO staff. In Colombo and Gampaha, which have the highest HIV burden, these activities are coordinated by the Family Planning Association (FPA), under which several NGO/CBO partners deliver targeted services for key populations. In the remaining 13 districts, KP units staffed by contract-based NGO staff, attached to the STD clinics. They work under the supervision of consultant venereologists or Medical Officers in Charge, operating through the peer-led service delivery model.

In 2025, the NSACP HIV Testing Unit and the National Reference Laboratory jointly conducted two-day hands-on training workshops on HIV, Hepatitis B, hepatitis C, and syphilis rapid testing for community-based NGO staff in Anuradhapura, Badulla, and Hambantota districts. These capacity-building programmes were well received and considered highly successful. Further three similar training programmes are planned for 2026 in other districts to further strengthen the skills of NGO/CBO staff involved in community-based testing services.

Table 5.2: Details of HIV testing among Key population in 2025

Type of key population	Number tested in the STD clinic, including the KP unit	Number tested by FPA	Total
Men having sex with men	12159	5147	17306
Female sex workers	8063	3313	11376
Beach boys	2907	0	2907
PWID	1135	222	1357
Transgender women	203	343	546
Prison inmates	21468	0	21468
Total	45935	9025	54960

Table 5.3: HIV positivity rate by type of key population

Type of key population	Total tested	Total HIV positive	Percentage of HIV positives
Men having sex with men	17306	430	2.48
Female sex workers	11376	4	0.04
Beach boys	2907	0	0.00
PWID	1357	7	0.52
Transgender women	546	3	0.55
Prison inmates	21468	22	0.10
Total	54960	466	0.85

HIV testing through online outreach.

Online outreach testing continued through online outreach workers attached to the NSACP and peripheral STD clinics. In 2025, HIV tests were conducted through virtual outreach activities. Clients reached through online platforms were linked to HIV testing through multiple pathways, including referral to physical outreach workers, referral to STD clinics, or provision of HIV self-test kits delivered directly to their doorstep through the Know4Sure website. This approach expands access to HIV testing services, particularly for individuals hard to reach through conventional testing services.

HIV Self-Tests

A total of 9,116 HIV self-test kits were distributed in 2025, demonstrating the continued role of self-testing as an additional option for expanding HIV testing services. However, utilization remained suboptimal in some STD clinics due to low demand. Family Planning Association (which implements key population interventions in Colombo and Gampaha districts) and clients accessing through the Know4Sure website were among the main users of HIV self-test kits.

Index case testing pilot project

Contact tracing has been implemented for all newly diagnosed HIV cases since the establishment of HIV diagnostic services. To strengthen this process, the NSACP developed a new Index Case Testing (ICT) protocol and monitoring tools in 2024, which were piloted at the NSACP Central Clinic and Kalubowila HIV Clinic from January to March 2025. The pilot focused on identifying and offering HIV testing to sexual partners, drug-sharing partners, and biological children of newly diagnosed individuals, with the aim of facilitating early diagnosis and linkage to care. The new protocol and monitoring tools enabled a more standardised, systematic, and transparent approach to implementing, documenting, and evaluating ICT activities.

Table 5.4: Findings of index case testing pilot project

	Number of new registrations	Number of contacts identified	Number of contacts contacted	Number	Number positive	Positivity percentage
January	24	42	36	25	4	16%
February	40	24	16	10	1	10%
March	15	2	0	0	0	0
Total	79	68	52	35	5	14%

Programme performance was highest in January, with 86% of identified contacts invited for testing and 60% tested. Although February recorded the highest number of newly diagnosed cases (n=40), testing uptake declined. By March, all indicators had fallen to zero, suggesting a disruption in programme implementation. The decline was likely due to operational challenges such as staff workload, training needs, and limited supervision, highlighting the need for ongoing support and monitoring to sustain programme effectiveness.

Way forward

1. Scale up index case (index patient) testing activities islandwide to improve identification of undiagnosed HIV infections among contacts.
2. Integrate the index case testing data collection sheets into the EIMS monitoring system to enhance real-time monitoring and programme effectiveness.
3. Further strengthen indicator condition–driven HIV testing in hospital settings to ensure routine testing of all patients presenting with HIV-related clinical conditions.
4. Scale up HIV self-testing services, through online outreach work and also through STD clinics where routine facility-based testing is challenging.

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06 HIV TREATMENT AND CARE

UMEDHA JAYASINGHE [1], MANATHUNGA ARIYARATNE [1]

The National STD/AIDS Control Programme (NSACP) under the Ministry of Health, Sri Lanka, delivers comprehensive clinical services for people living with HIV (PLHIV) through 37 full-time, island-wide Antiretroviral Therapy (ART) centers. Supported by robust data privacy protocols that ensure client confidentiality, the program focuses on maximizing treatment effectiveness, reducing community transmission, and preventing drug resistance through structured public health interventions.

Clinical Objectives

Optimizing treatment and care yields two critical clinical and epidemiological outcomes:

- Morbidity reduction: Early therapeutic intervention optimizes CD4 recovery, minimizes viral load, and secures a near-normal life expectancy.
- Transmission interruption: Achieving viral suppression prevents sexual transmission to partners and vertical transmission to newborns.

Key Performance Indicators & Epidemic Data

The NSACP surveillance data shows an upward trend in reported cases over recent years. National targets strictly follow the globally aligned UNAIDS 95-95-95 treatment cascade goals to map program efficacy.

Program Indicator (KPI)	Target	Clinical Focus
Linkage to Care	100%	Transitioning newly diagnosed individuals to ART clinics.
Rapid Initiation	> 90%	Starting therapy on day one or within the first week of registration.
12-Month Retention	> 95%	Minimizing lost-to-follow-up via active defaulter tracing.
Viral Suppression Rate	95%	Achieving plasma viral loads < 1,000 copies/mL at 12 months.
Vertical Transmission	0%	Achieving triple elimination (HIV, Hepatitis B, Syphilis).
TB Co-infection Screening	100%	Routine screening for Tuberculosis among all newly enrolled PLHIV.

Scope of Clinical & Preventive Services

The 37 ART centers serve as specialized hubs, providing an integrated package of care:

- Therapeutic Interventions: Standardized ART provisioning and specialized laboratory diagnostics.

- COMORBidity Management: Screening, prevention, and treatment for Opportunistic Infections (OIs) including Tuberculosis (TB), and Hepatitis B and C co-infections.
- Prophylaxis & Immunology: Administration of Co-trimoxazole and Isoniazid (INAH) preventive therapy alongside Hepatitis B vaccinations for eligible clients.
- Non-Communicable Diseases (NCDs): Integrated screening and metabolic management for chronic conditions, including diabetes and hypertension.
- Reproductive Health & PMTCT: Routine PAP smears, family planning, dedicated sexual health interventions, and protocols to support the Triple Elimination Programme.
- Psychosocial Support: Professional counseling and treatment, assisted disclosure, partner notification, and active defaulter tracing to maximize retention.

Policy Protocols for Initiation and Adherence

The NSACP enforces an active "Test and Treat" policy to optimize public health outcomes:

- Rapid Initiation: Eligible PLHIV are offered ART ideally on the same day or within the first week of registration, unless clinically contraindicated.
- Drug Resistance Monitoring; Proactive drug resistance monitoring is critical to sustaining long-term HIV treatment success, particularly when direct viral load (VL) or genotypic resistance testing is delayed or unavailable. Therefore, centers maintain oversight by combining stringent adherence tracking with proxy clinical markers.

1. Adherence Monitoring Methods

These methods are designed to identify poor adherence early, which is the primary driver of resistance.

- Pharmacy Refill Records (Electronic): Tracking on-time pickup of antiretroviral therapy (ART) via electronic databases to measure retention in care.
- Pill Counts: Manual inspection of remaining medication tablets by staff during clinic visits to measure adherence rates.
- Validated Self-Report Questionnaires: Brief, non-judgmental interviews (e.g. assessing missed doses over the past 3-7 days) to identify behavioral barriers to adherence.
- Treatment Supporters & Peer Support: Engaging family, peers, or community health workers to verify daily medication intake, especially useful in decentralized care models.

2. Surrogate Clinical Markers for Monitoring Treatment Failure

- In the absence of timely viral load data, the following markers act as proxies to detect virologic failure and potential drug resistance:
- CD4 T-Cell Count Trends: Regular tracking for declines, which may indicate immune failure despite treatment.
- Symptom Scoring & Clinical Assessment: Evaluating for new or recurring World Health Organization (WHO) Stage 3 or 4 opportunistic infections (e.g. persistent fever, significant weight loss, chronic diarrhea etc.)
- Weight Gain/Stability Monitoring: Tracking Body Mass Index (BMI) or weight to detect metabolic or opportunistic infection-related wasting.
- Functional Status Evaluation: Monitoring patient reports of daily energy levels and physical activity capacity.

Current protocols favor dolutegravir (DTG) based ART due to its high genetic barrier to resistance, often maintaining suppression even with imperfect adherence.

Table 6.1: National HIV Clinic Attendance Data

S. No.	HIV Clinic	Female	Male	TG	Total	% of National Total
1	Colombo	255	1,299	4	1,558	33.95%
2	Ragama	67	346	5	418	9.11%
3	Kandy	64	185	0	249	5.43%
4	Kalubowila	31	190	0	221	4.82%
5	Kurunegala	44	169	0	213	4.64%
6	Gampaha	27	152	0	179	3.90%
7	Mahamodara	30	129	0	159	3.46%
8	Matara	26	132	0	158	3.44%
9	Kalutara	27	119	0	146	3.18%
10	Negombo	28	103	2	133	2.90%
11	Anuradhapura	30	86	0	116	2.53%
12	Hambantota	10	95	0	105	2.29%
13	Chilaw	33	68	0	101	2.20%
14	Rathnapura	19	71	0	90	1.96%
15	Kegalle	15	71	0	86	1.87%
16	Polonnaruwa	23	59	0	82	1.79%
17	IDH	23	43	0	66	1.44%
18	Badulla	15	47	0	62	1.35%
19	Jaffna	25	34	1	60	1.31%
20	Matale	20	37	0	57	1.24%
21	Avissawella	6	37	0	43	0.94%
22	Panadura	7	35	0	42	0.92%

23	Trincomalee	8	28	0	36	0.78%
24	Ampara	9	22	0	31	0.68%
25	Vavuniya	9	21	0	30	0.65%
26	Nuwara Eliya	9	20	0	29	0.63%
27	Batticaloa	7	12	0	19	0.41%
28	Wathupitiwala	1	18	0	19	0.41%
29	Monaragala	6	12	0	18	0.39%
30	Balapitiya	1	15	0	16	0.35%
31	Homagama	2	12	0	14	0.31%
32	Puttalam	0	12	0	12	0.26%
33	Kuliyapitiya	3	5	0	8	0.17%
34	Tangalle	0	7	0	7	0.15%
35	Dambulla	1	2	0	3	0.07%
36	Kilinochchi	1	1	0	2	0.04%
37	Kalmunai	1	0	0	1	0.02%
-	**TOTAL**	**883**	**3,694**	**12**	**4,589**	**100.00%**

Demographic Disparity: Males represent the vast majority of patients at 80.50% (3,694) cases, while females make up 19.24% 883cases, and Transgender (TG) individuals account for 0.26% 12 cases.

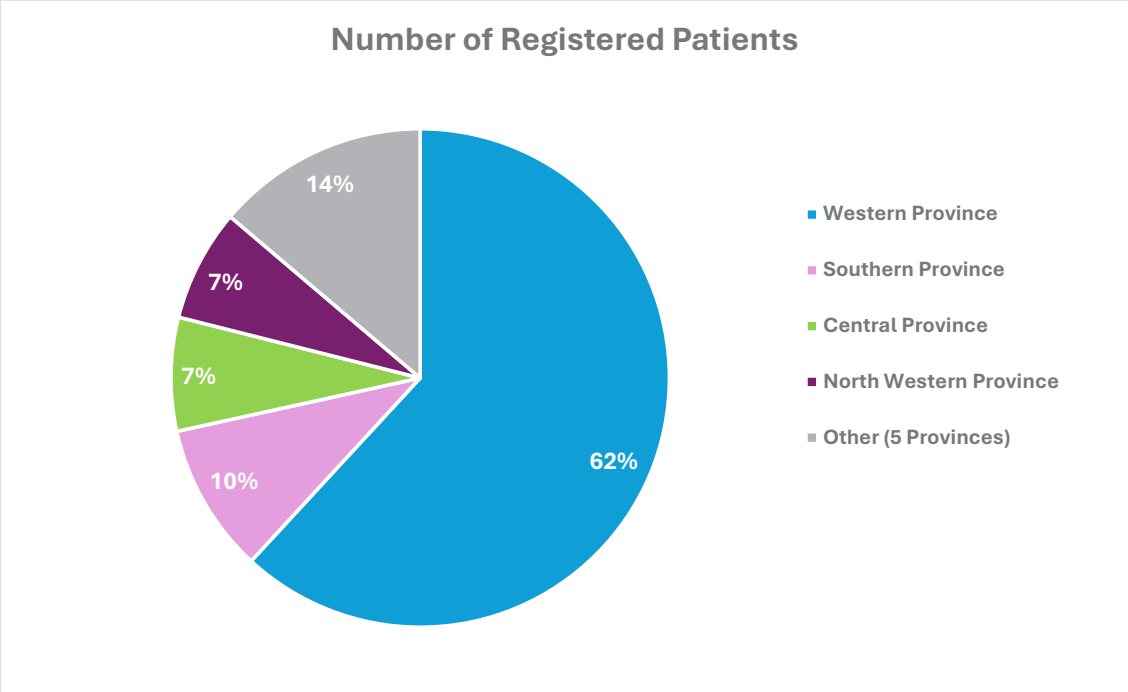
High Urban Concentration: The top 5 clinics (Colombo, Ragama, Kandy, Kalubowila, and Kurunegala) manage 57.94% of the national patient volume.

Primary Hotspot: The Colombo clinic alone accounts for 33.95% of all national registered patients (1,558 cases.

Table 6.2: National Regional Summary of PLHIV (by Province)

Province	Female	Male	TG	Total Patients	% of National Total
Western Province	417	2,126	11	2,554	55.65%
Central Province	93	242	0	335	7.30%
Southern Province	67	261	0	328	7.15%
North Western Province	80	244	0	324	7.06%
North Central Province	53	145	0	198	4.31%
Sabaragamuwa Province	34	142	0	176	3.84%
Northern Province	36	57	1	94	2.05%
Uva Province	21	59	0	80	1.74%
Eastern Province	25	40	0	65	1.42%
Total	**883**	**3,694**	**12**	**4,589**	**100.00%**

Figure 6.3: Regional Distribution of PLHIV across province-2025



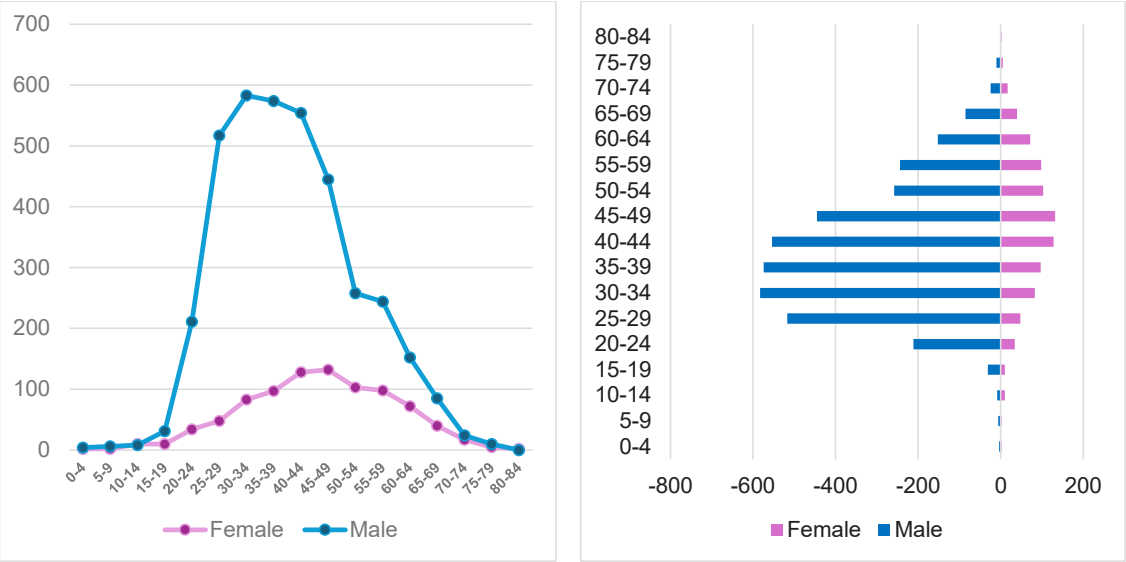
The Western Province manages 55.6% of the national clinical cohort. In contrast, the Central (7.3%), Southern (7.1%), and North Western (7.1%) provinces exhibit uniform, mid-tier volumes, while the remaining five provinces collectively account for just 13.4% of the country's registered clinical load. This severe geographic skew strongly suggests a pattern of patient migration from rural localities to centralized urban hubs, likely driven by seeking enhanced medical infrastructure and greater social anonymity.

Age-Based Distribution of PLHIV

The age demographics of the 4,589 registered PLHIV show that the epidemic is heavily concentrated among the active working-age population.

- Peak age cohort: The highest volume of patients sits within the 35–44 age range, accounting for 29.48% (1,353 patients) of all cases.
- Young adults risk: A massive escalation of cases occurs during transition into young adulthood, surging from 41 cases in the late teens (15-19) to 245 cases in the early twenties (20-24).
- Pediatric and adolescent cohort: Children and young adolescents under 15 years old make up a very low fraction of the total population at just 0.70% (32 patients).

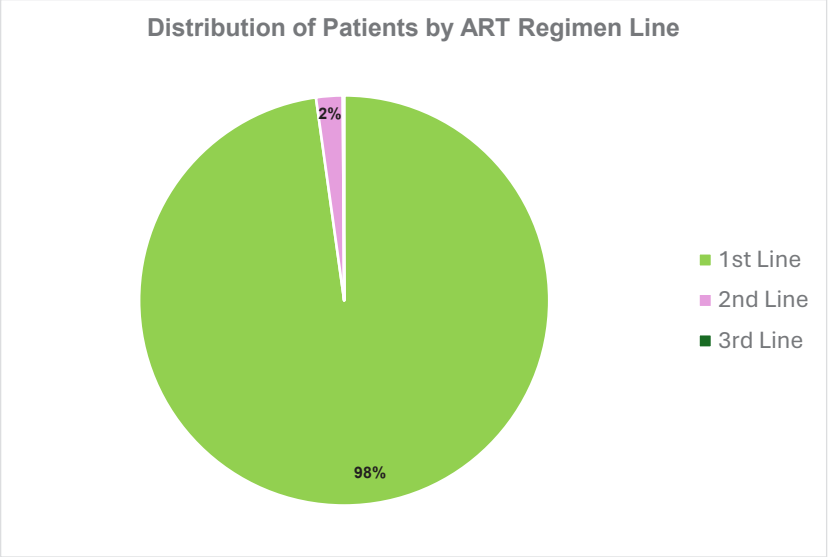
Figure 6.4: Demographic Profile and Gender-Age Pyramid of PLHIV Cohort (As of End 2025).



This graphic visualizes the age and gender distribution of registered individuals living with HIV (\(N = 4,589\)). The population pyramid (left panel) illustrates a profound gender divergence that manifests sharply in early adulthood. Male cases spike rapidly in the 20–24 demographic and peak dynamically between the ages of 30 and 44, establishing a massive statistical block. The female patient trajectory (right panel) follows a significantly flatter, more distributed curve, peaking much later in life between the 40–49 age brackets. This structural shift highlights distinct epidemiological characteristics between genders, suggesting that transmission tracking and prevention programs must prioritize different age-based touchpoints for male and female demographics

Distribution of PLHIV by Treatment Line

Figure 6.5: Distribution of PLHIV by Treatment line

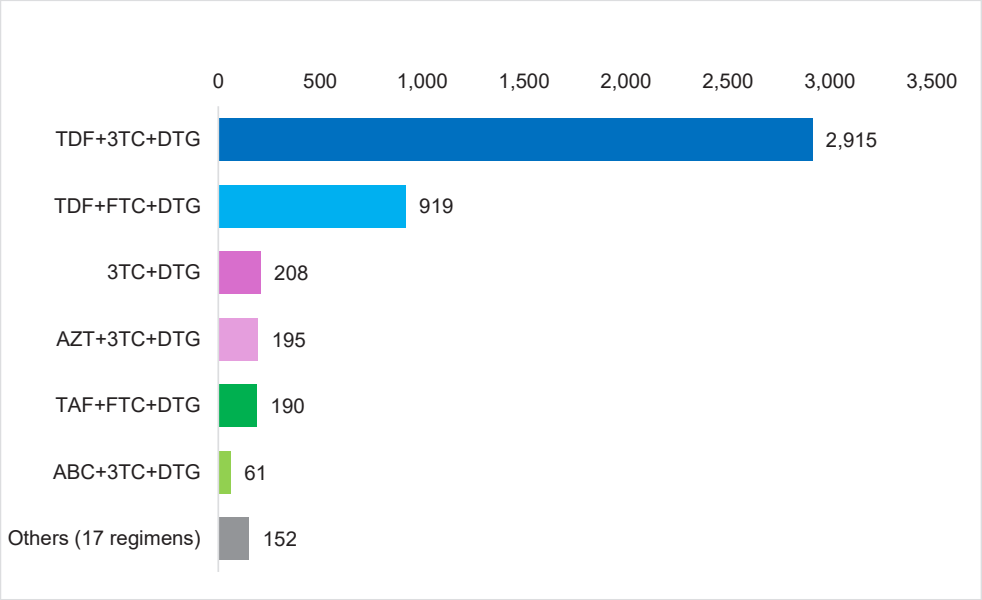


- 1st Line (4,440 patients): Accounts for 97.8% of the clinical population.
- 2nd Line (95 patients): Accounts for 2.1% of the clinical population.
- 3rd Line (5 patients): Accounts for a marginal 0.1% of the clinical population.

Top 6 dominant regimens (96.7% of patients)

Out of 23 unique regimens listed, the top 6 regimens support 4,388 patients, while the remaining 17 regimens account for just 152 patients combined.

Figure 6.6: Top ART regimen by patient Volume



- The TDF+3TC+DTG Standard: With 2,915 patients, this single regimen represents nearly two-thirds of the entire programmatic workload.

- DTG-Backed Core: 98.8% (4,484 patients) are on a DTG-containing regimen Dolutegravir (DTG) forms the backbone of all top 6 regimens, underscoring its role as the preferred first-line agent due to its high genetic barrier to resistance.
- Efavirenz (EFV) Phase-Out: Only 0.5% (21 patients) remain on EFV-based lines, showing a nearly complete transition away from older NNRTIs.

- Protease Inhibitors (PIs): The remaining 0.7% (35 patients) utilize PIs like Darunavir (DRV/r), Lopinavir (LPV/r), or Atazanavir (ATV/r), typically reserved for advanced salvage lines.

HIV and Tuberculosis Co-infection

Tuberculosis (TB) remains the most common opportunistic infection and a leading cause of morbidity among people living with HIV (PLHIV) in Sri Lanka. To mitigate this dual burden, the National STD/AIDS Control Programme (NSACP) collaborates with the National Programme for Tuberculosis Control and Chest Diseases (NPTCCD) to enforce an integrated “Two-Way Screening” and management framework.

Tuberculosis (TB) and HIV Co-infection Protocols

1. Routine Screening and Early Diagnosis

- Universal Clinical Screening: Every PLHIV registered at an ART center undergoes mandatory screening for active TB at every clinic visit using the four-symptom checklist: persistent cough, night sweats, weight loss, and unprovoked fever.
- Molecular Diagnostics: For individuals showing symptoms, sputum samples are immediately fast-tracked to one of the designated NPTCCD molecular testing sites for GeneXpert MTB/RIF assay testing. This ensures rapid detection of Mycobacterium tuberculosis and simultaneous screening for rifampicin resistance.
- Latent TB Surveillance: As noted by the Epidemiology Unit of Sri Lanka, asymptomatic PLHIV are recognized as a high-risk group for latent TB infection (LTBI) reactivation. These patients receive routine baseline screening to rule out active disease before initiating preventive therapy.

2. Therapeutic Management and Integration

- Concurrent Treatment Strategies: In cases of confirmed active TB/HIV co-infection, therapeutic protocols prioritize managing both conditions dynamically. Anti-tuberculosis treatment (ATT) is initiated first using standard first-line regimens.

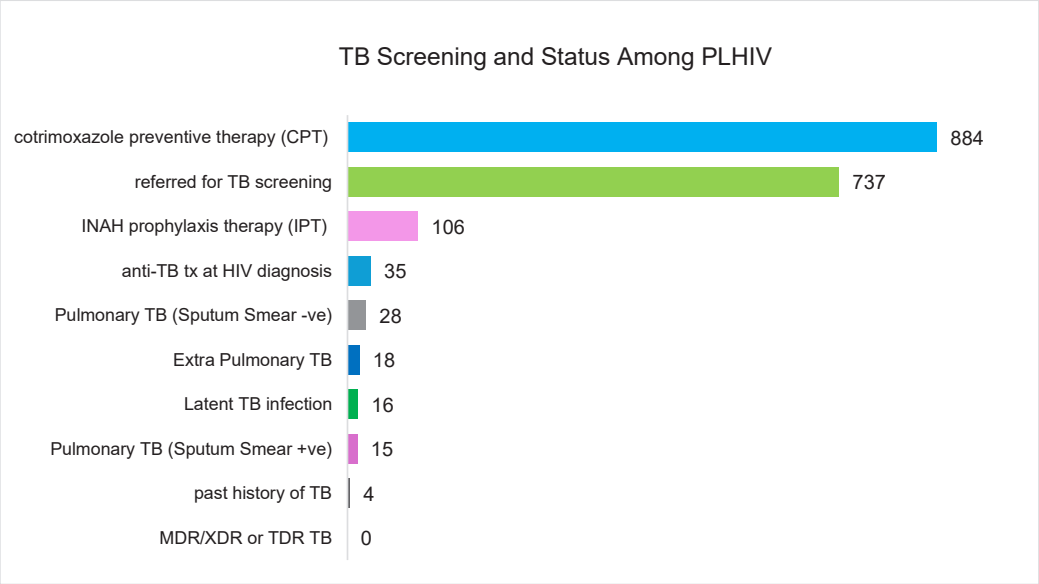
3. Pharmacovigilance and Drug-Drug Interactions

- Managing co-infected patients requires stringent monitoring for drug-drug interactions, particularly between rifampicin and specific antiretroviral classes.

4. Preventive Prophylaxis

- For PLHIV in whom active TB has been clinically and diagnostically ruled out, preventative measures are deployed to block latent reactivation:
- Isoniazid Preventive Therapy (IPT): Enrolled clients receive a standardized course of Isoniazid (INAH) prophylaxis alongside Co-trimoxazole.
- Clinical Monitoring: Patients on dual preventive therapies are closely monitored for hepatotoxicity, peripheral neuropathy, and treatment adherence during regular ART clinic visits.

Figure 6.7: TB screening and status among PLHIV



- High Screening and Baseline Care Coverage: A total of 884 patients received Cotrimoxazole Preventive Therapy (CPT), and 737 HIV-positive patients were systematically referred for TB screening, demonstrating strong entry-level intervention pathways.

- Active vs. Latent TB Breakdown: Among the screened population, active TB manifests primarily as Pulmonary TB with a negative sputum smear (28 cases), followed by Extra-Pulmonary TB (18 cases), and Sputum Smear-positive Pulmonary TB (15 cases). Latent TB infection was confirmed in 16 patients.

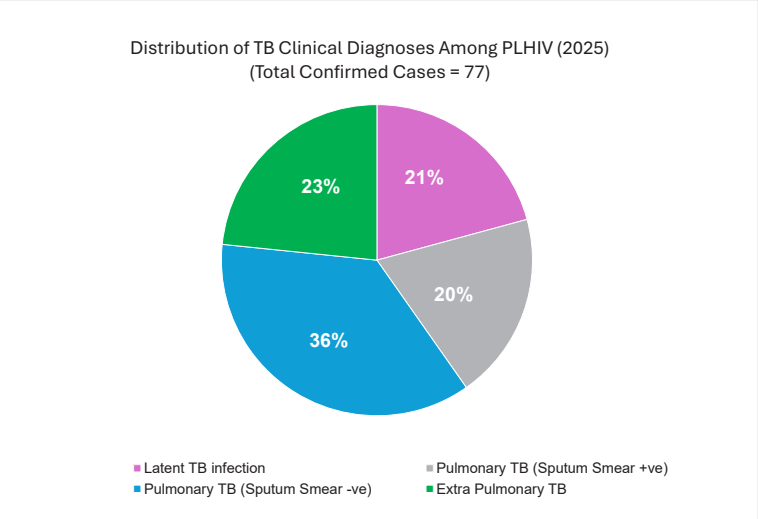
- Drug Resistance: There were 0 reported cases of MDR/XDR or TDR TB, indicating excellent control over drug-resistant strains within this co-infected cohort for 2025.
- Prophylaxis Gap: While 737 patients were referred for screening and 16 were confirmed with latent TB, only 106 patients are actively on INAH Prophylaxis Therapy (IPT), suggesting a metric worth monitoring against total clinical eligibility.

- Pulmonary TB: Over half of all clinical presentations (55.8%) are pulmonary TB, with negative sputum smears making up the single largest clinical category at 36.4%.

- Extra-Pulmonary TB: Extra-pulmonary manifestations comprise nearly a quarter of all diagnoses (23.4%), illustrating the system-wide impact of TB in immunocompromised individuals.

- Latent vs. Active TB: Latent TB infections (20.8%) closely mirror the volume of positive sputum smear pulmonary infections (19.5%)

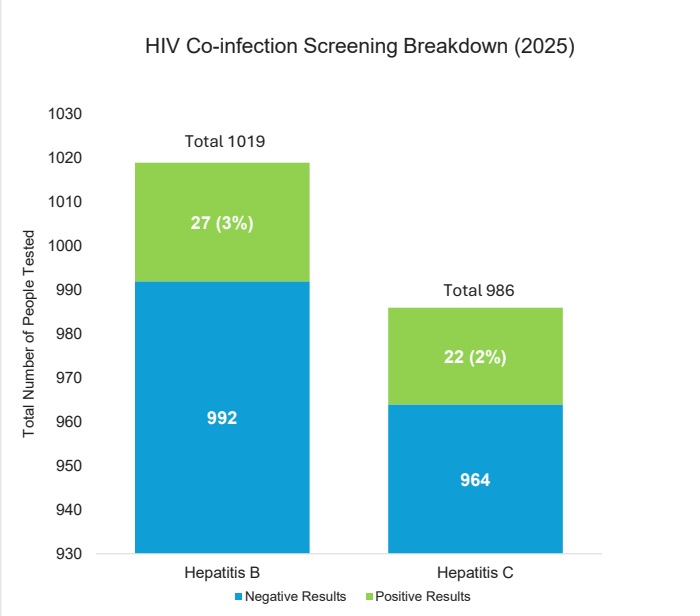
Figure 6.8: Distribution of TB diagnosis among PLHIV



HIV and Hepatitis Coinfection

- Hepatitis B: Showed slightly higher volume across the board, with 1,019 tested, 27 positives, and a 3% positivity rate.
- Hepatitis C: Had slightly fewer total records, reporting 986 tested, 22 positives, and a 2% positivity rate.

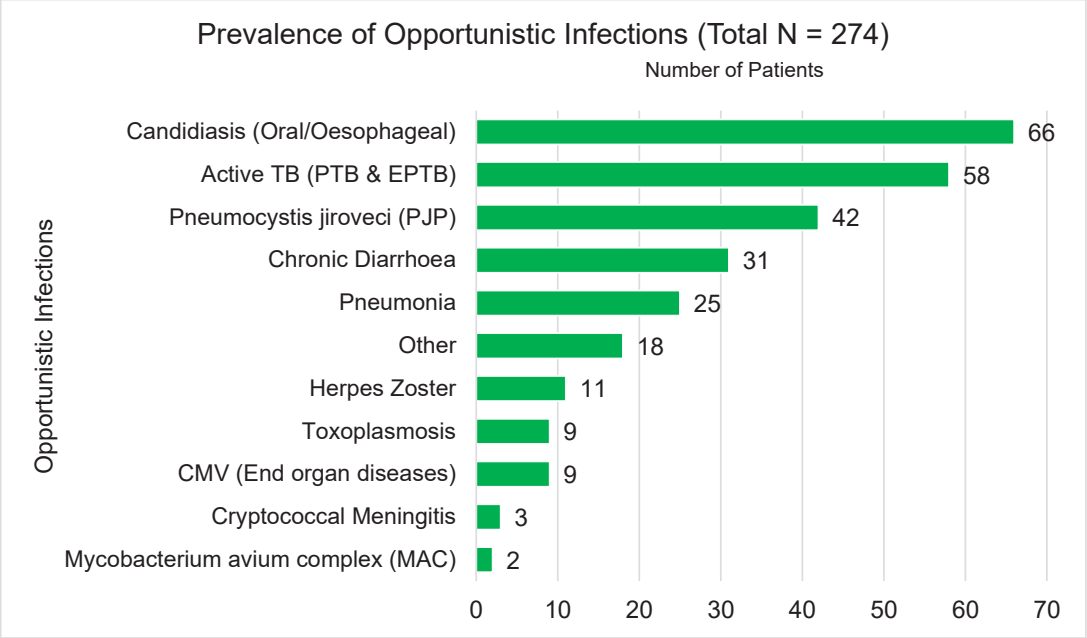
Figure 6.9: HIV co-infection breakdown



Opportunistic Infection distribution

Candidiasis, Active TB, and PJP are the top three most prevalent opportunistic infections (OIs) in this dataset, collectively accounting for over 60% of all reported patient cases. Out of a total sample size of 274 patients, fungal and bacterial infections significantly outnumber viral and protozoal conditions.

Fogure 6.10: Prevalence of opportunistic infections



- High-Burden Infections (20%+): Candidiasis (66 patients, 24.1%) and Active TB (58 patients, 21.2%) represent the primary clinical burden. TB management remains a critical intervention priority due to its highly infectious nature.

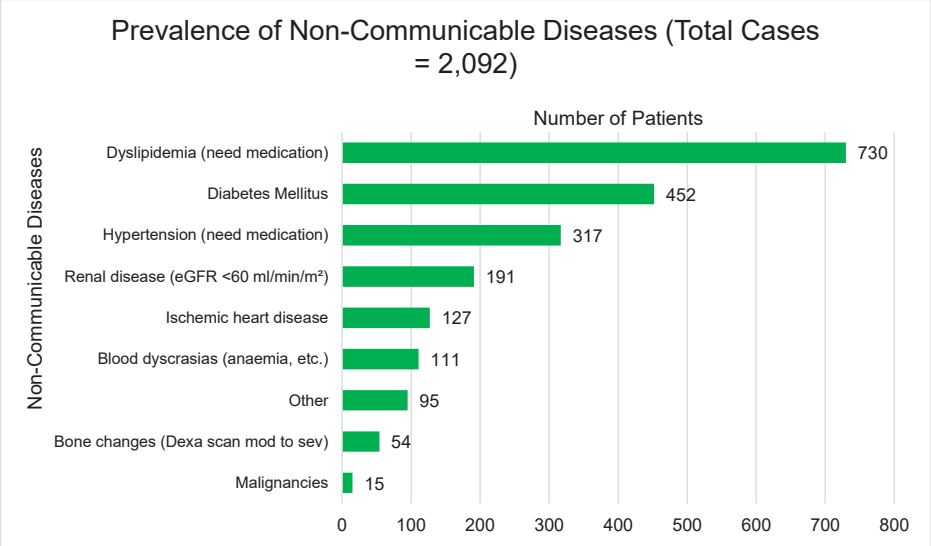
- Moderate-Burden Infections (10% to 19%): Pneumocystis jiroveci pneumonia (42 patients, 15.3%) and Chronic diarrhoea (31 patients, 11.3%) are highly common, typically correlating with severely compromised immune systems (such as advanced HIV/AIDS).

- Low-Burden Infections (Under 5% each): Severe systemic or neurological conditions like Toxoplasmosis (3.3%), Cryptococcal Meningitis (1.1%), and MAC (0.7%) are less frequent but generally carry higher mortality risks if left untreated.

Prevalence of Non Communicable Diseases

- Dyslipidemia requiring medication and Diabetes Mellitus remain the leading non-communicable diseases (NCDs) in this expanded dataset, making up over half of the total clinical conditions. With the inclusion of Hypertension, Blood Dyscrasias, and other conditions, the total recorded case burden rises to 2,092 cases.

Figure 6.11: Prevalence of Non-Communicable Diseases

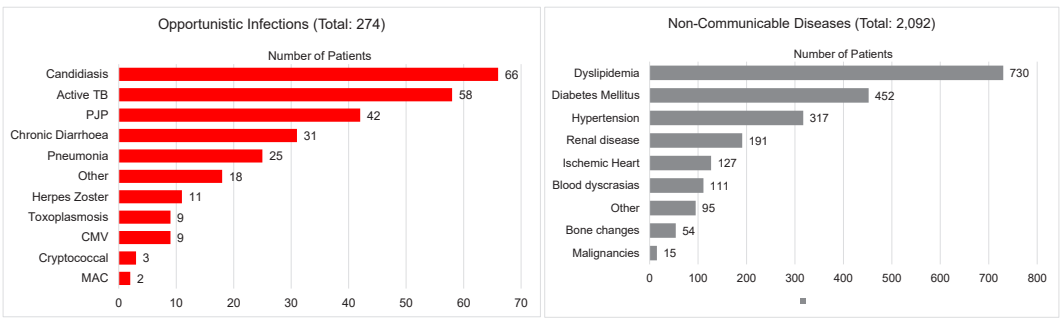


- Total Burden Baseline: The total number of reported NCD cases across the entire cohort is now 2,092.
- The "Big Three" Cardiovascular/Metabolic Risks: Dyslipidemia (730 cases, 34.9%), Diabetes Mellitus (452 cases, 21.6%), and the newly added Hypertension (317 cases, 15.2%) form a massive 71.7% of the total caseload. This strongly suggests high metabolic syndrome prevalence.
- Secondary Organ & Systemic Issues: Renal disease (9.1%), ischemic heart disease (6.1%), and Blood Dyscrasias (5.3%) represent significant secondary chronic conditions that require ongoing multi-disciplinary medical management.
- Low-Volume Specialist Care: Bone changes (2.6%) and Malignancies (0.7%) represent the smallest patient segments but still dictate a need for specialized oncology and rheumatology screening.

Given below is a side-by-side comparison of the two datasets. Combining them highlights that Non-Communicable Diseases (2,092 cases) present a significantly higher volume of clinical management needs compared to Opportunistic Infections (274 cases) within this patient cohort.

Figure 6.12: Side -by Side Comparition;OI vs NCDs

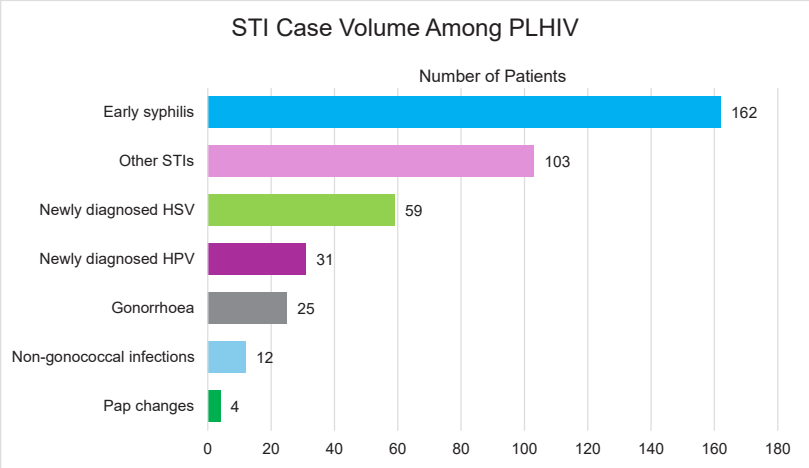
Side-by-Side Comparison: OIs vs. NCDs



- The volume of NCD complications is over 7.5 times larger than that of opportunistic infections, indicating a population living with long-term chronic disease management.
- Metabolic issues dominate the profile. Dyslipidemia and Diabetes Mellitus together account for 1,182 patients, which represents over 56% of all recorded NCD conditions.
- The high numbers of oral/oesophageal Candidiasis (66), Tuberculosis (58), and PJP (42) are highly characteristic clinical milestones typically monitored in immunocompromised patient cohorts (such as HIV/AIDS populations),indicating the increase of late diagnosis.

Sexually Transmitted infections among PLHIV

Figure 6.13: Sexually Transmitted Infections among PLHIV



- With 162 patients, early syphilis presents a massive public health concern in this group. Syphilis ulcers facilitate HIV transmission and complicated clinical management, requiring aggressive screening and partner notification strategies.
- High Ulcerative STI Burden: Combining Syphilis (162) and HSV (59) reveals that 55.8% of all recorded STI cases are ulcerative in nature.
- Viral vs. Bacterial: Chronic or viral STIs (HSV, HPV, and related Pap changes) account for 23.7% (94 cases) of the total burden, indicating a need for long-term monitoring, oncological screening (Pap smears), and vaccination discussions.
- Low Classic Bacterial Rates: Gonorrhoea (25) and non-gonococcal infections (12) represent a smaller slice of the overall dataset (9.3% combined), though still clinically significant.

Enhancing HIV Care in Sri Lanka

To minimize patient burden and improve treatment compliance, the NSACP has shifted toward an integrated, multidisciplinary care model. At the central hub, the Colombo HIV Clinic—which manages the nation's highest volume of PLHIV—has successfully embedded specialized clinics within its premises.

Operating on a weekly schedule, these units provide direct access to:

- Tuberculosis and Respiratory Care (supported by the Central Chest Clinic, Colombo)
- Mental Health Services (supported by the National Institute of Mental Health)
- Nutritional Management (supported by the National Hospital of Sri Lanka)

This integrated approach allows medical officers to refer patients during routine HIV check-ups, consolidating multiple consultations into a single visit. To replicate this efficiency nationwide, peripheral district clinics have established internal hospital referral pathways, significantly reducing travel times and enhancing treatment compliance for peripheral populations.

Governance, Estimations, and the Global Fund Transition

Strengthening the administrative framework remains a priority for long-term program sustainability. The HIV Treatment and Care Subcommittee, chaired by the Deputy Director General of Public Health Services 1, was convened this year. This multi-sectoral forum united NSACP consultants, district venereologists, and external stakeholders—including the World Health Organization (WHO) and civil society groups—to refine diagnostic strategies, laboratory standards, and counseling protocols.

A primary focus of governance this year was securing the future of Antiretroviral Therapy (ART) procurement. Utilizing the CHAI ART Estimation Tool, an expert working group drafted a rigorous forecasting model. While initial estimates spanned 2024–2026, the timeline was extended to 2025–2027 to align with the upcoming Global Fund (GF) grant cycle.

To navigate economic recovery challenges, the Government of Sri Lanka (GoSL) negotiated a gradual funding transition model with the Global Fund, shifting financial responsibility step-by-step to state(GOSL)

Community Mobilization and Peer Support

Civil society remains the cornerstone of patient-centric care in Sri Lanka. Three prominent PLHIV-led organizations—Positive Women's Network, Positive Hopes Alliance, and Lanka Plus—work in partnership with the NSACP. Beyond offering peer counseling and education, these groups play an important role in the National AIDS Committee (NAC) and subcommittees, ensuring patient perspectives driven national policy.

To professionalize and scale these interventions, the NSACP launched several Global Fund-backed initiatives:

- Institutional Capacity Building: The program initiated mandatory quarterly review meetings to systematically refine service delivery and elevate patient welfare standards.

- Adherence and Retention Outreach: Targeted awareness programs were deployed for PLHIV to strengthen treatment adherence and improve long-term retention in care.
- Advocacy and Alliance Building: Strategic stakeholder meetings were institutionalized to advance advocacy efforts and secure broader institutional support.
- Allied organizations, including the Family Planning Association of Sri Lanka (SLFPA), the National AIDS Foundation (NAF), and NEST, provided additional operational support to reinforce the safety net for vulnerable patients.
- Systemic Challenges and Strategic Mitigation

As the number of newly diagnosed PLHIV rises, the healthcare system faces distinct operational bottlenecks. Identifying these pain points has allowed the NSACP to implement targeted counter-strategies.

- Human Resource Maldistribution: Severe patient overcrowding at the Colombo HIV Clinic contrasts with underutilized peripheral clinics. This is exacerbated by a shortage of permanent medical officers in the capital and vacant consultant venereologist posts in outlying districts. Mitigation: Provincial health authorities implemented cross-coverage mechanisms, allowing active consultants to cover unstaffed neighboring clinics.
- Infrastructure and Diagnostics: Limited physical space for clinical care and patient file (BHT) storage hampers daily operations. Additionally, centers face inconsistent supplies of CD4 reagents, viral load kits, and Opportunistic Infection (OI) diagnostic tools. Mitigation: The NSACP submitted emergency supply requests to the Global Fund to secure critical diagnostic kits and short-supply medications.
- Procurement Pipelines: The standard GoSL medical procurement process routinely exceeds 12 months. This delay is worsened by a strict regulatory landscape requiring WHO-prequalified or NMRA-registered suppliers, which often deters international bidders from competing for small-quantity, niche ART formulations (e.g., Abacavir, Lamivudine, and TAF-based regimens). Mitigation: The Drug and Therapeutic Committee institutionalized aggressive stock-consumption monitoring, alongside regular procurement alignment meetings with the Medical Supplies Division (MSD) and the State Pharmaceutical Corporation (SPC) to expedite clear-channel purchasing.

CONSULTANT VENEREOLGIST [1]

07 ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV, SYPHILIS AND HEPATITIS B

NIMALI JAYASURIYA [1]

Introduction

Sri Lanka continues to demonstrate strong commitment and sustained success in the Elimination of Mother-to-Child Transmission (EMTCT) of HIV and syphilis. Following its successful validation achievements, the country underwent the second maintenance review in 2025 to assess the sustainability of EMTCT outcomes for HIV and syphilis. This reflects Sri Lanka's ongoing dedication to maintaining elimination status while strengthening maternal and child health services.

In parallel, Sri Lanka has advanced efforts toward Triple Elimination of HIV, syphilis, and hepatitis B, aligning national strategies with global and regional targets.

During the 2025 maintenance review, the Global Validation Advisory Committee (GVAC) commended Sri Lanka's achievements and provided several key recommendations to further strengthen programme sustainability and progress toward triple elimination.
Key recommendations included:

- Strengthening triple EMTCT data systems by disaggregating indicators between public and private healthcare sectors to better assess programme performance and service delivery outcomes.
- Reviewing HIV re-testing policies in antenatal care, including consideration of third-trimester testing and risk-based re-testing approaches based on maternal and partner risk profiles.
- Enhancing maternal and child health records and case investigation systems to better identify women at risk and improve follow-up of HIV-exposed infants.
- Ensuring timely initiation of antiretroviral therapy (ART), including access to same-day treatment services for pregnant women diagnosed with HIV.
- Improving management of syphilis-positive pregnant women, particularly those with penicillin allergy or those presenting late for care.
- Strengthening laboratory quality systems, including expansion of external quality assurance (EQA) programmes, accreditation processes, viral load quality monitoring, and inclusion of private laboratories in national quality assurance systems.
- Preventing stock-outs of testing commodities and medicines through strengthened supply chain planning and procurement mechanisms.
- Expanding human rights, gender equality, and community engagement initiatives, including community-led monitoring, stigma reduction activities, advocacy for legal reform, and improved access to sexual and reproductive health services for women and adolescents.
- Continuing efforts toward validation of EMTCT of hepatitis B, including strengthening antenatal antiviral therapy, partner screening, and linkage to treatment and care services.

These recommendations provide an important roadmap for sustaining EMTCT achievements and advancing Sri Lanka's progress toward comprehensive Triple Elimination.





Key activities

Key EMTCT activities continued during the reporting period with a focus on advancing the Triple Elimination agenda. Triple Elimination Steering Committee meetings were conducted regularly, and key decisions were made to officially launch the Triple Elimination Programme in 2026.

In addition, several stakeholder consultation meetings were carried out to support programme planning and implementation. These included the development of Triple Elimination IEC materials, preparation of the Triple Elimination Strategy, Triple elimination circulars, and the development of national guidelines on the management of pregnant women with hepatitis B.

Preparatory activities for the Triple Elimination pilot programme were also initiated in selected high-burden districts. The pilot programme aimed to strengthen the integration of HIV, syphilis, and hepatitis B services within existing maternal and child health services, particularly antenatal care settings. The programme focused on improving early screening, timely referral and linkage to care, treatment initiation, partner management, and follow-up of mothers and exposed infants.

The Triple Elimination pilot programme was conducted from 15 July 2025 to 31 August 2025 in the Western Province. A total of 10,586 pregnant women were screened during the programme, including 6,364 from Colombo District, 2,468 from Kalutara District, and 1,754 from Gampaha District. No newly detected hepatitis B positive pregnant women were identified during the pilot programme.

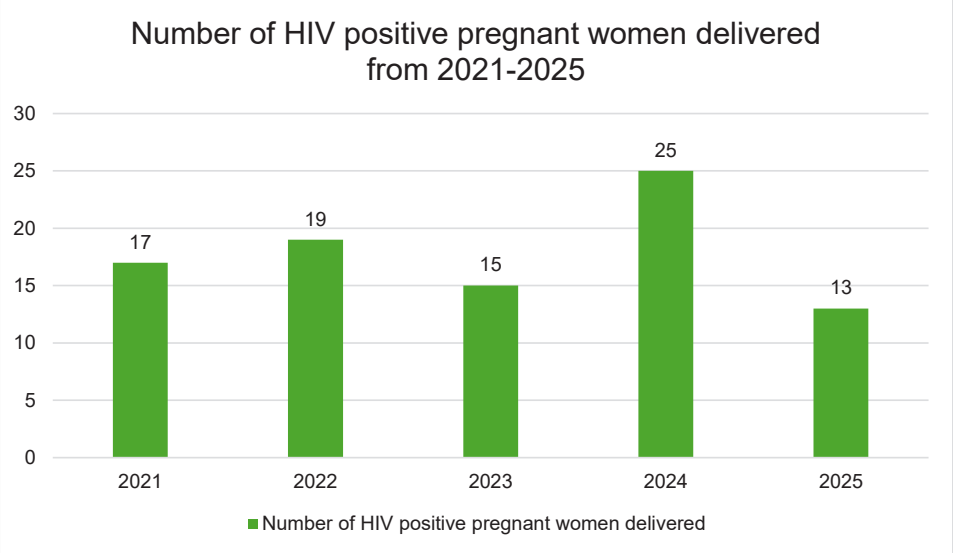
Capacity-building activities for healthcare workers, strengthening laboratory systems, improving data collection and reporting mechanisms, and ensuring uninterrupted availability of test kits and medicines were identified as key components of the pilot phase. The pilot programme is also expected to assess the feasibility of integrated service delivery models and identify operational challenges prior to national scale-up of Triple Elimination activities.

Programme data

Pregnant Women with HIV:

- In 2024, 25 pregnant women living with HIV delivered, and all infants tested HIV-negative, confirming the effectiveness of EMTCT interventions. A total of 29 pregnant women with HIV were identified, and all were linked to EMTCT services for continued care and support.

Figure 7.1: Number of HIV positive pregnanat women delivered from 2021-2025



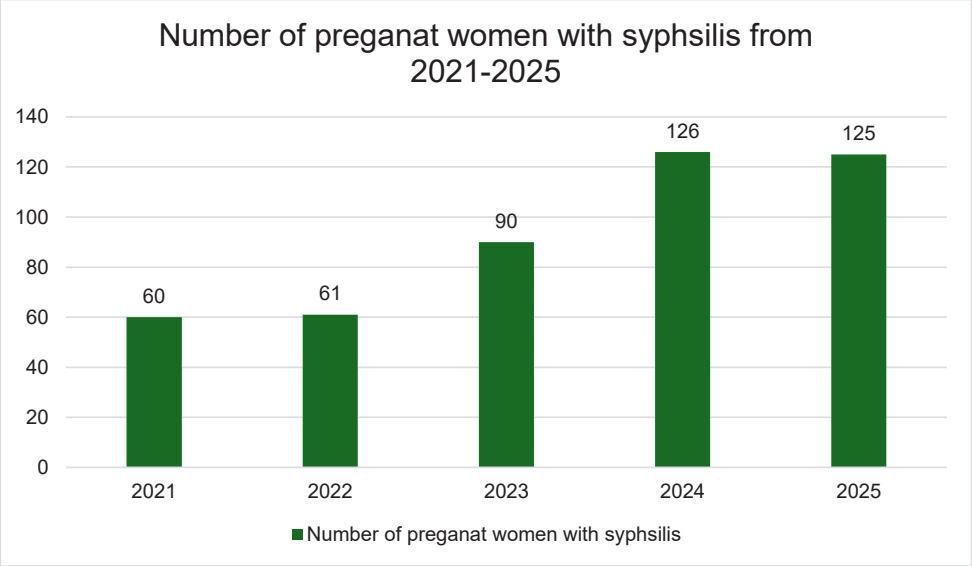
The number of HIV-positive pregnant women delivered in Sri Lanka showed some fluctuations during the period from 2021 to 2025. In 2021, a total of 17 HIV-positive pregnant women delivered, which increased slightly to 19 in 2022. The number decreased to 15 in 2023, followed by a notable increase to 25 cases in 2024, representing the highest number reported during the five-year period. In 2025, the number declined significantly to 13 cases.

Overall, despite year toyear variations, the relatively low number of HIV-positive pregnant women delivered reflects the continued effectiveness of Sri Lanka's EMTCT programme, including strengthened antenatal screening, early diagnosis, linkage to care, and treatment services for pregnant women living with HIV.

Pregnant Women with Syphilis:

In 2024, 126 pregnant women with syphilis were registered. Efforts were made to strengthen treatment uptake, with nationwide promotion of same-day administration of Benzathine Penicillin to ensure timely and adequate treatment.

Figure 7.2: Number of pregnant women with syphilis from 2021-2025



The number of pregnant women diagnosed with syphilis in Sri Lanka has shown a concerning and steady upward trend between 2021 and 2025. Cases remained relatively stable in 2021 and 2022, with 60 and 61 cases respectively, before rising sharply to 90 in 2023 a 48% increase from the previous year. This upward trajectory continued dramatically in 2024, reaching a peak of 126 cases, more than double the figure recorded in 2021.

Although 2025 recorded a marginal decline to 125 cases, the figure remains alarmingly high, suggesting that the surge observed from 2023 onwards has not been meaningfully reversed. The overall rise of more than 108% over five years highlights a significant public health challenge, emphasizing the urgent need to strengthen antenatal syphilis screening programmes, ensure timely treatment with Benzathine Penicillin G, improve partner notification and treatment, and intensify efforts to eliminate mother-to-child transmission of syphilis in line with WHO's dual elimination targets for both syphilis and HIV.

Capacity Building and Service Strengthening

- EMTCT annual review and district-level EMTCT reviews were conducted as routine activities.
- Refresher training programmes were conducted for Maternal and Child Health (MCH) staff to ensure consistent implementation of updated guidelines and to maintain high standards of service delivery.

CONSULTANT VENEREOLGIST [1]

08 PRE-EXPOSURE PROPHYLAXIS (PREP)

NIMALI JAYASURIYA [1]

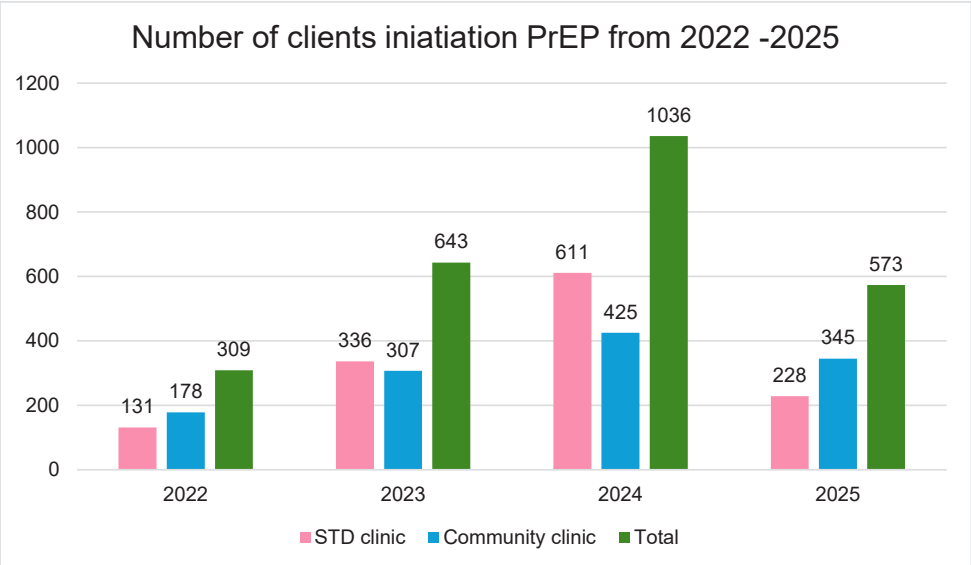
Pre-Exposure Prophylaxis (PrEP) Services in Sri Lanka

Sri Lanka has progressively aligned its HIV prevention strategies with World Health Organization (WHO) guidelines by expanding access to Pre-Exposure Prophylaxis (PrEP) as a key biomedical intervention among populations at substantial risk of HIV acquisition. In accordance with both WHO recommendations and the National STD/AIDS Control Programme (NSACP) of Sri Lanka, oral PrEP is offered to high-risk groups including men who have sex with men (MSM), transgender individuals, female sex workers, people who inject drugs, and serodiscordant couples.

The recommended PrEP regimen in Sri Lanka follows the WHO-endorsed oral combination therapy comprising Tenofovir Disoproxil Fumarate (TDF) paired with either Lamivudine (3TC) or Emtricitabine (FTC), providing dual nucleoside reverse transcriptase inhibitor (NRTI) backbone protection. In line with evolving global guidance and the growing evidence base supporting enhanced efficacy, Dolutegravir (DTG) an integrase strand transfer inhibitor is incorporated into the regimen, forming the triple combination TDF/3TC or TDF/FTC + DTG, which offers superior viral suppression, a high barrier to resistance, and a favorable safety profile.

PrEP services in Sri Lanka are delivered through NSACP clinics, designated government hospitals, and partner non-governmental organizations, with eligibility assessment, baseline HIV testing, renal function evaluation, and regular three-monthly follow-up reviews forming the standard of care. Ongoing efforts focus on reducing stigma, improving PrEP literacy among key populations, and ensuring sustained adherence to maximize the preventive benefit of this life-saving intervention

Figure 8.1: Number of clients initiated on PrEP from 2022-2025



The number of clients initiated on PrEP shows a steady increase from 2022 to 2024, followed by a decline in 2025. In 2022, a total of 309 clients were initiated on PrEP, which increased to 643 in 2023 and peaked at 1036 in 2024, reflecting a substantial scale up of services, particularly through STD clinics.

However, in 2025, the total number decreased to 573, with a notable reduction in initiations from STD clinics. This decline is likely attributable to stock-outs of PrEP, which limited service delivery despite continued demand. Overall, the trend indicates strong program expansion up to 2024, with the 2025 reduction being a temporary setback due to supply constraints. PrEP services in Sri Lanka have demonstrated a consistent rise in uptake, indicating improved expansion and accessibility of HIV prevention services through both STD/sexual health clinics and community-based clinics.

CONSULTANT VENEREOLGIST [1]

09 POST EXPOSURE PROPHYLAXIS

NIMALI JAYASURIYA 1

Post-Exposure Prophylaxis (PEP) is an emergency HIV prevention intervention provided to individuals following potential exposure to HIV. Sri Lanka provides both Occupational PEP (oPEP) for healthcare and other workers exposed during their duties, and Non-Occupational PEP (nPEP) for exposures occurring in the community, including sexual exposures, sexual assault, and other non-occupational incidents. PEP services are available free of charge through government STD clinics and designated healthcare institutions throughout the country.

PEP services in Sri Lanka are delivered in accordance with the national Protocol for HIV Post-Exposure Prophylaxis (2023) and are aligned with the latest WHO recommendations. All clients undergo a comprehensive risk assessment that considers the nature of the exposure, timing since exposure, HIV status of the source person (if known), and the likelihood of HIV transmission. PEP is recommended only when the exposure presents a significant risk of HIV acquisition.

Timely initiation of PEP is critical for effectiveness. Individuals are advised to seek care immediately after a potential exposure. PEP should ideally be started within 24 hours and no later than 72 hours after exposure. A 28-day course of a three-drug antiretroviral regimen is recommended, consistent with WHO and national guidelines.
Sri Lanka has strengthened access to PEP through the availability of PEP starter packs, which facilitate the rapid initiation of treatment, particularly in emergency settings and outside routine clinic hours. Starter packs enable exposed individuals to commence treatment without delay while arrangements are made for clinical review, counselling, baseline investigations, and continuation of the full 28-day regimen. This approach supports improved adherence and maximizes the effectiveness of PEP.

PEP services include:

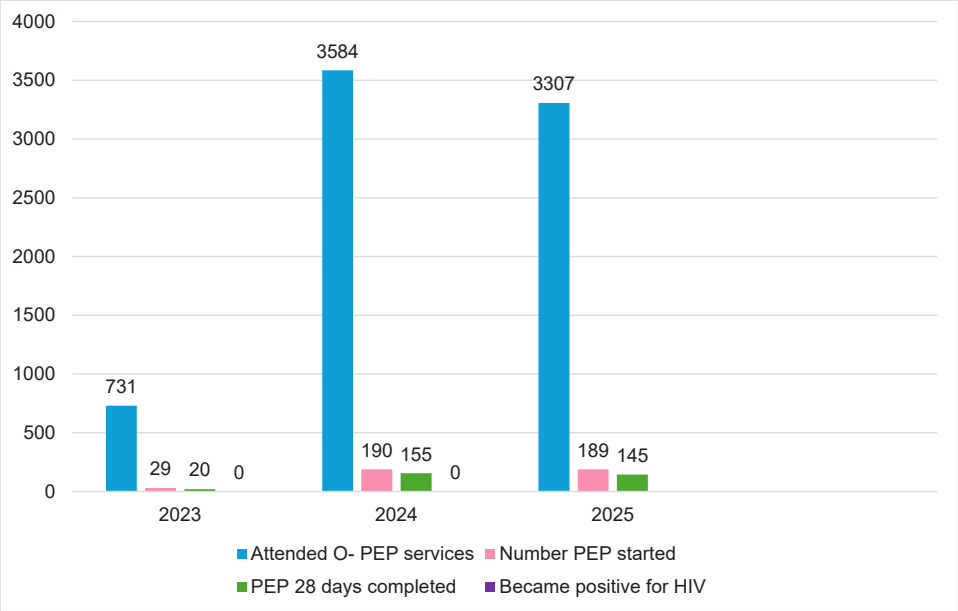
- Immediate assessment of exposure risk.
- Baseline HIV testing and counselling.
- Provision of PEP when indicated.
- Follow-up clinical review and laboratory investigations.
- Adherence support and management of adverse effects.
- Risk-reduction counselling and linkage to ongoing HIV prevention services, including PrEP for individuals with continuing risk.

Through the provision of both occupational and non-occupational PEP services, Sri Lanka continues to strengthen its comprehensive HIV prevention programme and contribute to the national goal of ending HIV transmission.

Post-Exposure Prophylaxis following Occupational (o-PEP) Exposures

For occupational exposures, PEP "starter packs" are available in most government and private health institutions and are strategically placed in high-risk and 24-hour service areas to allow immediate initiation of therapy at any time, including nights and weekends. Their main purpose is to provide rapid access to antiretroviral medication following a potential HIV exposure, while the exposed individual undergoes full clinical assessment and baseline investigations. Each starter pack generally contains enough medication for the first 3–5 days, ensuring that treatment begins without delay, with continuation to the full 28-day regimen provided through follow-up at the STD clinic once eligibility is confirmed.

Figure 9.1:Occupational Exposures Managed with Post-Exposure Prophylaxis, 2023–2025



The figure illustrates the outcomes of individuals who attended occupational post-exposure prophylaxis (o-PEP) services during 2023–2025.

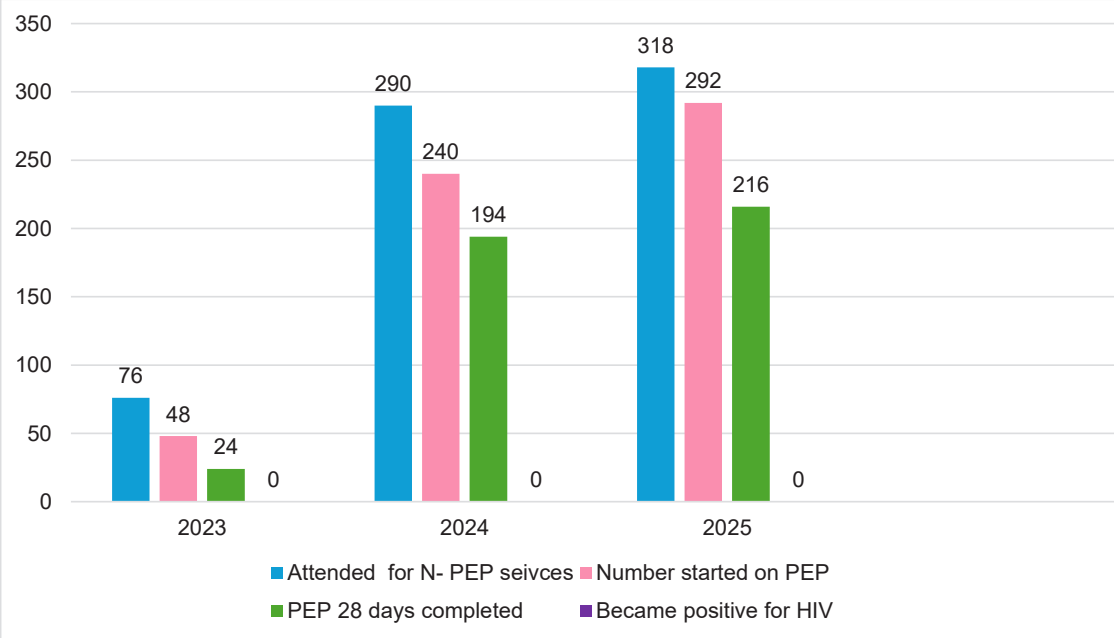
- The number of clients attending o-PEP services increased markedly from 731 in 2023 to 3,584 in 2024, followed by a slight decline to 3,307 in 2025.
- The number of individuals who initiated PEP rose from 29 in 2023 to 190 in 2024, with a similar level maintained in 2025 (189).
- Completion of the full 28-day PEP regimen increased substantially from 20 in 2023 to 155 in 2024, with 145 clients completing treatment in 2025.
- Importantly, no individuals who received o-PEP became HIV-positive during the follow-up period in any of the three years.

Overall, the data demonstrates a substantial expansion of o-PEP service utilization since 2023, with high levels of PEP initiation and completion among eligible clients and no documented HIV seroconversions, highlighting the effectiveness of the o-PEP programme.

Post-Exposure Prophylaxis following Non-Occupational (n-PEP) Exposures

Non-Occupational Post-Exposure Prophylaxis is a time-sensitive, evidence-based intervention designed to prevent HIV infection following potential non-occupational exposures, such as sexual contact or needle-sharing incidents. The utilization of n-PEP services has increased significantly, driven by greater awareness among the public and key populations regarding its availability and effectiveness. The provision of antiretroviral therapy free of charge has removed financial barriers, encouraging uptake among at-risk individuals. n-PEP services are accessible at government STD clinics.

Figgure 9.2: Non-Occupational Exposures Managed with Post-Exposure Prophylaxis, 2023–2025



The n-PEP (Non-Occupational Post-Exposure Prophylaxis) service has demonstrated remarkable growth and effectiveness between 2023 and 2025. Attendance rose sharply from 76 in 2023 to 318 in 2025, reflecting increasing awareness and accessibility of the service. The proportion of attendees who initiated PEP remained consistently high, reaching 92% in 2025, with 292 out of 318 individuals commencing treatment. Treatment completion also improved significantly, growing from just 24 in 2023 to 216 in 2025, representing approximately 74% of those who started the course. Most strikingly, not a single attendee across all three years tested positive for HIV, underscoring the programmer's outstanding clinical effectiveness in preventing HIV transmission among those who accessed care in a timely manner.

Government Health Care Centres Providing ART for Occupational Post-Exposure Prophylaxis (o-PEP) in Sri Lanka

District	Institution	Unit of location	Contact Number
Ampara	DGH – Ampara	PCU STD Clinic	063 2222261
	BH - Dehiaththakandiya	ETU	027 2250344
	BH- Mahaoya	PCU	063 2244061
Anuradhapura	TH – Anuradhapura	ETU STD Clinic	0252222261 025 2236461
Badulla	PGH – Badulla	STD Clinic	055 2222261
	BH – Diyathalawa	ETU	057 2245161 057 2229061
	BH – Mahiyanganaya	ETU STD clinic	055 4936722 055 4936779
Batticaloa	TH Batticaloa	STD clinic ETU	065 2057078 065 2222261-2
Colombo	National STD/AIDS Control programme	STD clinic	0112667163
	National Hospital of Sri Lanka	OPD room number 08	0112691111 Ext 2417
	Lady Ridgeway Hospital	Indoor Dispensary	011 2693711-2 Ext. 219, 242
	De Soysa Maternity Hospital	Emergency theatre (OT2)	0112696224-5 Ext.326
	Castle Street Hospital for Women	Intensive care unit (ICU)	0112696231-2 Ext.2230
	National Eye hospital	Room 4 (OPD)	0112693911-5 Ext.231
	Sri Jayewardenepura Teaching Hospital	Indoor pharmacy	0112802695-6 Ext.3032
	Mulleriyawa Base Hospital	ETU	0112549390
	Police Hospital Colombo	Infection Control Unit	0112501385
	TH- Kalubowilla	Infection Control unit (From 7am-4pm) OPD room number 20 (after 4pm)	0112763261 Ext. 129 0112763261 Ext. 218
		STD clinic	0114891055
		Infection control unit Ward 03	011 2411284 Ext.264 011 2411284 Ext. 210
	DGH Awissawella	STD clinic PCU	036 2222003 036 2222261
	BH - Homagama	STD clinic PCU	0112855200 011 2855200 Ext. 224
Puttalam	BH - Puttalam	PCU	0322265496
		STD clinic	0322265496 Ext 132
	DGH Chilaw	PCU	032 2223261
		STD clinic	032 2220750
Galle	TH Mahamodara	STD clinic Indoor Drug Dispensary	0912245998 0912222261, 0912234951
	TH Karapitiya	ETU	0912232267, 0912232176
	BH Balapitiya	STD clinic ETU	0912258261 0912 256822
	BH Elpitiya	ETU	0912 291 261 Ext.

Gampaha	TH Ragama	SICU STD Clinic	011 2960224 Ext 258 011 2960224
	Welisara chest Hospital	Infection Control Unit	0112956702
	DGH – Gampaha	PCU STD Clinic	033 2222261 Ext 200 033 2234383
	DGH Negombo	MICU STD clinic	031 2222261 Ext 439 031 2222261 Ext 144 031 2239016
	BH – Wathupitiwala	ICU STD Clinic	033 2280261 033 2280261-2 Ext 255
Hambantota	DGH – Hambantota	STD Clinic PCU	047 2222247 047 2222247
	BH - Tangalle	STD clinic, ICU ,infection control unit	047 2240261
	BH - Tissamaharama	Pharmacy	0472237261
	BH - Walasmulla	ETU	0472245261
Jaffna	TH Jaffna	ETU STD Clinic	021 2222261 021 2217756
Kalmunai	BH -Kalmunai	STD Clinic	0672223660
Kalutara	GH - Kalutara	PCU STD Clinic - Kalutara	0342222261, Ext. 250 034-2236937
	BH - Panadura	ETU	038 2222261 Ext. 4298
	BH- Horana	PCU	0342261261 Ext.1135
	Kethumathi Maternity Hospital	ward 2	038 2232361 Ext.
Kandy	TH- Kandy	ETU STD Clinic	081 2233338, 081 2234208 081 2203622
	BH - Gampola	ETU	081 2352261
	BH- Teldeniya	ETU	081-2374055
	BH - Nawalapitiya	ETU STD Clinic	054 2222261 0542222261 Ext. 230
Kegalle	TH- Kegalle	ETU STD Clinic	035 2222261 035 2231222
	BH - Mawanella	ETU	035 2247835
	BH - Karawanella	ETU	036 2267374
	BH - Warakapola	ETU	035 2267261
Kilinochchi	BH -Kilinochchi	STD clinic	021 2285329 021 2283709
Kurunegala	TH - Kurunegala	STD Clinic A&E,	037 2224339 037 2233909
	BH - Kuliyapitiya	A&E STD clinic	037 2281261
	BH - Nikaweratiya	ICU	037 3378060
	BH - Dambadeniya	PCU	037 2266592
	BH - Galgamuwa	PCU	037 2253061
Mannar	DGH - Mannar	STD clinic	0232250573
Matale	DGH - Matale	ETU STD clinic	 066 2053746

Matara	DGH - Matara	ETU STD Clinic	041 2222261 Ext.161 041 2232302
	BH - Deniyaya	ETU	O412273261
	BH - Kamburupitiya	ETU	0412292261
	DH - Kamburugamuwa	ETU	0412222589
Monaragala	DGH Monaragala	Primary care unit STD Clinic	055 2277024 055 2276826
	BH Bibila	PCU	055 2265461 Ext 135
	BH Wellawaya	PCU	055 2274861 Ext 159
	BH Siyambalanduwa	PCU	055 2279460 Ext 109
Mullaitivu	DGH Mullaitivu	STD clinic	021 2061412
Nuwara Eliya	GH Nuwara Eliya	OPD STD Clinic	052 2234393 052 2223210
	BH Dickoya	OPD	051 2222261
Polonnaruwa	GH- Polonnaruwa	ETU STD Clinic	027 2222384 027 2225787
Ratnapura	PGH - Ratnapura	ICU STD Clinic	0452225396, Ext.225, 337 045 2226561
	BH - Balangoda	Ward 02 (Medical ward)	045 2287261 Ext 273
	BH - Embilipitiya	ICU STD Clinic	047 2230261 Ext 244 047 2230261 Ext 192
Trincomalee	GH Trincomalee	ETU STD Clinic	026 2222261 026 2222563
Vavuniya	DGH Vavuniya	STD Clinic	024 2224575

CONSULTANT VENEREOGIST [1]

10 KEY POPULATION INTERVENTIONS

SATHYA HERATH [2]

The key populations (known as KP) at high risk of contracting HIV are, Men who have sex with men (MSM), female sex workers (FSW), and people who use drugs specially focusing people who inject drugs (PWID), Transgender (TG) beach Boys (BB) and people in closed settings like prison inmates.

Full functioning Community PrEP clinics, expanding virtual interventions, increasing community led testing, expanding services through community clinics, improving and scaling up one stop shop models for Hepatitis C management, and PrEP delivery were given priority in 2025.

Special interventions in 2025

1. While focussing on scaling up and sustaining the interventions initiated in previous years, Point of Care testing for Hepatitis B Viral Load testing (PCR) and point of care testing for liver and renal profile were introduced as new Point of Care technique within the Key Population unit of the National STD/AIDS Control Program in 2025.
2. Community PrEP clinics were continued regularly for Men sex with men, Female Sex Workers and Transgenders. After performing point of care testing, same day PrEP was offered. New Community PrEP clinics launched in certain locations during 2025.
3. As part of Community Led KP intervention, a new NGO/CBO supported KP intervention was launched in Nuwara Eliya district for MSM and FSW components in 2025.
4. Guided Monitoring and Evaluation series were initiated. Each district KP interventions team (NGO/CBO administration, Program implementing Community team and the clinic team) were invited to the KP unit of the NSACP. Each document competency, data entered in the Prevention Information Management System (PIMS) and evidence of physical and virtual programs were cross-checked and mentoring were done to each individual in small groups. These guided M & E help the team to understand the intervention comprehensively. The KP intervention and the PIMS data entering improved with the introduction of these approaches.
5. Training on Key population programs and Legal literacy on laws that affect KP attending health services were conducted for undergraduate medical students of Colombo medial college and Kotelawala Defence University, Major, minor staff of Island wide STD clinics during the in-service trainings, and to the staff of Judicial medical officers in a workshop.
6. A Europe delegation and a Nepal delegation visit arranged by the Family

Planning Association visited the community centres to get experience about KP program and Drug use program in Sri Lanka in mid-2025

7. As a continuation from previous years, Community Led Monitoring activity continued providing further structured trainings to the communities and health care staff in 2025.

8. In order to facilitate smooth functioning of Drug use interventions, several pocket advocacy programs to the police and other stakeholders were conducted throughout high injecting drug use prevalence Municipal Wards of Colombo Municipal Council.

9. A study on "Rapid Assessment (RA) of Drug Use situation among school leavers and higher educational institution students in Colombo" was completed in 2025.

10. As part of the series of drug use specific interventions Vavuniya STD clinic staff were trained on harm reduction interventions in December 2025. This training was a continuous mentoring and case discussion on management of hepatitis C infection.

11. The National Apprentice and Industrial Training Authority (NAITA) course module was completed and finalised in 2025.

12. Three days special training on developing social media post was organized to the virtual outreach workers in December 2025.

13. A team of individuals consist of medical officers, nurses, and outreach workers were trained on the whole technic of organizing and conducting PrEP clinics to ensure smooth functioning of Community PrEP clinics.

14. The year end assessment for community led KP intervention team was completed for the second year, in spite of disaster consequences following Cyclone Dithwa in December 2025.

15. Mobile Container clinic functioning was planned and regularized.

Deputy Director General (Public Health Services 1) Ministry of Health & Mass Media Visiting the Drug Use Program Community Centre



Role of Key Population Unit at the National STD/AIDS Control Program

- Technical guidance to the district clinics, NGO/CBOs and to the communities
- Capacity building of the Health Care staff and field staff.
- Ensuring National and District level Advocacy to ensure Multisectoral collaboration.
- Engage in community-based activities, conducting community-based one-stop clinics for Pre-Exposure Prophylaxis (PrEP), and Community-based Hepatitis C treatment clinics.
- Monitoring and Evaluation of Key Population intervention by monthly progress reviews, district reviews and National reviews.
- M & E through mentoring and guidance of the documents and data entry platforms (PIMS)
- Conduct Regular supervision visits to District clinic KP units and community centers operating by the NGO/CBO in KP interventions districts.
- Conduct year end assessment to the KP program team.

Services provided at the district sexual health clinic level and in the community clinics by NGO/CBO

District clinics facilitate the community led activities in the district with the support of the NGO/CBO.

Services provided

- Health education, promotion, and communication on safe sexual practice, safe injection practice, and drug use specific harm reduction.
- Condom and lubricant promotion and distribution. Distribution of needles and syringes for People Who Inject Drugs.
- HIV testing, counseling, and linking for services (Community-based testing, Community Led Testing, and HIV self-testing)
- Referring clients for HIV/STI services: STI screening, treatment, PrEP, PEP, Hepatitis B vaccination, Community-based HCV treatment for PWIDs, and giving support for treatment adherence and psychological support
- Applying innovative approaches in providing services, and reaching clients through online applications and mobile applications.

In addition to these NGO/CBO supported KP interventions, routine integrated Health care worker model reach KP in the clinics and field. Education, provision of condoms and lubricant, HIV/STI testing, PrEP, PEP and HIV/STI/ Hepatitis treatment care and support services are routinely provided.

Monitoring and Evaluation Activities

1. KP interventions are monitored by the relevant district clinics, and NSACP
2. Community center activities are monitored by both NGO/CBO and district clinics.
3. Monthly reviews are conducted by the KP/Unit/NSACP in collaboration with district clinics and NGO/CBO
4. PIMS data entering is continuously monitored by the district clinics, NGO/CBO and SIM unit/NSACP.
5. Performance of achieving the targets is continuously monitored by the NGO/CBO, district clinic, and KP unit/ NSACP.
6. Indicators are monitored by the SIM unit quarterly and reported annually to National and International reporting entities.

Strengths

1. Efficient supportive staff to conduct community-based activities and clinics
2. Dedicated Outreach staff with a well-coordinated system with the government and NGO/CBO
3. Establishment of Community-based PWID clinics and PrEP clinics
4. Scaling up of community clinics through mobile container clinics
5. Increase the coverage of services for the KP HIV and identify more HIV/STIs and Hepatitis C

Challenges

1. Delay and interruption of intervention time to time due to multiple challenges from STD clinics, NGO/CBO and communities.
2. Delay in salary and incentives.
3. Lack of internal motivation of some staff.
4. Lack of external motivation due to no salary or incentives increment since many years past in spite of high economic burden in the current years.
5. Reluctance and lack of understanding of the KP intervention process lack of continuous guidance in certain locations.
6. NGO/CBO lacking honest administrative requirement in recruiting suitable individuals for each position. Eg: KP are not recruited as Peer Educators, Inappropriate individual selected as outreach workers.
7. Lack of system to monitor administrative and human resource requirement at the field level. Due to this salary and allowances get delayed.
8. Lack the Human Resource Module in the PIMS. This create delay in salary and allowances.
9. Certain NGO/CBO do not perform their role as it is standardized by the KP intervention. E.g. Difficult to access locations have been used as community centers by certain NGO/CBO, NGO/CBO executive staff play key roles in the field program thereby, the it is difficult to perform continuous field work.

Future Action Plan

1. Establish, scale up, sustain community led interventions through community centers and mobile container clinics.
2. Close supervision and technical support by inviting to the KP unit/ NSACP. This is done as a team supervision by checking the manual form set and PIMS data entering.
3. Lauch Community PrEP clinics in suitable locations.
4. Advocate district and provincial authorities for sustainability, transition and co-financing of community led approach.
5. Develop and obtain cabinet approval of Harm reduction policy and National Health sector Hepatitis Strategic Plan.

Programmatic performance in 2025

Programmatic performance is monitored by set indicators against agreed targets for each KP group. The Prevention Information Management System is used for Community Led data reporting. Therefore, data can be obtained through the PIMS.

Table 10.1: Community Led Testing HIV/STI/ Hepatitis reported in 2025.

Indicators	MSM	FSW	TG	PWID	BB
Number tested for HIV	11,801	6,888	448	460	941
Number tested for Syphilis	1,254	218	12	454	24
Number tested for Hepatitis B	673	90	5	267	33
Number tested for Hepatitis C	642	22	4	453	8
HIV Positive number	89	2	3	4	0
Syphilis positive number	41	4	5	17	0
Hepatitis B positive number	1	0	1	9	0
Hepatitis C positive number	3	0	0	184	0

Source: Prevention Information Management System (PIMS), NSACP Service Package CT Report and Service CT Report

Table 10.2: Community Led services reported in 2025

Indicators	MSM	FSW	TG	PWID	BB
Number of condoms distributed	360840	766691	46644	4488	16378
Number of PrEP tablets distributed	16176	1754	743	0	0
Number of people treated for Hepatitis C	0	0	0	97	0
Number of people cured of Hepatitis C	0	0	0	35	0
Number of needles and syringes distributed	0	0	0	3429	0

Source: Prevention Information Management System (PIMS), NSACP Service Package CT Report and Service CT Report

CONSULTANT COMMUNITY PHYSICIAN [2]

11 LABORATORY SERVICES -2025

JAYANTHI ELWITIGALA [4]

1. Overview

The National STD/AIDS Control Programme (NSACP) operates a coordinated national laboratory network providing diagnostic and monitoring services for HIV and sexually transmitted infections (STIs) across Sri Lanka. The network comprises of the National Reference Laboratory (NRL) for STI & HIV, located at the NSACP headquarters in Colombo, supported by peripheral STD clinic laboratories distributed across all districts.

The NRL at Colombo serves as the apex technical reference laboratory and the primary diagnostic laboratory for the Colombo clinic, providing reference and confirmatory testing, reagent supply to district laboratories, external quality assessment coordination, staff training, and technical oversight. The peripheral clinics — all other STD clinics collectively — provide frontline diagnostic access across the country, performing routine serology, microscopy, and HIV rapid testing, with referral of complex specimens to the NRL.

2. Accreditation status of the laboratories - ISO 15189 Accreditation – NRL- 2025

A landmark achievement for the NRL in 2025 was the successful completion of the annual ISO 15189:2022 accreditation renewal assessment. Following a rigorous evaluation, the NRL was granted accreditation valid through 4th December 2029. This renewal reaffirms the NRL's sustained commitment to internationally recognised standards for medical laboratory quality and competence, and provides continued assurance to stakeholders regarding the reliability and accuracy of STI/HIV diagnostic services delivered through the national network.

The ISO 15189 accreditation underscores the NRL's compliance with stringent quality management systems, technical competence requirements, and patient-centred quality assurance — positioning it as a credible reference institution for STI and HIV diagnostics in South Asia.

3. Testing for Syphilis– 2025

Syphilis testing is conducted across all clinic sites using a combination of non-treponemal (VDRL, RPR), treponemal (TPPA) and rapid tests. Confirmatory treponemal and CSF-based testing is largely centralized at the NRL.

Table 11.1: Testing for syphilis - 2025

Test	Tested	Positive	Positivity %	NRL Share (%)
VDRL (Blood)	290,686	7,713	2.65%	18.4%
VDRL (CSF)	821	7	0.85%	3.8%
RPR	312	5	1.60%	0%
TPPA (Blood)	31,314	2,395	7.65%	29.9%
TPPA (CSF)	483	185	38.30%	96.5%
Syphilis Rapid	6,834	415	6.07%	2.5%
Duo Test (Syph+)	33,300	136	0.41%	6.6%

Key observations for 2025:

- VDRL Blood: 290,686 tests performed island wide with an overall positivity of 2.65%. Colombo NRL contributed 18.4% of total VDRL testing with a markedly higher local positivity of 7.02%, reflecting the high-risk client base of the Colombo clinic.
- TPPA Blood confirmatory testing showed a 7.65% positivity rate nationally. The NRL performed 29.9% of all TPPA testing. TPPA CSF positivity was 38.30%, indicating neurosyphilis among reactive cases — with near-total centralization (96.5%) at the NRL.
- Syphilis Rapid tests (6,834 tests; 6.07% positivity) were deployed primarily at peripheral clinics for point-of-care screening.
- The HIV/Syphilis Duo test was performed 33,300 tests island wide.

4. HIV Testing – 2025

HIV testing across the network covers screening (ELISA, Rapid Combo), supplemental/ confirmatory testing (serological and molecular) and population-based monitoring through CD4 and viral load testing.

Table 11.2: HIV test2025

Test	Tested	Positive	Positivity %	NRL Share (%)
HIV ELISA	218,063	1,805	0.83%	26.3%
HIV Rapid (Combo)	125,421	2,540	2.03%	19.2%
RDT 2	5,419	1,974	36.43%	58.9%
RDT 3	7,032	1,941	27.60%	30.5%

Test	Tested	NRL Share (%)
CD4 Count	3,780	72.1%
Viral Load	3,630	92.9%

Key observations for 2025:

- HIV ELISA: 218,063 tests conducted nationally with a 0.83% overall positivity. The NRL (Colombo) performed 26.3% of all ELISA tests, with a clinic-level positivity of 2.04%, indicative of higher-risk attendees.
- HIV Rapid (Combo): 125,421 tests performed (2.03% positivity). Peripheral clinics bore the majority of rapid testing volume (80.8%), consistent with their frontline screening role.
- RDT2 and RDT3 — performed on reactive specimens for initial supplemental/ confirmatory purposes — showed positivity rates of 36.43% and 27.60% respectively, confirming their targeted use in reactive populations. The NRL performed 58.9% of RDT2 testing and 30.5% of RDT3 testing.
- CD4 Count: 3,780 tests conducted nationally, with the NRL accounting for 72.1% (2,724 tests), reflecting its continued role as the primary CD4 testing centre.
- Viral Load Testing: 3,630 tests performed nationally; 92.9% (3,372 tests) conducted at the NRL, with peripheral centres in Anuradhapura and Galle contributing the remainder.

5. Hepatitis and Other STI Testing – 2025

Hepatitis B and C ELISA testing is almost entirely centralised at the NRL, while rapid testing is distributed across peripheral clinics. GC culture and CT/NG molecular diagnostics remain predominantly at the NRL.

Table 11.3: Hepatitis and Other HIV test positivity in 2025

Test	Tested	Positive	Positivity %	NRL Share (%)
Hepatitis B ELISA	5,846	72	1.24%	100%
Hepatitis B Rapid	16,222	120	0.74%	44.3%
Hepatitis C ELISA	3,256	144	4.41%	100%
Hepatitis C Rapid	20,054	211	1.05%	13.9%
GC Culture	17,387	301	1.73%	86.2%
CT/NG PCR	2	0	—	0%

Key observations for 2025:

- Hepatitis B ELISA: 5,884 tests nationally (1.24% positivity); 99.4% performed at the NRL. Rapid Hep B testing expanded across peripheral sites (16,222 tests, 0.74% positivity).
- Hepatitis C ELISA: 3,289 tests nationally (4.41% positivity); 99.0% at NRL. Hep C Rapid expanded considerably to 20,054 tests (1.05% positivity).
- GC Culture: 17,387 tests nationally (1.73% positivity); 86.2% at NRL (14,991 tests), underlining the continued dependence on central laboratory infrastructure for bacteriological STI diagnostics.
- CT/NG PCR testing remains minimal islandwide (2 tests), suggesting limited roll-out of molecular diagnostics beyond the NRL for chlamydia/ gonorrhoea screening.

6. Clinic-wise Testing Summary – 2025

The table below presents selected testing indicators by clinic. Colombo (NRL) data is highlighted. Peripheral clinics collectively comprise all other listed sites.

Table 11.4: Clinic-wise Testing Summary- 2025

STD Clinic	VDRL Tested	VDRL +ve	HIV ELISA Tested	HIV ELISA +ve	HIV Rapid Tested	HIV Rapid +ve	CD4	VL
Ampara	4,060	78	4,653	28	886	8	—	—
Anuradhapura	21,402	188	13,534	22	6,517	25	156	205
Badulla	10,171	112	2,362	4	11,755	16	95	—
Balapitiya	3,019	61	138	—	3,829	7	—	—
Baticaloa	5,879	45	5,543	11	2,175	3	17	—
Chilaw	12,675	267	825	—	8,891	43	—	—
Colombo (NRL)	**53,583**	**3,761**	**57,285**	**1,170**	**24,079**	**1,874**	**2,724**	**3,372**
Embilipitiya	—	—	—	—	1,349	—	—	—
Galle	5,865	312	6,928	56	3,506	43	213	53
Gampaha	10,529	401	6,541	36	2,332	21	—	—
Hambanthota	8,722	77	7,189	17	3,323	14	—	—
Jaffna	8,874	68	9,233	6	1,032	6	—	—
Kalmunai	7,187	28	6,424	1	1,490	1	—	—
Kalubowila	—	—	—	—	944	44	—	—
Kalutara	15,623	204	13,988	52	1,909	24	165	—
Kandy	17,623	352	18,408	83	859	99	58	—

STD Clinic	VDRL Tested	VDRL +ve	HIV ELISA Tested	HIV ELISA +ve	HIV Rapid Tested	HIV Rapid +ve	CD4	VL
Kegalle	6,873	160	4,852	22	3,280	26	—	—
Kilinochchi	3,287	26	150	3	3,173	3	—	—
Kurunegala	13,726	237	3,660	63	13,464	77	277	—
Mannar	1,982	12	—	8	2,004	1	—	—
Matale	8,659	225	7,486	36	632	17	—	—
Matara	8,944	128	8,489	37	1,816	37	—	—
Monaragala	13,131	108	6,312	12	6,814	9	—	—
Mullaithivu	36	—	—	—	31	—	—	—
Negombo	6,745	290	461	—	7,400	26	—	—
Nuwara-Eliya	9,279	300	9,606	53	405	13	—	—
Polonnaruwa	619	51	2,372	2	464	3	—	—
Ragama	—	—	—	—	—	—	—	—
Rathnapura	19,423	—	14,849	45	4,651	21	75	—
Trincomalee	7,890	73	5,123	32	3,614	46	—	—
Vavuniya	4,880	149	1,652	6	2,797	33	—	—
TOTAL	**290,686**	**7,713**	**218,063**	**1,805**	**125,421**	**2,540**	**3,780**	**3,630**

Source – Laboratory data -NRL

7. NRL Workload Distribution – 2025

The following table summarises the NRL's (Colombo) contribution to national testing across major test categories, demonstrating its central role in confirmatory, specialised, and monitoring investigations.

Table 11.5: NRL Workload Distribution -2025

Test Category	NRL Volume	National Total	NRL Share (%)
VDRL Blood	53,583	290,686	18.4%
TPPA Blood	9,353	31,314	29.9%
TPPA CSF	466	483	96.5%

Test Category	NRL Volume	National Total	NRL Share (%)
HIV ELISA	57,285	218,063	26.3%
HIV Rapid (Combo)	24,079	125,421	19.2%
RDT 2	3,191	5,419	58.9%
RDT 3	2,147	7,032	30.5%
Hepatitis B ELISA	5,846	5,846	100%
Hepatitis C ELISA	3,256	3,256	100%
GC Culture	14,991	17,387	86.2%
CD4 Count	2,724	3,780	72.1%
Viral Load	3,372	3,630	92.9%

The NRL's burden of work load is most pronounced in ELISA-based hepatitis testing (99%), TPPA CSF (97%), GC culture (86%), viral load (93%), and CD4 (72%). Routine syphilis and HIV screening are more evenly distributed, reflecting effective engagement of peripheral clinics in front-line testing.

8. Performance of Peripheral STD Clinics – 2025

The 30 peripheral STD clinics collectively form the backbone of front-line STI/HIV diagnostic access in Sri Lanka. Their combined contribution in 2025 reflects the geographic reach of the national network.

Notable performances among peripheral clinics:

- Anuradhapura: Highest viral load testing among peripheral sites (205 tests) and one of the highest VDRL volumes (21,402 tests, 188 positives).
- Gampaha: Highest VDRL positives among peripheral clinics (401 from 10,529 tested; 3.8% positivity).
- Kandy: Second highest VDRL positives peripherally (352 from 17,623 tested; 2.0%). HIV Rapid Combo showed a notable 11.5% positivity (99/859 tested).
- Galle: High VDRL positivity (5.3%; 312/5,865) and active CD4 testing (213 tests) and VL testing (53 tests).
- Nuwara-Eliya: Elevated VDRL positivity (3.2%; 300/9,279), with significant Duo testing (1,699 tests, 684 HIV-reactive), likely reflecting targeted key population testing.
- Negombo: Contributed 290 VDRL positives (4.3% positivity; 290/6,745), one of the highest peripheral positivity rates.
- Kurunegala: High HIV Rapid Combo volume (13,464 tests; 77 positives) alongside substantial VDRL testing.
- Badulla: Notable HIV Rapid Combo volume (11,755 tests).

- Embilipitiya and Kalubowila: Reported selective test types with no VDRL data, suggesting partial service deployment at these sites.
- Ragama and Mullaithivu: Minimal or no activity reported in 2025; these sites require attention for capacity building and reporting compliance.

9. Key Observations – 2025

- Syphilis persists as a significant STI burden, with VDRL blood positivity at 2.65% nationally and as high as 7.02% at the NRL clinic, reflecting concentration among high-risk populations. TPPA CSF positivity (38.30%) highlights continuing neurosyphilis occurrence.
- HIV prevalence remains below 1% in general ELISA screening (0.83%), but rises substantially in targeted populations — RDT2 positivity of 36.43% and RDT3 of 27.60% confirm ongoing transmission in key risk groups.
- CD4 and viral load testing expanded significantly compared to prior years, demonstrating improved HIV treatment monitoring capacity across the country.
- Hepatitis diagnostics — particularly ELISA-based — remain almost entirely centralised at the NRL, indicating a need to strengthen hepatitis testing capacity at peripheral laboratories.
- GC culture positivity at 1.73% indicates ongoing gonorrhoea transmission; the near-total centralisation of culture (86%) and molecular diagnostics (CT/NG) at the NRL underscores the urgency of expanding these services peripherally.
- The ISO 15189 accreditation renewal through December 2029 validates the NRL's quality systems and provides a strong foundation for continued expansion of quality-assured diagnostics nationally.

10. Conclusion

The NSACP laboratory network delivered a substantial volume of STI and HIV diagnostic services across Sri Lanka in 2025. The NRL at Colombo continued to serve as the national technical hub, bearing the highest burden of confirmatory, molecular, and specialised testing, while peripheral STD clinics effectively extended screening access to all districts.

The successful achievement of ISO 15189 accreditation through 4th December 2029 is a milestone that validates the quality and reliability of the NRL's operations and strengthens the credibility of Sri Lanka's national STI/HIV diagnostic infrastructure. Continued investment in peripheral laboratory capacity — particularly for hepatitis ELISA, GC culture, and molecular diagnostics — will be essential to reduce over-centralisation, improve turnaround times, and build a more resilient and equitable national diagnostic network.

CONSULTANT MICROBIOLOGIST [4]

12 CONDOM PROMOTION

VINO DHARMAKULASINGHE [1]

Condoms offer triple protection by simultaneously preventing HIV transmission, other sexually transmitted infections (STIs), and unintended pregnancies. Comprehensive condom programming implemented by the National STD/AIDS Control Programme (NSACP) targets key and vulnerable populations, including youth, with the aim of sustaining high levels of correct and consistent condom use

Condom estimation committee

The Condom Estimation Committee functions as the national-level advocacy and coordination body responsible for forecasting, procurement planning, and ensuring the uninterrupted supply and distribution of condoms and lubricants throughout the network of forty Sexual Health Clinics across the country.

The committee is chaired by the Director of the National STD/AIDS Control Programme (NSACP), while the National Programme Consultant for IEC, Advocacy and Condom Promotion serve as the Secretary to the committee. Members of the committee include NSACP consultants, peripheral consultants from selected Sexual Health Clinics, the pharmacist of NSACP, representatives from the Medical Supplies Division (MSD) of the Ministry of Health, the National Medicines Regulatory Authority (NMRA), key population representatives, and people living with HIV.

Implementation of the Swastha System for Distribution of Condoms and Lubricants to Sexual Health Clinics

Two Condom Estimation Committee meetings were conducted during the year 2025 to discuss forecasting, procurement, and distribution of condoms and lubricants across the country. During these meetings, the committee decided to implement the Swastha system for the distribution of condoms and lubricants to sexual health clinics under the National STD/AIDS Control Programme (NSACP).

The Swastha system is a digital Medical Supply Management Information System introduced by the Ministry of Health, Sri Lanka, to manage medicines, surgical items, laboratory supplies, and consumables across government health institutions. The system was introduced to improve efficiency, transparency, monitoring, and accountability in the supply chain management process.

Under this system, the Family Health Bureau (FHB) distributes condoms to Medical Officer of Health (MOH) offices throughout the country, while the NSACP distributes condoms and lubricants to sexual health clinics through the same platform. The implementation of the Swastha system is expected to strengthen inventory management, improve monitoring

of stock levels, minimize stock-outs, and ensure timely distribution of commodities to service delivery points.During the Condom Estimation Committee meetings, several gaps and challenges related to the implementation of the Swastha system were discussed. These included technical issues, delays in data entry and updating, limitations in staff capacity, and the need for further training and coordination among stakeholders. Recommendations were made to improve system utilization and strengthen the supply management process to ensure uninterrupted availability of condoms and lubricants for HIV/STI prevention activities across the country.

Condom and Lubricant Orders Planned for the Year 2026

During the year 2024, a total of 5.5 million non-flavoured condoms were ordered through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) under the GC6 grant cycle. However, the Condom Estimation Committee decided to delay the receipt of these consignments considering the limited condom storage facilities available at the National STD/AIDS Control Programme (NSACP). Subsequently, the consignments were delivered to the NSACP in three phases as follows:

1st consignment –

1,999,872 non-flavoured condoms received on 23rd December 2024

2nd consignment –

2,067,696 non-flavoured condoms received on 25th February 2025

3rd consignment –

1,500,048 non-flavoured condoms received on 25th February 2025

By early 2025, approximately 5.8 million non-flavoured condoms were available at the NSACP central stores. On average, around 2 million condoms are distributed annually through Sexual Health Clinics and linked NGO/CBO networks for STI/HIV prevention activities among key and vulnerable populations. After reviewing the available stock balance and annual consumption patterns, the Condom Estimation Committee decided not to place any orders for non-flavoured condoms through either GFATM or Government of Sri Lanka (GOSL) funds for the year 2026. In addition, the Committee also decided not to procure flavoured condoms for the year 2026, considering the need to maximize the utilization of the existing large stock of non-flavoured condoms available at the NSACP.

Furthermore, a total of 782,200 lubricant sachets were received through Global Fund support during the year 2025. Lubricants are mainly distributed for men who have sex with men (MSM) to reduce condom rupture during anal intercourse and thereby strengthen HIV/STI prevention efforts.

Table 12.1: Condoms and lubricants received by NSACP by sources from 2019 to 2025

Year	condoms				Lubricants		
	GOSL	GFATM	UNFPA	Total	GOSL	GFATM	Total
2019	200,000	2,289,600		2,489,600		1,775,000	1,775,000
2020	-	-	-	-	-	-	-
2021	-	-	-	-	-	-	-
2022	104,500	1,668,960	-	1,773,460	-	648,000	648,000
2023	-	770,400	-	770,400	-	702,000	702,000
2024	-	1,999,872	2,102,400	4,102,272	-	565,000	565,000
2025	-	2,067,696 1,500, 048		3,567,744	-	728,000	728,000

Condom and lubricant Distribution in 2025

The Condom Estimation Committee regularly reviewed the distribution of condoms and lubricants through Sexual Health Clinics in collaboration with NGO/CBO partners in their respective districts, using quarterly STD clinic returns (Table 17) for monitoring and evaluation purposes. These collaborations played an important role in strengthening HIV/STI prevention activities and improving access to condoms among key and vulnerable populations across the country.

In 2025, the Sexual Health Clinic Anuradhapura distributed more than 200,000 condoms within the district through coordinated activities with NGO/CBO partners. In addition, the Sexual Health Clinics in Polonnaruwa and Kurunegala each distributed more than 100,000 condoms in collaboration with the respective NGO/CBO networks operating in those districts.

The Family Planning Association of Sri Lanka (FPASL), which implements condom distribution activities in Colombo and Gampaha districts, received condom and lubricant stocks directly from the National STD/AIDS Control Programme (NSACP). During the year 2025, FPASL distributed a total of 895,507 condoms through its outreach and prevention programmes.

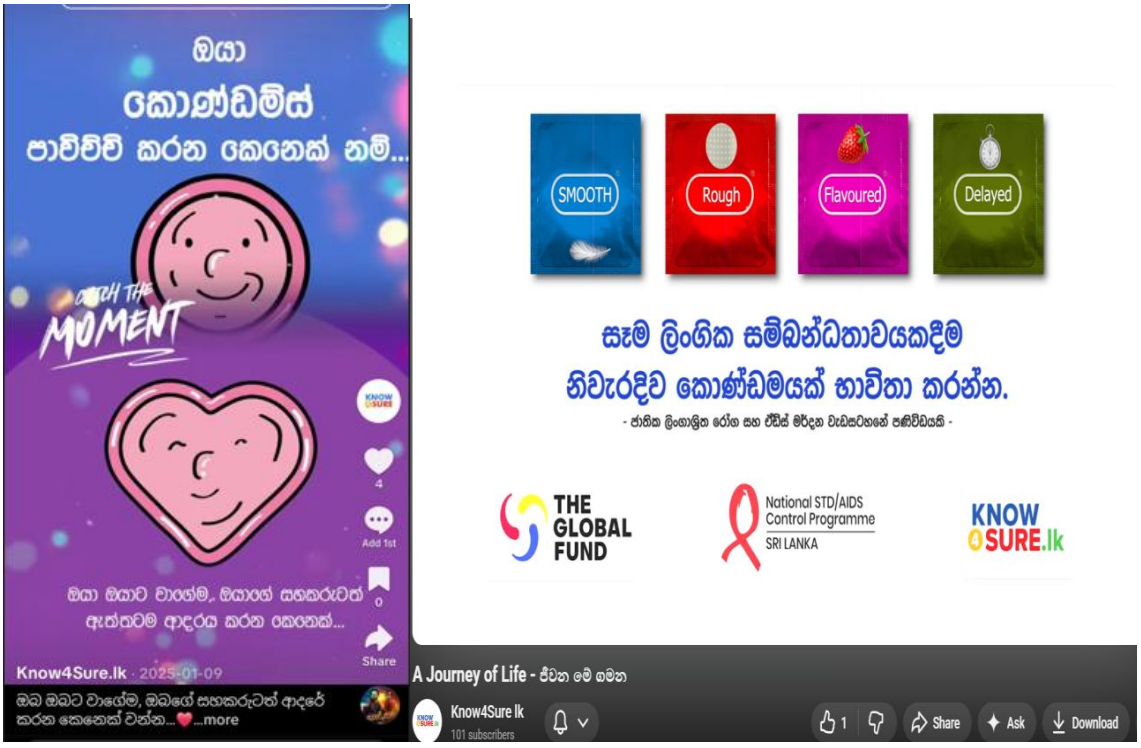
Table 12.2: Condom and lubricant distribution through STD clinics and FPASL in 2025

No	STD clinic	Condoms			Lubricants
		Non-Flavoured	Flavored	Total	
01	Ampara	29,161	15,272	44,433	14,950
02	Anuradhapura	203,120	3312	206,432	12,500
03	Awissawella	7032	0	7032	80
04	Badulla	45,047	0	45,047	4445
05	Balapitiya	13,020	6940	19,960	4000
06	Batticaloa	4108	500	4608	2635
07	Chillow	30,124	0	30124	9500
08	Colombo	43,005	28,882	71887	54,598
09	Dambulla	17,008	1008	18,016	5050
10	Embilipitiya	1073	2185	3258	785
11	Gampaha	10,980	0	10,980	3410
12	Hambanthota	56,887	4386	61,273	10,817
13	Homagama	0	688	688	0
14	Jaffna	13,282	16,525	29,807	10,407
15	Kalmunai	22,608	4032	26,640	5300
16	Kalubowila	34,799	2489	37,288	4522
17	Kalutara	24,041	0	24,041	5590
18	Kandy	51,008	16,848	67,856	13200
19	Kegalle	36,702	0	36,702	20,575
20	Kilinochchi	11,748	0	11,748	3500
21	Kuliyapitiya	7260	90	7350	1570
22	Kurunegala	105,887	0	105,887	25,470
23	Mahamodara	37,698	14,838	52,536	10,816
24	Mahiyanganaya	2330	0	2330	0
25	Mannar	1152	0	1152	788
26	Matale	20,030	55,877		2810
27	Matara	5609	21,474	27,083	5874
28	Monaragala	1240	4732	5972	1671
29	Mullativ	100	0	100	50
30	Nuwaraeliya	0	7200	7200	0
31	Negambo	5966	0	5966	840
32	Panadura	239	180	419	295
33	Polonnaruwa	84,847	35,836	120,683	2460
34	Puttalam	2000	6848	8648	1584
35	Ragama	8428	0	8428	5215
36	Rahnapura	4007	34,222	38,229	21,900
37	Tangalle	160	0	160	0
38	Trincomalee	720	0	720	0
39	Vavuniya	2086	784	2870	440
40	Wathupitiwala	1051	576	1627	949
	FPASL	895,507	0	895,507	276,370
	Grand total	**1,841,070**	**285,724**	**2,294,520**	**544,966**

Condom Promotion Strategies Using Social Media Platforms

Condom promotion campaigns implemented by the National STD/AIDS Control Programme (NSACP) focused on addressing behavioural barriers that negatively influence condom use, including stigma, poor negotiation skills, misconceptions, and low-risk perception among key populations, vulnerable populations, youth, and the general public. These interventions aimed to improve awareness and encourage the correct and consistent use of condoms as an effective HIV/STI prevention strategy. During the year 2025, two video clips were developed with support from GFATM funds to promote condom use and to reduce stigma and myths associated with condoms. These videos specifically targeted key populations, vulnerable groups, youth, and the general public through culturally appropriate and youth-friendly messaging.

In addition, NSACP actively utilized social media platforms for condom social marketing and awareness creation. Many TikTok videos and Facebook posts were developed and disseminated throughout the year to increase public engagement and promote positive attitudes towards condom use. These digital campaigns helped expand the reach of HIV/STI prevention messages, particularly among younger populations and hard-to-reach groups who frequently use social media platforms.



Condom Dispensers

A total of 200 condom dispensers were procured using Government of Sri Lanka (GOSL) funds and distributed through district sexual health clinics across the country in the year 2025. These dispensers were introduced as an important strategy to improve easy and discreet access to condoms, particularly among key and vulnerable populations as well as the general public. Several advocacy meetings conducted at national and district level highlighted the importance of placing condom dispensers in public locations such as railway stations, bus stands, public toilets, and shopping malls to enhance demand generation for condom use and strengthen STI/HIV prevention efforts. The placement of condom dispensers in high-traffic public settings was identified as an effective approach to reduce stigma associated with obtaining condoms and to promote correct and consistent condom use.

Addressing Barriers to Access Condoms

The Sri Lanka Police Headquarters issued a circular instructing all police stations to discontinue the practice of producing used condoms as case evidence during arrests related to prostitution or brothel raids. This important directive safeguards the medical rights of suspects and recognizes condoms as legitimate preventive measures for Sexually Transmitted Diseases (STDs), including HIV. In addition, regular advocacy and sensitization programmes conducted for police officers and Magistrates during the year 2025 played a significant role in reducing barriers to condom access among key populations. These programmes focused on improving awareness of HIV/STI prevention, reducing stigma and discrimination, and addressing legal and social barriers that limit the availability and accessibility of condoms. Such interventions contributed to creating a more supportive environment for condom promotion and HIV prevention efforts in Sri Lanka.

CONSULTANT VENEREOLOGIST [1]

13 MULTISECTORAL RESPONSE TO HIV AND STI PREVENTION IN SRI LANKA: STRENGTHENING

JANAKA WERAGODA [2]

Partnerships for Sustainable Impact – 2025

The Multisectoral Unit (MSU) of the National STD/AIDS Control Programme (NSACP) plays a key role in supporting the national response to HIV and sexually transmitted infections (STIs) in Sri Lanka. In line with the National HIV/STI Strategic Plan, the unit works with a wide range of government institutions, civil society organizations, development partners, and community groups to strengthen HIV prevention activities.

During 2025, the MSU continued to coordinate, implement, and monitor HIV prevention programmes targeting key populations, vulnerable groups, and the general population. Special attention was given to young people, prison inmates, uniformed services, and other groups at increased risk of HIV infection.

The unit focused on advocacy, awareness creation, behavior change communication, capacity building, and strengthening partnerships. Efforts were also made to promote safe sexual practices, increase access to HIV testing, reduce stigma and discrimination, and create a supportive environment for HIV prevention.

Through strong multisectoral collaboration, the MSU continued to contribute to the national goal of reducing new HIV infections and improving access to HIV-related services across the country.

Human Resources – Addressing Gaps to Sustain Impact

The Multisectoral Unit is headed by a Consultant Community Physician who provides overall leadership and technical guidance for the unit's activities.

During 2025, the unit continued to experience human resource shortages. The approved positions for Medical Officers and the Development Officer remained vacant throughout the year. The unit functioned with the support of an Assistant Coordinator and other supporting staff.

Despite these limitations, the MSU successfully carried out its key activities and continued to support the implementation of the National HIV/STI Strategic Plan. Staff commitment and close collaboration with partner organizations helped ensure the continuity of planned programmes.

Prevention and Multisectoral Subcommittee

The Prevention and Multisectoral Coordination Subcommittee is one of the four subcommittees operating under the National STD/AIDS Control Programme. The subcommittee serves as a platform for reviewing progress, identifying challenges, planning future activities, and providing recommendations to strengthen the national

HIV response.

The subcommittee brings together representatives from government institutions, health sector organizations, civil society groups, development partners, and youth organizations. This collaborative approach helps ensure that HIV prevention activities are coordinated, evidence-based, and responsive to the needs of different population groups.

Key stakeholders include:
Department of Prisons
Sri Lanka Police
Sri Lanka Army, Navy, and Air Force
National Youth Services Council
National Youth Corps
National Child Protection Authority
Ministry of Education and Higher Education Sector
Vocational Training Authority
Sri Lanka Bureau of Foreign Employment
Family Health Bureau
Health Promotion Bureau
Directorate of Mental Health
Community-based organizations representing people living with HIV and key populations
Development partners including UNFPA and WHO
Family Planning Association of Sri Lanka (FPA)
Youth organizations and youth representatives
The subcommittee continues to play an important role in strengthening partnerships and promoting a coordinated national response to HIV and STIs.

HIV and STI Prevention in the Prison Sector

Prison inmates are identified as a key population in the National HIV/STI Strategic Plan due to their increased vulnerability to HIV and other sexually transmitted infections (STIs). The MSU continued to work closely with the Department of Prisons to implement HIV prevention, testing, treatment, and care activities in prison settings. According to prison statistics for 2024, the prison system comprised over 30 institutions with an average daily population of approximately 27,000 inmates, including around 1,200 women. The total annual admissions were approximately 185,000."

These activities are guided by the Prison HIV Prevention, Treatment and Care Policy and aim to ensure that prison inmates have access to services similar to those available in the general community.

Prison Steering Committee

The Prison Steering Committee serves as the main coordination mechanism for HIV prevention activities in the prison sector. The committee is chaired by the Commissioner General of Prisons and meets regularly to review progress, identify challenges, and plan future activities. During the year 2025 three (03) Steering Committee meetings were held with the participation of representatives from the Department of Prisons and NSACP. Discussions focused on strengthening HIV testing services, staff training, awareness programmes, and the management of inmates living with HIV. A strong emphasis was placed on enhancing HIV testing coverage across all prison institutions.
Training of Trainers (ToT) Programmes

Two Training of Trainers (ToT) programmes were conducted for prison officers during 2025. A total of 70 uniformed officers were trained on HIV prevention, stigma reduction, health education, and communication skills. These officers act as resource persons in their respective prisons and contribute to the implementation of HIV prevention activities within the prisons.

Peer Leader Training Programmes

Peer education remains one of the most effective approaches for delivering health messages within prisons. During the year, 60 peer leader training programmes were conducted in prisons across the country. Over 2000 selected inmates received training as peer leaders on HIV/ STIs prevention, and safer sexual behaviors. Upon completion, peer leaders were awarded badges to formally recognize their role. These trained peer leaders provide informal education sessions on HIV and STI prevention to their fellow inmates, and promote positive behavior change towards safe sexual practices within prison communities ultimately reaching more than 75,000 prison inmates during the year 2025

Awareness Programmes on HIV and STI for inmates

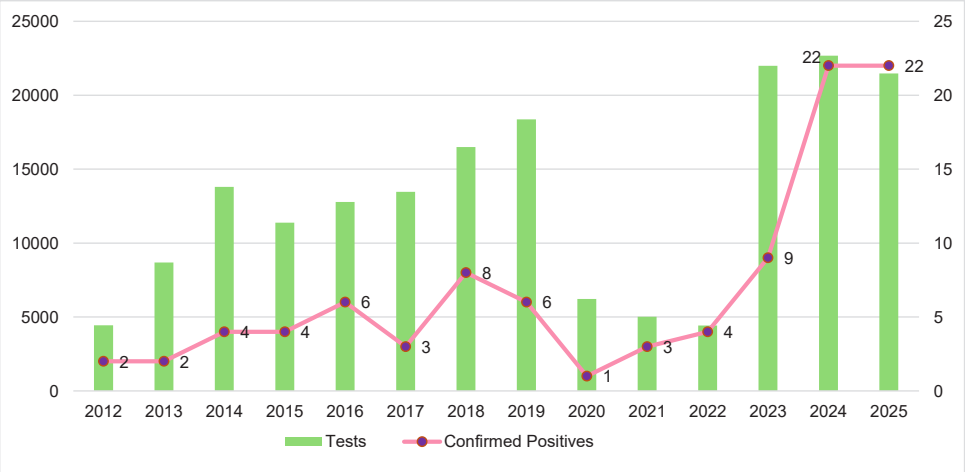
Awareness programmes on HIV and STI prevention were also conducted in prisons throughout the year by district STD clinics. These sessions focused on HIV transmission, prevention methods, safer sexual practices, stigma reduction, and the importance of HIV testing.

HIV Testing in Prisons

HIV testing remains a key component of HIV prevention and care services in prisons. During 2025, a total of 21,468 HIV tests were conducted among inmates through district STD clinics and prison health services, achieving approximately 86% of the annual target of 25,000 tests. Notably, 22 HIV-positive cases were confirmed in each of the last two consecutive years. Continuous awareness programmes and peer-led education activities contributed to improving the uptake of HIV testing services among inmates.

The prison health programme plans to expand its screening services by introducing routine testing for syphilis, Hepatitis B, and Hepatitis C among inmates, further strengthening the prevention, early detection, and management of infectious diseases within prison settings.

Figure 13.1: HIV Testing and Confirmed HIV Positive Cases among Prison Inmates over the past years



Health Promotion Activities

Drama competitions were organized in conjunction with the commemoration of World AIDS Day to increase awareness and promote positive attitudes towards HIV prevention among prison inmates. These activities provided inmates with an opportunity to actively participate in health promotion initiatives and communicate important HIV prevention messages in a creative manner. A total of 18 prisons participated in the competition and submitted video recordings of drama performances focusing on HIV awareness, HIV testing, stigma reduction, and discrimination. The performances were evaluated by an independent panel, and winners were awarded certificates, plaques, and gift items in recognition of their efforts.

To further support health promotion activities within prisons, indoor recreational items such as carrom boards, dam boards carrying printed HIV prevention and HIV testing messages were distributed to participating prisons. These materials were intended to reinforce key health messages and encourage ongoing discussion and awareness among inmates.

National Conference on HIV Prevention in Prisons

The annual National Conference on HIV Prevention in Prisons was conducted with the participation of prison rehabilitation and counselling officers from institutions across the country.

Participants shared experiences, discussed operational challenges, and identified priorities for future action to further strengthen HIV prevention, testing, treatment, and care services in prisons. The conference also provided an opportunity to update prison officers on emerging trends in the HIV epidemic and novel HIV prevention strategies, including recent advances in HIV testing, treatment, and prevention technologies.

HIV and STI prevention in the Tri-Forces

The Sri Lanka Army, Navy, and Air Force continue to be important partners in the national HIV prevention programme. NSACP recognizes the importance of maintaining HIV awareness, prevention services, and regular HIV testing among military personnel.

During 2025, a number of awareness programmes on HIV/STIs prevention, and safer sexual practices were conducted in collaboration with military authorities and district STD clinics. In addition, two national-level Training of Trainers (ToT) programmes were conducted for 70 paramedical personnel from the Sri Lanka Army and Navy. These programmes enhanced participants' knowledge and skills in HIV prevention, HIV testing, stigma reduction, and health education. The trained personnel are expected to serve as resource persons within their respective institutions and support the implementation of HIV prevention and awareness activities among military personnel.

One awareness programme was conducted for medical officers of the Tri-Forces in collaboration with the Sri Lanka College of Military Medicine. The programme focused on strengthening the knowledge and capacity of military medical officers in HIV prevention, diagnosis, management, and current developments in HIV care and treatment.

HIV and STI prevention program for Sri Lanka Police

The Sri Lanka Police is an important stakeholder in the national HIV response. Police officers play a key role in creating a supportive environment that enables people living with HIV and key populations to access HIV prevention, testing, treatment, and care services without fear of stigma or discrimination.

To strengthen awareness and promote a rights-based approach to law enforcement, the NSACP continued its collaboration with the Sri Lanka Police during 2025, conducted three (03) advocacy and sensitization programmes for police officers in the Gampaha District. A total of 200 police officers participated in these programmes. The sessions focused on HIV prevention, human rights, stigma and discrimination, legal and policy issues related to HIV, the role of law enforcement in creating a supportive environment for HIV prevention and access to services and the public health importance of ensuring access to services for vulnerable populations. Special emphasis was placed on creating a supportive environment for people living with HIV and key populations.

The programmes also highlighted the important role of police officers in supporting public health interventions and strengthening partnerships between the health sector and law enforcement agencies. These efforts contributed to improving awareness and fostering a more supportive environment for HIV prevention activities in Sri Lanka. HIV and STI Prevention Programmes for Young People and Education Sector

Young people remain a priority population in the national HIV response, particularly in view of the increasing number of new HIV infections reported among young people in recent years. The Multisectoral Unit continued to collaborate with youth-focused

organizations, including the National Youth Services Council (NYSC), National Youth Corps (NYC), and other youth organizations, to strengthen HIV prevention efforts among young people.

During 2025, in collaboration with Family Health bureau, Training of Trainers (TOT) programmes and awareness sessions were conducted on HIV prevention, sexually transmitted infections, sexual and reproductive health, life skills, and behavior change communication. Youth leaders and youth officers from various organizations participated in these programmes and were equipped with the knowledge and skills required to conduct awareness activities within their communities.

These interventions aimed to improve HIV-related knowledge, promote safer sexual practices, encourage HIV testing, and empower young people to make informed decisions regarding their health and wellbeing.

Education sector

The education sector continues to be an important platform for HIV prevention and health promotion among young people. Recognizing the increasing vulnerability of adolescents and young adults to HIV infection, the National STD/AIDS Control Programme worked closely with education sector stakeholders during 2025. Vulnerable population groups and General population

The Multisectoral Unit continued to implement a range of awareness and advocacy activities targeting vulnerable populations and the general public during 2025. These activities aimed to improve knowledge on HIV and sexually transmitted infections (STIs), promote safer sexual practices, encourage HIV testing, and reduce stigma and discrimination associated with HIV.

A variety of communication channels were utilized to disseminate HIV prevention messages, including television, radio, newspapers, social media platforms, exhibitions, and printed information, education, and communication (IEC) materials. These interventions were designed to reach diverse population groups and improve public awareness of HIV-related issues.

Special attention was given to promoting understanding of sexual orientation, gender identity, and expression (SOGIE), as well as reducing stigma and discrimination faced by people living with HIV and other vulnerable populations. Awareness activities emphasized human rights, equality, inclusion, and the importance of ensuring access to health services for all individuals.

CONSULTANT COMMUNITY PHYSICIAN [2]

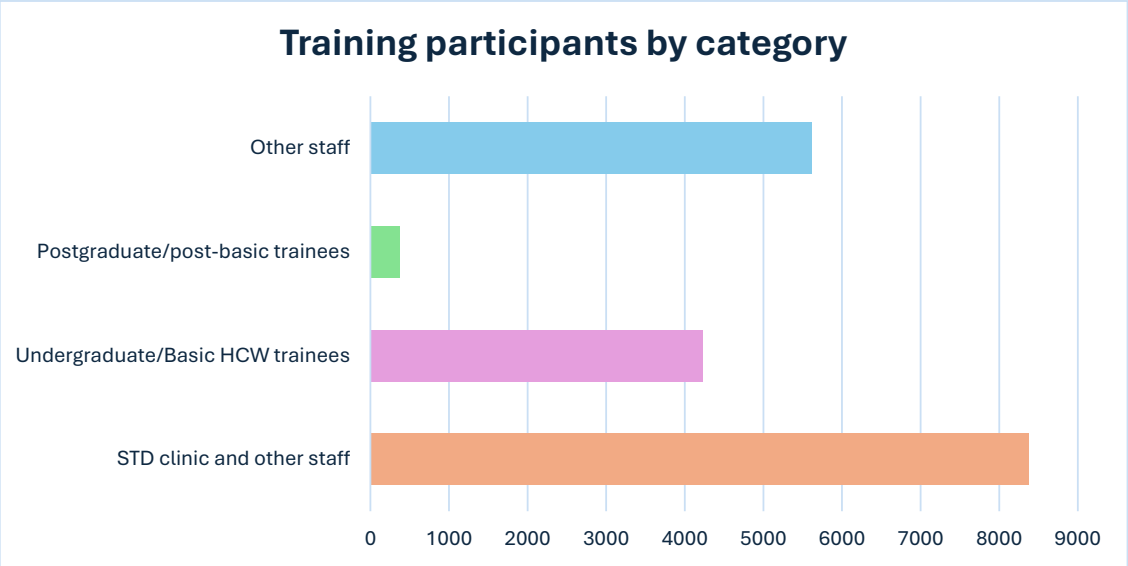
14 TRAINING AND CAPACITY BUILDING

IRUKA RAJAPAKSHA [1]

The Training and Capacity Building and Research Unit of the National STD/AIDS Control Programme serves as the central driver of human resource development and knowledge generation within Sri Lanka's national response to HIV and sexually transmitted infections. The unit oversees the workforce development from needs assessment and strategic planning through to the design and implementation of training activities targeting a broad spectrum of stakeholders including STD clinic staff, frontline healthcare workers, undergraduate and postgraduate trainees in medicine and allied health disciplines and members of key populations. Its mandate encompasses the organization of training programmes, counselling workshops, refresher courses, and clinical meetings, alongside the continuous development and updating of national policies, strategies, guidelines, curricula, and training materials.

Complementing this capacity-building mandate, the unit houses the Research Review Committee of the NSACP, which provides oversight to ensure that research activities related to HIV, STIs, and sexual health are evidence based, ethically sound, and aligned with national strategic plan.

Figure 14.1: Training participants by category



Capacity Building Activities Conducted During 2025

Pre-service and In-service Training for STD Clinic Staff

Pre-service and in-service training programmes were conducted for major staff categories attached to STD clinics island-wide, covering the management of STIs, HIV, and related conditions. Pre-service training serves as a structured orientation for newly joined staff, while in-service training addresses identified knowledge and skill gaps among existing staff to ensure continued delivery of high-quality clinical care. The training was conducted at the NSACP over one week and comprised lectures, group work, and clinical exposure sessions.

Training Programme on STD/HIV Counselling

A five-day counselling workshop was conducted for 30 major staff members from STD clinics across the island, aimed at equipping participants with the knowledge, attitudes, and skills necessary for effective counselling in an STI/HIV setting. The programme covered key counselling components including prevention, behavioural change, disease-specific counselling, pre- and post-test counselling for HIV testing services, PrEP and PEP counselling, and adherence counselling for people living with HIV. Sessions incorporated lectures, group activities, case scenario discussions, and role plays to build practical counselling competencies.

Provincial and District Level Sensitization & Training on Human Rights, Stigma & Discrimination for Healthcare Professionals (Doctors, Nurses, and Allied Health Staff)

HIV-related stigma and discrimination continue to hinder access to prevention, testing, treatment, and care services. Strengthening supportive, inclusive, and non-discriminatory healthcare environments is a key priority within the national HIV response. To address this, 30 district-level programmes were conducted islandwide for health sector staff under the leadership of consultant venereologists. In addition, 4 provincial-level programmes were organized to reach a broader healthcare workforce through multidisciplinary collaboration involving venereologists and other medical specialties.

National Level Training and workshop NGO/ CBO Administration & Management staff

A national-level workshop was conducted in Colombo for heads and management staff of NGOs, and CBOs working island-wide to strengthen their capacity in administration, management, social contracting, grant management, and legal compliance. The program recognized the vital role of NGOs and CBOs in HIV prevention and service delivery among key populations, including sex workers, MSM, PWID, transgender individuals, and other high-risk groups. By enhancing organizational leadership, operational efficiency, accountability, and sustainability, the workshop aimed to improve collaboration and expand the quality and reach of HIV prevention and care services across Sri Lanka.



Strengthening Capacities for KP/PLHIV Program Planning & Implementation at the District Level

A series of 12 district-level, one-day participatory workshops were conducted across 12 districts, targeting field KP units, outreach workers, NGO and CBO members. The program aimed to strengthen the capacities of key personnel involved in HIV prevention by enhancing their knowledge and skills in behaviour change communication and psychological support for Key Populations (KP) and People Living with HIV (PLHIV). Since outreach workers and NGO/CBO members routinely deal with high-risk behaviours and psychosocial challenges within KP communities, these ongoing refresher training plays a vital role in upholding service quality in peer-led outreach.

Anti Retroviral Therapy, Opportunistic Infection/Hep B/ Hep C Management & PLHIV Care Guidelines Update Training for STD Clinic Medical Officers and Healthcare Staff

A national-level training was conducted for NSACP Consultants, STD clinic consultants and Medical Officers, focusing on updating knowledge and clinical competencies across a broad range of areas including HIV, Hepatitis B and C testing guidelines, ART and opportunistic infection management, advanced HIV disease management, STD management, PLHIV care and counselling, and sexual and reproductive health. The training aimed to ensure that senior medical personnel island-wide are equipped with the latest diagnostic and clinical management guidelines to deliver high-quality, evidence-based care for patients living with HIV and co-infections.

In a similar manner, four additional one-day participatory workshops were conducted across the Western, Central, Southern, and North Western Provinces, targeting a wider range of STD clinic staff including Public Health Inspectors, Public Health Nurses, and PLHIV Outreach Workers. These workshops aimed to further broaden the reach of capacity building efforts, updating frontline healthcare staff on the latest clinical guidelines and care practices. By expanding the number of trained personnel within STD clinics, the program sought to enhance the overall quality of service delivery and contribute to improved health outcomes for Key Populations and People Living with HIV at the provincial level.

Monthly STI/HIV & Sexual Health Knowledge Update Forum for Medical Officers and Venereology Postgraduate Trainees

The field of STI, HIV, and sexual health is continuously evolving, with emerging evidence and frequent updates to clinical guidelines demanding that healthcare professionals remain current in their knowledge and practice. Recognizing this need, a monthly hybrid update program is conducted to ensure that Medical Officers and Venereology Postgraduate Trainees working in STD clinics are consistently informed of the latest advancements, guideline revisions, and best practices. This regular forum serves as a vital platform for continuous professional development, bridging knowledge gaps and strengthening clinical competencies to uphold the highest standards of patient care in the ever-changing landscape of STI and HIV management.

Research Review Committee – National STD/AIDS Control Programme (NSACP), Sri Lanka

The Research Review Committee of the National STD/AIDS Control Programme is actively contributing to strengthening evidence-informed practices within Sri Lanka's national HIV and STI response. The Committee meets monthly and is mandated to foster a strong research culture among professionals in the field of STIs and HIV by promoting, advising, and reviewing research activities related to HIV and sexual health. Its core responsibilities include providing guidance on national research priority areas, reviewing proposals, progress and final reports, ensuring scientific rigor, ethical compliance, and methodological soundness. Through a thorough and anonymous assessment process, the Committee evaluates research applications for administrative clearance based on feasibility, scientific merit, and alignment with national priorities, thereby ensuring that all research activities effectively contribute to strengthening the country's HIV and STI response.

CONSULTANT VENEREOLOGIST [1]

15 IEC AND ADVOCACY PROGRAMMMES

VINO DHARMAKULASINGHE [1], DR.SAJITH NIZAM [5]

District AIDS Committee meetings in the year 2025

District AIDS Committee (DAC) meetings are important multi-stakeholder advocacy and coordination forums conducted at district level to strengthen HIV prevention, testing, treatment, and enabling environment activities. During the year 2025, eighteen (18) District AIDS Committee meetings were conducted in Colombo, Kalutara, Gampaha, Galle, Rathnapura, Kegalle, Kurunegala, Puttalam, Anuradhapura, Polonnaruwa, Badulla, Monaragala, Kandy, Matale, Jaffna, Vavuniya, Batticaloa, and Trincomalee districts with the support of GFATM funds. The Regional Director of Health Services (RDHS) functioned as the Chairperson of the DAC meetings, while the Consultant Venereologist of the district served as the Secretary. In districts without a Consultant Venereologist, the Medical Officer In-Charge of the STD clinic functioned as the Secretary. These meetings provided a valuable platform to review the district HIV situation, identify emerging risks and vulnerabilities, discuss barriers affecting key population interventions, and strengthen multisectoral collaboration for HIV prevention and testing services. The DAC meetings also facilitated district-level planning and implementation of evidence-based interventions tailored to the local HIV epidemiological context.

Provincial AIDS committee meeting for the year 2026

During the year 2025, all nine Provincial AIDS Committee (PAC) meetings were successfully conducted with the support of GFATM funds. The Provincial Director of Health Services (PDHS) chaired the meetings, while the Senior Consultant Venereologist within the respective province functioned as the secretary. Provincial AIDS Committees served as important multi-stakeholder platforms to plan and coordinate HIV and STI prevention and control interventions within the provinces, particularly based on the recommendations made at the District AIDS Committee meetings. In addition, these meetings played a key role in monitoring the implementation of the NSACP National Strategic Plan 2023–2027 and strengthening the overall provincial response to HIV/AIDS.

National AIDS Committee Meeting

The National AIDS Committee (NAC) meeting for the year 2025 was held on 25th July 2025 with the participation of the Secretary of Health, Provincial Directors of Health Services (PDHSs), and representatives from several key stakeholder institutions. Participants included higher officials from the National Institute of Education (NIE), Prison Department, Tri-forces, Youth Affairs sector, General Practitioners' Association, legal experts, media professionals, representatives of key populations(NGO/CBO), and people living with HIV (PLHIV).According to the National AIDS Policy, the Secretary of Health serves as the Chairperson of the National AIDS Committee. The NAC functions as the highest national-level multi-sectoral platform for policy guidance, coordination,

and monitoring of HIV and STI prevention, treatment, care, and support activities in Sri Lanka. During the meeting, recommendations and key issues identified at the Provincial AIDS Committee meetings were reviewed and discussed. Special attention was given to gaps, challenges, and priority interventions required to strengthen the national HIV response.

The National AIDS Committee consists of four technical sub-committees:

1. HIV Treatment and Care Sub-Committee
2. IEC, Advocacy and Condom Promotion Sub-Committee
3. Legal and Ethical Sub-Committee
4. Prevention Sub-Committee

All four sub-committees conducted meetings prior to the National AIDS Committee meeting in 2025. During these meetings, members reviewed the current HIV situation in the country and developed concept notes related to their respective technical areas. The sub-committees discussed existing gaps, operational challenges, and recommendations for strengthening programme implementation and service delivery. The recommendations presented by the sub-committees contributed significantly to the discussions at the National AIDS Committee meeting and supported evidence-based decision-making for the national HIV response.

Development of National Communication strategy (2026-2030)

The National STD/AIDS Control Programme (NSACP) developed the National Communication Strategy 2018–2021 alongside World AIDS Day 2018. In 2025, the National communication strategy document was updated to align with the goal of ending AIDS by 2030 through a broad consultative process involving national coordinators of NSACP and recommendations from thirteen(13) focus group discussions with healthcare professionals, people living with HIV, key populations, three-wheel drivers, STD clinic attendees, youth, tri-forces, migrant workers, estate communities Tamil speaking populations from North and East, media representatives, university academics, and other stakeholders.

Development of IEC Materials for the Year 2025

The IEC Unit of the National STD/AIDS Control Programme (NSACP) developed several Information, Education, and Communication (IEC) materials in 2025 utilizing both GFATM and Government of Sri Lanka (GOSL) funds to scale up HIV testing, prevention, and treatment services. Four video clips were developed using GFATM funds to enhance HIV testing and prevention activities. One of these video clips featured Chathuranga Kodithuwakku, one of the most popular teledrama actors in Sri Lanka in 2025, to promote HIV testing among the general public. In addition, separate video clips were produced on HIV sero-disclosure to adolescents and on improving adherence to antiretroviral therapy (ART) among people living with HIV (PLHIV).



Several leaflets and printed IEC materials were also developed during 2025 using both GFATM and GOSL funds. Tamil translations and printing of pocket bookmarks promoting PrEP and know4sure.lk services were completed using GOSL funds to improve demand creation among Tamil-speaking populations. A separate bookmark was also developed in parallel with World AIDS Day 2025 using GOSL funds. Furthermore, innovative leaflets with vibrant colours and creative designs were developed targeting key populations and PLHIV using GFATM funds to improve awareness, service uptake, and engagement with HIV prevention and treatment services.

Conduction of Awareness Activities Across the Country

Sexual Health Clinics across the country conducted not only curative services but also a wide range of preventive activities during the year 2025. Almost all clinics organized several awareness programmes within their respective districts to enhance HIV prevention and promote HIV testing. These awareness programmes targeted key populations, vulnerable populations, and the general population, including youth. The programmes were implemented through various approaches such as community awareness sessions, outreach activities, school programmes, workplace interventions, and public campaigns. The IEC, Advocacy and Condom Promotion Unit monitored the awareness activities conducted across the country through the STD quarterly return Table 19. In addition, the unit provided IEC materials and technical support for IEC/BCC awareness programmes implemented at district level.

Conducting STD/HIV Awareness Programmes for School Children

Most sexual health clinics across the country have conducted numerous STD/HIV awareness programmes for school children to improve their knowledge and skills in preventing sexually transmitted infections and HIV, in alignment with the national school curriculum.

Table 15.1: School health programmes conducted by sexual health clinics in the year 2025

	Sexual health clinic	Total number of school awareness programmes	Total number of participants
1.	Badulla	106	8230
2.	Kegalle	11	1112
3.	Chilaw	11	878
4.	Kalubowila	4	510
5.	Kilinochchi	3	86
6.	Awissawella	0	-
7.	Gampaha	15	11250
8.	Batticaloa	5	482
9.	Hambanthota	29	5916
10.	Ampara	3	432
11.	Kalutara	6	1334
12.	Kurunegala	5	2350
13.	Kalmunai	20	1000
14.	Nuwara Eliya	3	600
15.	Trincomalee	18	784
16.	Polonnaruwa	5	1070
17.	Jaffna	9	530
18.	Negombo	2	160
19.	Matale	20	2411
20.	Wathupitiwala	4	635
21.	Matara	3	810
22.	Monaragala	6	983
23.	Anuradhapura	8	1100
24.	Galle	2	400
25.	Ragama	0	-
26.	Mahiyanganaya	23	1881
27.	Vavuniya	0	-
28.	Balapitiya	4	1070
29.	Embilipitiya	0	-
30.	Tangalle	0	-
31.	Homagama	0	-
32.	Mullaitivu	0	-
33.	Rathnapura	15	2780
34.	Panadura	3	275
35.	Puttlam	6	690
36.	Dambulla	0	-
37.	Kuliyapitiya	1	600
38.	Kandy	6	1350
39.	Colombo	05	1500
40.	Mannar	0	0

The IEC Unit of the National STD/AIDS Control Programme had previously developed a PowerPoint presentation in collaboration with the education sector in 2018 to support these awareness programmes. In 2025, the IEC Unit of the National STD/AIDS Control Programme updated and shared the presentation with all STD clinics. The revised package included recent statistics and video clips to further improve the quality and effectiveness of school awareness programmes.

Chemsex interventions to prevent STI/HIV

Chemsex is the intentional use of specific psychoactive and disinhibiting drugs before or during sexual activity to enhance, prolong, or alter the sexual experience. It is often associated with group sexual activity and prolonged sexual sessions, sometimes lasting for several days. Chemsex can lead to increased sexual risk behaviors, lowered inhibitions, and significant physical and mental health consequences, including an increased risk of HIV and other sexually transmitted infections (STIs). In recent years, chemsex has emerged as an important public health concern, particularly among men who have sex with men (MSM). During several advocacy meetings conducted in 2025, the importance of introducing targeted chemsex interventions was identified as a key strategy to curb the HIV/STI epidemic in Sri Lanka. The National STD/AIDS Control Programme (NSACP) initiated the collection of chemsex-related data from all STD clinics in the year 2025 to better understand the magnitude and patterns of this emerging issue.

Table 15.2: Reported Chemsex Practices Among Attendees of Sexual Health Clinics in Sri Lanka: 2025

No	STD clinic	Number reported chemsex among STD clinic attendees	Number of reported chemsex and positive for HIV	Number of reported che,msex and hepatitis C positive
1	Anuradhapura	5	01	-
2	Awissawella	6	-	-
3	Badulla	01	01	01
4	Colombo	244	31	05
5	Gampaha	14	01	01
6	Hambantota	11	-	-
7	Jaffna	1	-	-
8	Kalubovila	03	-	-
9	Kalutara	07	-	-
10	Kandy	8	03	-
11	Kegalle	8	-	-
12	Kurunegala	21	-	-
13	Mahamodara	2	-	-
14	Negombo	3	03	-
15	Polonnaruwa	6	01	-
16	Ragama	16	04	01
17	Panadura	1	-	-
18	Dambulla	03	-	-
	Total	**360**	**45**	**08**

Although chemsex was initially expected to be mainly concentrated in the Colombo and Gampaha districts, data reported from STD clinics have revealed that people engaging in chemsex are also identified in several other districts across the country. Furthermore, significant number of HIV and hepatitis C infections have been reported among individuals who engaged in chemsex during the year 2025.However, there were no hepatitis B cases were reported among those who reported chemsex in the year 2025.

Furthermore, a national-level advocacy meeting on chemsex interventions for HIV/STI prevention was conducted on 27th October 2025 with the participation of the President of the Sri Lanka College of Psychiatrists, representatives from the National Dangerous Drug Control Board(NDDCB), legal experts, Consultant Venereologists from Colombo and Gampaha districts, Consultant Community Physicians, representatives from NGOs/ CBOs working on chemsex interventions, and key population members. The meeting served as an important platform to identify existing gaps, challenges, and future directions for implementing effective and evidence-based chemsex interventions in Sri Lanka.

Virtual Interventions to Prevent STI/HIV

The IEC unit continued to strengthen virtual interventions during 2025 to improve access to HIV/STI prevention, testing, and related services through digital platforms. These interventions played an important role in reaching key and vulnerable populations while improving accessibility and convenience of services across the country. Know4Sure.lk, the national online sexual health platform introduced in collaboration with FHI360 several years ago, continued to function as an important virtual service delivery platform during the year. Through this website, users can assess their sexual risk, book appointments at government Sexual Health Clinics, and place free online orders for HIV self-test kits, condoms, and lubricants for doorstep delivery. Throughout 2025, a total of 315 HIV self-test kits, together with condoms and lubricants, were distributed through the online ordering system. The courier charges for these deliveries were supported through GFATM funds. However, temporary interruptions to the delivery service were experienced during the year due to delays in the procurement of courier services. Online outreach workers attached to NGO/CBO partner organizations in selected districts continued to work closely with the NSACP and the Sexual Health Clinic network to promote HIV/STI testing and improve access to HIV preventive commodities through virtual platforms. In addition, public health staff attached to Sexual Health Clinics utilized Facebook pages and other social media platforms to communicate with clients, disseminate health information, and strengthen linkage to services.

To further strengthen the quality and effectiveness of virtual interventions, the IEC Unit of NSACP organized a national training programme on virtual interventions for online outreach workers and STD clinic staff. The training programme was conducted on 28th June 2025 at the Distance Learning Centre, SLIDA, with the objective of enhancing the capacity of healthcare workers and outreach staff engaged in virtual HIV/STI prevention activities.

Media Reporting and Social Media Campaigns

The IEC Unit of the National STD/AIDS Control Programme (NSACP) actively engaged in media reporting and communication activities to strengthen awareness on sexually transmitted infections (STIs) and HIV prevention. The unit contributed articles to various newspapers focusing on sexual health, promotion of HIV testing particularly through the Know4Sure.lk platforms and dissemination of key HIV/STI prevention strategies. In addition, sponsored newspaper advertisements were published in relation to World AIDS Day 2025 to enhance public visibility of HIV-related messages.

The IEC Unit also coordinated resource persons for radio and television talk shows to further improve public awareness on STI/HIV issues. Two media conferences were jointly organized with the Health Promotion Bureau and the Media Department in parallel to World AIDS Day 2025, which received extensive coverage in major television news bulletins. The unit also played an active role in promoting responsible media reporting

by identifying inaccurate information circulating in relation to STI/HIV and taking appropriate corrective actions.

In line with the increasing digital connectivity in Sri Lanka, social media campaigns were identified as a key strategy to reach underserved and hard-to-reach populations. According to the Digital Outlook Report 2025, Sri Lanka had 13.9 million internet users, with 92% of the population owning mobile phones. The IEC Unit maintains Know4Sure.lk social media platforms across Facebook, YouTube, Instagram, Twitter, and TikTok, in addition to the main website, to enhance digital outreach on HIV testing and prevention. Facebook remains the most widely used platform, with approximately 6.2 K followers, reflecting its strong engagement given that around 83% of social media users in Sri Lanka are active on Facebook.

CONSULTANT VENEREOLOGIST [1]
MEDICAL OFFICER [5]

16 UPDATE OF ELECTRONIC SYSTEMS OF NSACP

ARIYARATNE MANATHUNGE[1], LAKSHAN FERNANDO[4]

A. Electronic information management system (EIMS)

The Electronic Information Management System (EIMS), introduced in 2019, functions as an electronic medical record system covering registration, STD clinic management, HIV care, laboratory, and pharmacy modules. Based on user feedback, several enhancements have been incorporated to improve usability and performance.

The Strategic Information Management (SIM) Unit oversees nationwide implementation, providing coordination, maintenance, user support, and staff training. The upgraded EIMS includes improved modules, questionnaires, and a more user-friendly reporting interface tailored to STD and HIV services. By the end of 2025, EIMS was implemented in 35 of STD clinics.



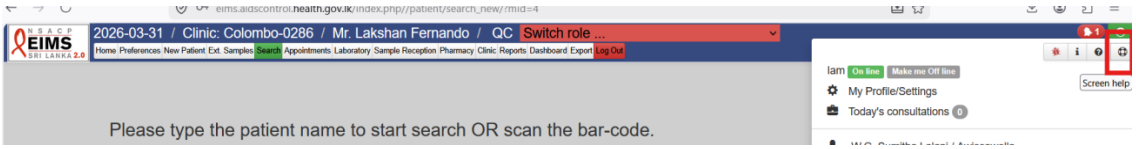
Figure 16.1: Electronic Information Management System (EIMS) login page

Key Upgrades in 2025

- User instructions
- User inbox
- Laboratory and pharmacy updates
- Graphing of biometric parameters
- HIV epidemiology module
- Appointment scheduling module
- Defaulter management module
- Patient file management
- Pregnancy module
- Semi-notes (overview/visit)
- SMS module
- Sample label management

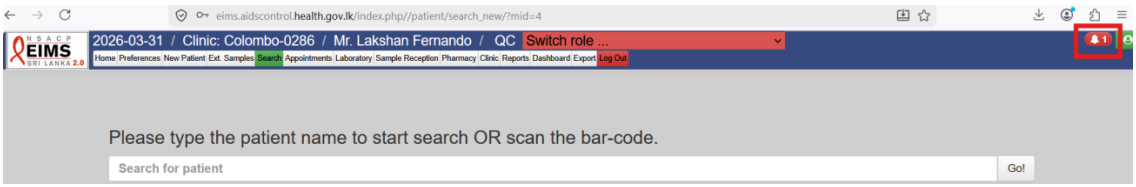
User instruction module

New user instruction module allows the administrator to give instruction of the screen or module that the user is working with. The system will open a simple document creating application where all common features were added for editing a document. Using this feature the administrator can enter the instruction on how to use that screen.



User Inbox

The user can access your alerts using this new button. here it will indicate how many unread message or alert you have



A message can be visible to all users.

Laboratory updates

When updating the result from the worksheet the system will open the laboratory result entering screen.

Graphing Lab-Biometric parameters and other updates

New graphing parameters feature can be accessed from the “Biometric & Vital Sign” panel section.

HIV epidemiology module
Appointment time slot scheduling module

New EIMS - Appointment time slot scheduling module allows users to select the date and the time slot for the appointment. Module display a standard calendar where all booked appointments are shown. Time

slot starts from 9:00 AM to 03:00 PM. Each slot allocated 30 minutes. In each time slot the information like clinic code and the PHN of the appointment is displayed.

Defaulter management module

Doctors can now see the action taken for each defaulted appointment in the timeline on the patient overview screen. Additional information is displayed on the appointment view screen for all users. Reception and PHN staff can see the information about the action plan from the ordered doctors for further action.

Patient files maintenance module

Now the user can see more information about the attached files by clicking on the Open folder. To edit the attached file, the user can click on the edit button.

Pregnancy Module

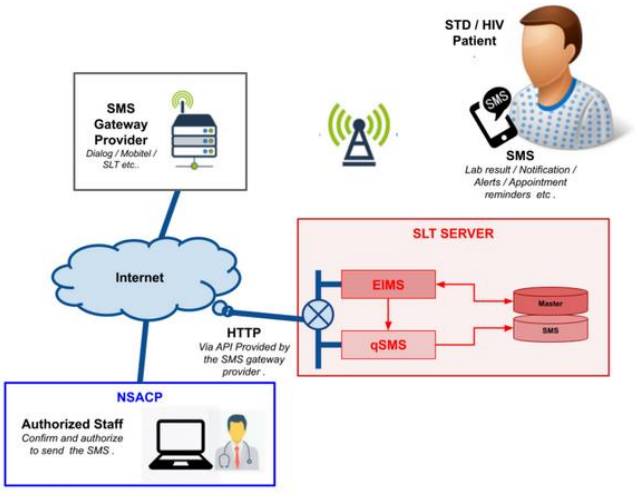
New Pregnancy module allows entering pregnancy information according to the request. Doctors can add/edit pregnancies and add this questionnaire information to each pregnancy.

1. Pregnancy update for pregnant women with HIV
2. Pregnancy update for pregnant women with syphilis
3. Pregnancy update for pregnant women with Hep B

Semi Notes module

In the "Semi Note-overview" menu the doctor can create a semi-note with adding dugs, treatment, remarks. The "Semi Note-visit", the doctor can create a semi-note with adding remarks field also has the Rich Editing feature. And also can order a lab test, prescribe drugs, order a treatment, or even close the current visit from this "Semi-note visit"

SMS Module



Above diagram describes how the system will work and interact with other existing systems. The new sending SMS module qSMS will interact with EIMS and receive messages as configured by the administrator. Eg: lab result of the patient, next appointment, appointment reminders etc. qSMS will also provide an interface for the NSACP staff to confirm the messages before sending them to the patients. After they are confirmed by the authorized staff SMS will be added to the queue for sending.

Another service module will process the queue and send the short messages to SMS GateWay providers via HTTP/S API given by SIM Unit. Finally, the SMS will be delivered to the patients' mobile phone by the SMS GateWay provider. Sending SMS can be automated to patients who have given the consent reminding their next appointment on the previous date.

Sample label management

Five random characters were used to identify the sample labels. It's generated when the staff click on generate labels. After some period 5-6 months all possible variant of codes may be used and the system will try to generate the available combination and the system may respond slow.

To avoid this new utility is created to archive the old codes after 6-7 months by doing this the system can use the same code again. This will generate the code faster.



B. Prevention information management system (PIMS)

Prevention information management system (PIMS) The Prevention Information Management System (PIMS) was established to oversee HIV prevention programs for key populations conducted by STD clinics and NGO partners using the peer-led intervention model. PIMS includes both a web platform and an Android mobile app.

Since 2022, the system has been gradually implemented in all key population units of STD clinics and is currently operational in all 15 KP intervention districts. The Family Planning Association (FPA-SL) functions in Colombo and Gampaha districts, focusing on MSM, TG, PWID, and FSW key population components, and have successfully adopted the platform in both physical and virtual working models.

Key feature in PIMS is the unique identifier code tracking of key population (KP) clients, hence the anonymity of the KP is ensured in the treatment and care provision cascade. PIMS currently have nearly 100,000 islandwide KP clients in the system. And the system tracks KP coverage indicators (reach and testing) as well as Hepatitis B and C , Syphilis testing and PrEP.

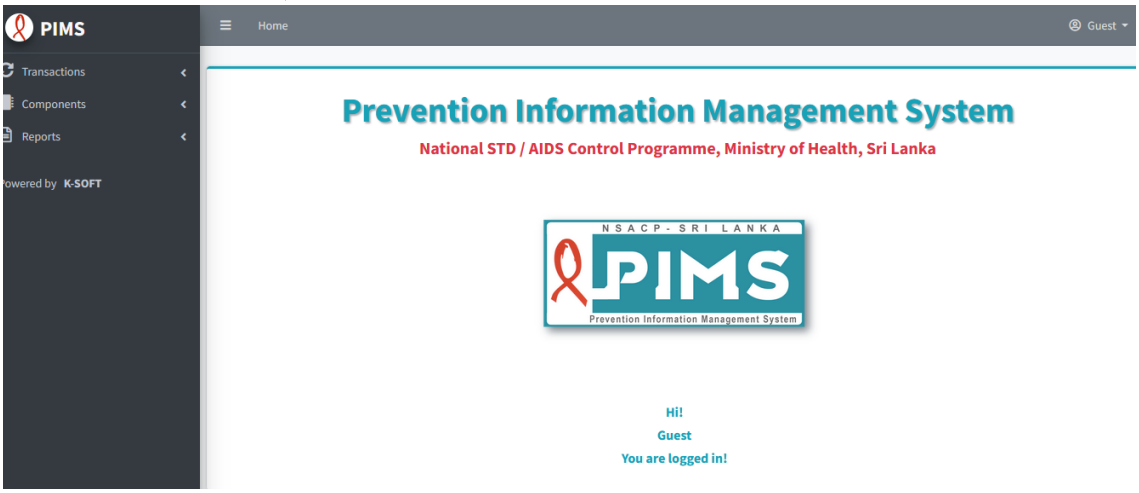


Figure 16.2: Prevention Information Management System (PIMS) website Home page

Know4sure.lk platform

Know4sure.lk provides virtual HIV services, allowing clients to schedule online appointments and receive health products like condoms, lubricants, and HIV self-test kits while maintaining confidentiality and privacy of the respective client. This website plays a crucial role in NSACP's efforts to engage the public and empower individuals with the knowledge necessary to prevent and manage HIV and other sexually transmitted infections (STIs).

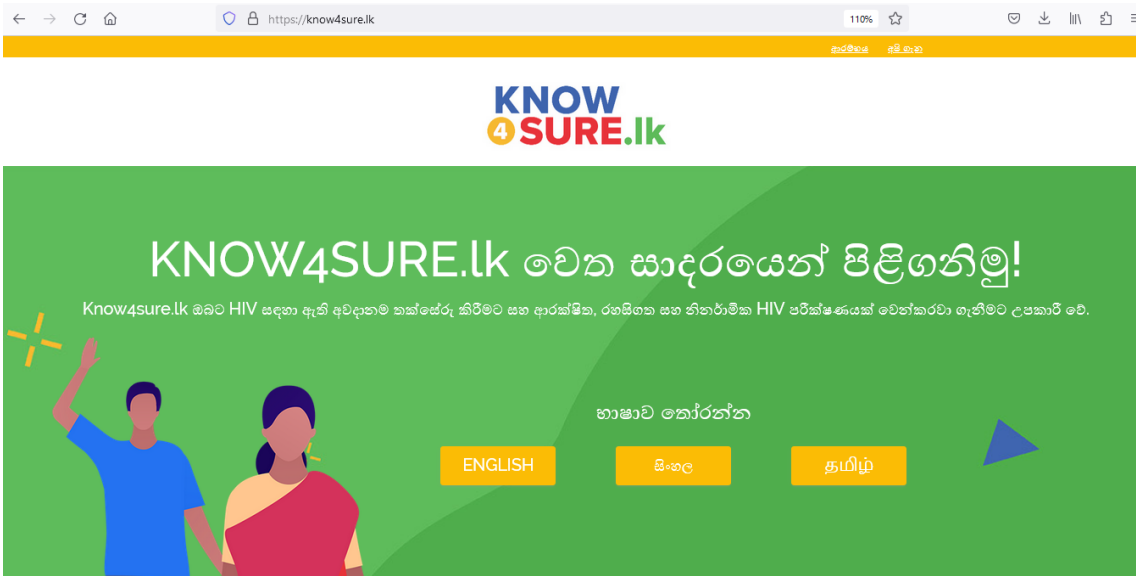


Figure 16.3: know4sure.lk website Home page

NSACP website and dashboard for key population interventions

NSACP website and dashboard for key population interventions The NSACP website, https://www.aidscontrol.gov.lk serves as the central digital platform for Sri Lanka's national response to HIV and sexually transmitted infections (STIs). It provides comprehensive

information on HIV/AIDS prevention, testing, treatment, and care services available across the country.

NSACP website includes key documents such as strategic plans, guidelines, surveillance reports, monitoring formats and training manuals. It also features updates on programmes, campaigns, and data related to national HIV statistics. The website has a dashboard to display key population coverage data upto 2025 and user feedback QR coded system shown in the clinic from STD clinic attendees, providing the public with insights into the quality of services offered by their respective STD clinics.



Figure 16.4: NSACP website's home page

MyView web based QR feedback system

Client feedback from STD clinic attendees is vital for enhancing service quality. MyView offers an easy and private way for clients to share their thoughts and experiences with the clinic staff. By simply scanning a QR code with their smartphones, clients can quickly provide brief feedback on the services they receive.

This input helps the clinic understand what is working well and where improvements are needed. To make it even easier, MyView flyers are available for all STD clinics.





A smartphone with QR Code scanning facility and a Mobile data or Wi-Fi are the only needed requirement for the client. The dashboard below will show the responses for each individual clinic and is displayed in the NSACP website's dashboard (client feedback dashboard).



Figure 16.5: client feedback dashboard page (for 2025)

Quarterly return Google Sheet

The introduction of the quarterly return google sheets represents a critical transition from conventional paper-based data entry to a more streamlined digital approach. This system is composed of three structured Google Sheets designed to capture comprehensive datasets: (1) STD Quarterly Return, (2) ART Quarterly Return, and (3) Cross-Sectional Database.

These tools are deployed across peripheral STD clinics and by Key Population (KP) program staff for data entry. The SIM Unit is responsible for aggregating, validating, analyzing, and visualizing the submitted data for programmatic and policy-level stakeholders. This digital cloud-based application improves timeliness, and accessibility, while minimizing data transcription errors, and logistical constraints in storage in manual paper formats.

The google sheets support more responsive decision-making, enhances national reporting efficiency, and strengthens evidence-based interventions for STD and HIV/ART service delivery. Additionally, it facilitates sharing of data and key statistics with local and international partners.

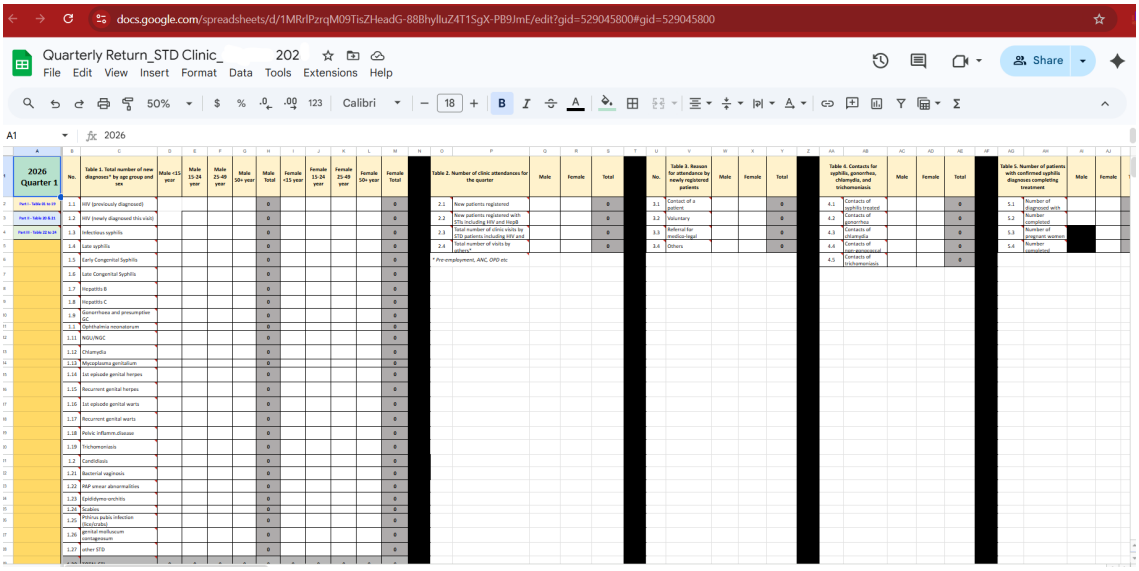


Figure 16.6: Quarterly return google sheet for STD Clinics

CONSULTANT VENEREOLOGIST [1],
SENIOR STRATEGIC MANAGEMENT OFFICER [4]

17 WORLD AIDS DAY 2025

VINO DHARMAKULASINGHE [1]

World AIDS Day (WAD) is commemorated annually on 1st December to remember those who have lost their lives due to AIDS and to renew global and national commitment toward ending HIV/AIDS. In 2025, the world marked the 37th World AIDS Day under the theme "Overcoming Disruption, Transforming the AIDS Response." This theme emphasized strengthening resilience, addressing persistent challenges, and fostering solidarity with people living with and affected by HIV. To mark World AIDS Day 2025, the National STD/AIDS Control Programme (NSACP) of the Ministry of Health implemented a series of island-wide activities aimed at raising awareness, promoting prevention, and strengthening partnerships with communities. A common logo was introduced to maintain a unified identity across all campaign activities.

The main objectives of the World AIDS Day 2025 programme were:

- To enhance community involvement in the HIV response and contribute toward ending AIDS as a public health threat by 2030
- To improve public awareness on HIV, its prevention strategies, and to promote HIV testing, including HIV self-testing, condom use, Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis following sexual exposure (PEPSE) Programme Implementation

The organizing committee, chaired by NSACP and comprising multisectoral stakeholders, coordinated an island-wide campaign. Key activities included:

1. World AIDS Day walk and public meeting
2. Press and media conferences
3. Social media campaigns
4. Island-wide banner campaign
5. Awareness programmes through peripheral sexual health clinics
6. Targeted HIV testing programmes among key and vulnerable populations

Awareness through Peripheral Sexual Health Clinics

All forty (40) sexual health clinics across the country conducted awareness programmes to commemorate World AIDS Day 2025. NSACP supported these clinics by providing banners, leaflets, and condom dispensers. These efforts strengthened outreach and reinforced HIV prevention messages at the community level.

HIV Testing Campaign

In parallel with WAD 2025 activities, a targeted HIV testing campaign was conducted focusing on key populations and vulnerable groups. Eight outreach testing sites were established in and around Colombo, utilizing rapid HIV testing methods and a mobile laboratory supported by NSACP healthcare staff. These outreach programmes were specifically designed to improve access to HIV testing services among populations in hard-to-reach settings. Testing activities were conducted from 21st November to 1st December 2025 at identified hotspots.

Table 17.1: HIV testing programmes in parallel to the WAD activities in the year 2025

	HIV testing site	Date
01	Fort Railway station	21/11/2025
02	Veheragoda Viharaya, Kolonnawa	23/11/2025
03	Thalangama Drug user rehabilitation center	24/11/2025
04	Bastian Bus stand	25/11/2025
05	Samadhi Viharaya, Badowita, Rathmalalana	26/11/2025
06	Makubura Multi Model Center	27/11/2025
07	New Bazar , MOH	28/11/2025
08	Bodiraja viharaya, Fort	29/11/2025

A series of similar HIV testing programmes were also conducted by sexual health clinics throughout the island, further expanding access to early diagnosis and linkage to care.

Media Engagement

Media engagement was a key component of the WAD 2025 campaign. A press conference was held on 26th November 2025 at the Health Promotion Bureau in collaboration with the Health Promotion Bureau, with the participation of mass media representatives. The session highlighted the WAD 2025 theme, current HIV epidemiology, testing strategies, treatment services, and prevention approaches.



A subsequent media briefing was conducted at the Government Information Department on 10th December 2025 to further disseminate updates on HIV trends and promote preventive interventions.

Capacity Building: Media Training for School Children and teachers for youth engagement for HIV prevention

In collaboration with the Family Planning Association of Sri Lanka (FPASL), NSACP organized a media training workshop on 18th December 2025 for school children and teachers from school media clubs. This initiative aimed to enhance youth engagement and promote HIV awareness through peer-led communication.

Development and Distribution of IEC Materials

To support awareness efforts, WAD 2025 banners and leaflets were developed and distributed nationwide. Nearly 1,000 banners carrying key HIV messages in Sinhala, Tamil, and English were displayed across the country. In addition, approximately 10,000 bookmarks with HIV awareness messages in Sinhala and Tamil were distributed. These materials played a vital role in promoting HIV testing, treatment, and prevention services while supporting the national goal of ending AIDS by 2030.

Social Media Campaign

A comprehensive social media campaign was conducted from 28th November to 31st December 2025 through the know4sure.lk and FPASL Facebook and TikTok platforms. The campaign focused on promoting HIV testing, prevention strategies, treatment services, and HIV self-testing. Engaging and tailored short video clips were developed and disseminated to increase public awareness and digital engagement, particularly among younger populations.

World AIDS Day Walk

The main commemorative event, the World AIDS Day walk, was planned for 1st December 2025, starting from Galle Face Green and proceeding through Kollupitiya, Liberty Junction, Dharmapala Mawatha, and Viharamahadevi Park to the NSACP headquarters. However, the event was postponed due to adverse weather conditions.

Youth Awareness Programmes

NSACP, in collaboration with FPASL, conducted awareness programmes targeting approximately 1,000 youth participants including school children especially adolescence during December 2025. These sessions named as “love and Hashtags” aimed to improve knowledge on HIV prevention, reduce stigma, and promote responsible health-seeking behaviors among young people.

CONSULTANT VENEREOLOGIST [1]

18 Progress of Global Fund Activities

GAYAN ARIYADASA [2], SHUNMUGANATHAN MURALIHARAN [5]

In 2025, marking the first year of the three-year Grant Cycle 7 (2025–2027), the Ministry of Health functioned as the Principal Recipient (PR), while the Family Planning Association served as the Sub-Recipient (SR). The initial budget allocation for the grant cycle was subsequently adjusted through reallocation, bringing the total to USD 5,430,811. The combined allocation for both implementing entities was established at the outset of the year.

National Strategic Plan (2023-2027): Strategic Directions	Strategy/Activities supported by the Global Fund
Prevention	Non-Governmental Organizations (NGO) / Community-Based Organizations (CBO) supported Peer-led HIV prevention programme for Key populations (KP).
	Community Dropping in Center, Salaries, and incentives Prison Peer led HIV prevention Programme
	Pre-exposure prophylaxis (PrEP) for Men who have sex with men (MSM) and Trans-gender (TG).
	Community-Based interventions and Harm Reduction Interventions for People who inject drugs (PWID).
	Procurement, procurement supply chain managing of HIV, Syphilis, Hepatitis B and C Rapid Diagnostic Tests, HIV Self-Tests, Condom programing to KP, procurement of male and Female condoms and Lubricants.
	Addressing stigma, discrimination, violence, re fresher training programmes, advocacy programmes, KP interventions reviews, supervisions, programme implementers meetings, information material printing, facilitate outreach activities.
Diagnosis, Treatment and Care	Improve Coverage of Sexually Transmitted Infection (STI) testing services, improving Anti-Retroviral Therapy (ART) adherence and monitoring.
	Training and meetings of subcommittees on Sexually Transmitted Infection (STI) testing services.
	Scaling up quality laboratory Services- Procurement of CD4 and Viral Load testing.

Strategic Information Management System	Establishing and maintenance of Programme monitoring and routine reporting, scaling up maintenance of Electronic Information Management System (EIMS) and Prevention Information Management System (PIMS).
Health Systems Strengthening	Grant and Programme Management costs (Human resources and other costs)
Supportive Environment	Programmes to reduce human rights-related barriers to HIV services.

Table 1: Summary of Global Fund–Supported Activities in 2025 Aligned with NSP Strategic Directions

Major Activity Progress in 2025

In 2025, the National STD/AIDS Control Programme (NSACP) continued to strengthen routine Global Fund-supported activities while scaling up interventions to enhance service delivery, data systems, and supply chain.

A. Expansion in Service Delivery

1. Expansion of HIV Prevention Services

Building on the expansion of existing HIV prevention services, programme activities in 2025 focused on further enhancing coverage, quality, and targeted interventions. This included:

- Scaling up HIV, Hepatitis B & C testing services through district and national-level training programmes.
- Strengthening index testing, harm reduction, and virtual interventions to improve reach among key populations.
- Expanding community-based prevention approaches, including awareness programmes, Behaviour Change Communication (BCC), and advocacy initiatives for vulnerable groups such as prisoners and PWID.
- Conducting awareness programmes targeting universities and schools, particularly in line with World AIDS Day activities, to improve knowledge and promote preventive behaviours among young populations.
- Introducing specialized interventions, including engagement with 'chemsex' venue stakeholders.

2. Strengthening Programme Information Systems Further to the operationalization of digital systems:

- Prevention Information Management System (PIMS) continued to be fully utilized across all districts, with improvements to data capture, monitoring, and reporting by KP intervention teams.
- Electronic Information Management System (EIMS) enhancements were effectively utilized, including the Short Messaging Module (SMS) to strengthen client follow-up, adherence support, and service linkage.
- Increased emphasis was placed on data-driven decision-making, supported by trained programme staff and improved reporting practices.

3. Expanding Access through Mobile Clinic Facilities and Outreach Services Following the introduction of mobile service delivery models:

- Mobile clinic facilities were initiated to further expand access to HIV, STI, and hepatitis testing, counselling, and referral services, particularly in underserved and high-risk areas.
- Outreach services were further strengthened through trained field teams, peer leaders, and People Living with HIV (PLHIV) networks, ensuring continuity of care and improved linkage to treatment.
- Service delivery was complimented by community-level awareness and prevention programmes, enhancing demand for services.

CONSULTANT COMMUNITY PHYSICIAN [1], MEDICAL OFFICER [5]

19 Financial Summary 2025

GAYAN ARIYADASA [2], SHUNMUGANATHAN MURALIHARAN [5]

Financial source	Description	Fund allocation (LKR)	Fund Utilization (LKR)
1. Capital Expenditure			
Ministry of Health	Building construction	-	-
	DDG (PH)1	20,000,000.00	15,819,649.05
	Furniture & Office Equipment	1,786,200.00	1,785,500.00
	Plant, Machinery & Equipment	9,570,469.00	9,570,468.30
	Maintenance of plant, machinery and equipment	448,358.00	332,016.60
	Building and Structures	21,929,027.32	2,280,390.41
	Other	-	-
	Sub-total	**53,734,054.32**	**29,788,024.36**
UNFPA	Consultative workshops, advocacy programmes, printing of publication	1,366,086.94	1,366,086.94
WHO	Consultative workshops, review meetings and training module	0	
GFATM	Human Resources (HR)	154,053,374.52	136,377,103.77
	Travel related costs (TRC)	52,879,637.37	35,824,681.03
	External Professional services (EPS)	65,856,831.09	16,153,148.67
	Health Products - Pharmaceutical Products (HPPP)	13,133,529.68	7,727,285.74
	Health Products - Non-Pharmaceuticals (HPNP)	19,706,789.00	64,672,946.43
	Health Products - Equipment (HPE)	4,460,050.06	0
	Procurement and Supply-Chain Management costs (PSM)	20,513,897.95	16,825,601.76
	Infrastructure (INF)	451,196.12	0
	Non-health equipment (NHP)	3,955,388.88	2,205,527.92
	Communication Material and Publications (CMP)	4,379,065.07	3,334,298.16
	Indirect and Overhead Costs	20,677,368.15	16,403,291.57
	Living support to client/ target population (LSCTP)	9,008,642.88	7,656,787.37
	Payment for Results	21,220,999.24	0.00
	Total	390,296,770.00	307,180,672.42
	Total Capital Expenditure	**445,396,911.26**	**338,334,783.72**
2. Recurrent Expenditure			
	Personal Emoluments	264,356,156.00	243,337,402.07
	Traveling expenses	515,000.00	456,788.50
Ministry of Health	Supplies	7,766,950.00	16,950,732.94
	Maintenance expenditure	6,025,701.27	5,422,498.21
	Services	23,604,560.00	21,245,772.75
	Medical supplies	0	0
	Transfers	419,820.00	383,984.63
	Total Recurrent Expenditure	**302,688,187.27**	**287,797,179.10**
	Grand Total (LKR)	**748,085,098.53**	**626,131,962.82**

Analysis and Observations

The Government of Sri Lanka (GoSL) capital expenditure demonstrated a high utilization, indicating effective implementation of planned capital investments, particularly in furniture, equipment, and machinery. However, relatively low utilization was observed in the Building and Structures category, suggesting delays in infrastructure-related activities.

Recurrent expenditure under GoSL also maintained a high utilization trend, reflecting strong financial management and efficient use of resources for routine operational activities. Notably, expenditure on supplies exceeded the allocated budget, indicating either increased programmatic demand or reallocation of resources to meet service delivery needs.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) remained the largest contributor to capital expenditure, with mixed performance across cost categories. High utilization was observed in human resources, procurement and supply chain management, and communication materials, reflecting strong implementation in these areas. However, low or zero utilization in categories such as equipment and infrastructure, along with under-performance in external professional services, suggests possible procurement delays, implementation bottlenecks, or deferred activities.

Among development partners, UNFPA achieved 100% utilization, demonstrating optimal execution of planned activities such as advocacy programmes and publications. No capital expenditure was reported under WHO for the year.

As in previous years, provincial allocations for peripheral Sexually Transmitted Disease (STD) clinics, which are managed through the Provincial Directorates of Health Services, are not captured in this summary, as they fall outside the direct financial oversight of the National STD/AIDS Control Programme (NSACP).

Conclusion

The financial performance of the National STD/AIDS Control Programme (NSACP) in 2025 reflects strong utilization of Government allocations, particularly in recurrent expenditure and most capital investment areas, demonstrating effective financial management and operational efficiency. The near-full utilization of recurrent funds and high absorption of capital allocations highlight the programme's ability to sustain service delivery and implement planned activities.

At the same time, variations in utilization across specific capital components, such as building and infrastructure, indicate areas where implementation delays may have

occurred. Within GFATM-supported activities, while key areas such as human resources and supply chain management showed satisfactory progress, lower or inconsistent utilization in selected categories points to the need for improved planning, procurement processes, and timely execution. Additionally, over-utilization in certain expenditure lines, such as supplies and non-pharmaceutical health products, suggests evolving programme demands and the need for more accurate budgeting and resource allocation.

Moving forward, enhancing budget forecasting, strengthening implementation mechanisms, and improving financial monitoring across funding streams will be essential to ensure balanced utilization and maximize the impact of available resources in the national response to STDs and HIV/AIDS.

CONSULTANT COMMUNITY PHYSICIAN [1] MEDICAL OFFICER [5]

20 Contact Information of Sexual Health Clinics

A) Central province

1. Dambulla STD clinic	
Address	STD clinic, District Base Hospital, Dambulla.
Email	dambullastdclinic@gmail.com
Telephone	066-2284761 (GH)
Contact person	Dr Chathuranga Hemakeerthi (MO)

2. Kandy STD clinic	
Address	STD clinic, P.O. Box 207, Kandy.
Email	stdclinic.kandy@gmail.com
Telephone	081-2203622
Fax	081-2203923
Contact Persons	Dr. Kanchana Weearasinghe (Venereologist)

3. Matale STD clinic	
Address	STD clinic, District General Hospital, Matale.
Email	stdclinic.matale@gmail.com
Telephone	066-2053746
Contact persons	Dr Anuradha Perera (Actg Venereologist)
	Dr. K.W.K.K.A. Bandara (MO/IC)

4. Nuwara Eliya STD clinic	
Address	STD clinic, District General Hospital, Nuwara Eliya.
Email	stdnuwaraeliya@gmail.com
Telephone	052-2223210, 052-2222261 (GH) Ext: 345
Fax	052-2223476 (GH)
Contact persons	Dr. Irani Gunathilaka (Actg Venereologist)

B) Eastern Province

5. Ampara STD clinic	
Address	STD clinic, District General Hospital, Ampara.
Email	stdclinicampara1@gmail.com
Telephone	063-2224239
Fax	063-2222988 (RDHS Office)
Contact person	Dr M.D. Rathnayaka (MOIC)

6. Batticaloa STD clinic	
Address	STD clinic, Health Friendly Center, 1st floor of Chest Clinic, Hospital Rd, Batticaloa.
Email	stdbatti@gmail.com
Telephone	065-2057078
Fax	065-2224401 (TH)
Contact persons	Dr Nishan Gunarathna (Actg Venereologist) Dr Tharmarathnam Thivakaran (MO)

7. Kalmunai STD clinic	
Address	STD clinic, District General Hospital, Sainthamaruthu, Sainthamaruthu.
Email	stdkalmunai@gmail.com
Telephone	067-2223660
Contact person	Dr. M H Rizfin (MO)

8. Trincomalee STD clinic	
Address	STD clinic, District General Hospital, Trincomalee.
Email:	stdunit2@gmail.com
Telephone	026-2222563
Fax	026-2222563
Contact person	Dr. Gaurishvaram (MO/IC)

C) North Central Province

9. Anuradhapura STD clinic	
Address	STD clinic, Room No 11, Teaching Hospital, Anuradhapura
Email	stdclinic.anuradhapura@gmail.com
Telephone	025-2236461, 071-8103001
Fax	025-2225616 (TH)
Website	https://sites.google.com/view/sexual-health-anuradhapura/home
Contact person	Dr. Ajith Karawita (Venereologist)

10. Polonnaruwa STD clinic	
Address	STD clinic, District General Hospital, Polonnaruwa.
Email	stdclinicpolonnaruwa1@gmail.com
Telephone	027-2225787
Fax	027-2225787
Contact Persons	Dr. Nalaka Kulathunga (Actg. Venereologist)
	Dr. Indra Peris (MO/IC)

D) North Western Province

11. Chilaw STD clinic	
Address	STD clinic, General Hospital, Chilaw.
Email	std.rdhspu@gmail.com
Telephone	032-2220750
Fax	032-2223200 (GH)
Contact persons	Dr Piyumi Perera (Venereologist) Dr Sasith Udugama (MO)

12. Kuliyapitiya STD clinic	
Address	STD clinic, Teaching Hospital, Kuliyapitiya.
Email	stdclinickuliyapitiya@gmail.com
Telephone	037-2281261 Ext 275
Contact person	Dr. CHithran Hathurusinghe (Venereologist) Dr Gayan Sanjeewa Hettiarachchi (MO)

13. Kurunegala STD clinic	
Address	STD clinic, Teaching Hospital, Kurunegala.
Email	stdclinic.kurunegala@gmail.com
Telephone	037-2224339
Fax	037-2224339
Contact persons	Dr. Shyama Somawardana (Venereologist)

14. Puttalam STD clinic	
Address	Unit 13, Base Hospital Puttalam, Puttalam.
Email	stdputtalama@gmail.com
Telephone	0322-265 261 (GH)
Contact person	Dr Dinindu Buddhika (MOIC)

E) Northern Province

15. Jaffna STD clinic	
Address	STD clinic, Teaching Hospital, Jaffna.
Email	stdclinic.jaffna@gmail.com
Telephone	021-2217756
Fax	021-2222262 (TH)
Contact persons	Dr Champika Gunawardene (Actg Venereologist) Dr Sivapadamurthi (MOIC)

16. Kilinochchi STD clinic	
Address	STD clinic, District General Hospital, Kilinochchi.
Email	stdkilinochchi@gmail.com
Telephone	021-2283709, 021-2285329 (GH) Ext: 194
Fax	021-2285327 (GH)
Contact persons	Dr. Elankumaran Velayathapillai (MO/IC)

17. Mannar STD clinic	
Address	STD clinic, District General Hospital, Mannar.
Email	stdclinicmannar2019@gmail.com
Telephone	023-2250573
Fax	023-2250748 (RDHS Office)
Contact persons	Dr. Dayani Dias (MO/IC)

18. Mullaitivu STD clinic	
Address	STD clinic, District General Hospital, Mullaitivu.
Email	stdaidscontrolprogramme.mtv@gmail.com
Telephone	021-2061414
Contact person	Dr. B. Thanshayan (MO/STD Mullaitivu)

19. Vavuniya STD clinic	
Address	STD clinic, District General Hospital, Vavuniya.
Email	stdclinic.vavuniya@gmail.com
Telephone	024-2224575
Fax	024-2222892 (RDHS Office)
Contact persons	Dr. Damindu Jalath Thanthri (Venereologist- Vavuniya) Dr Baskaran Arulmoly (MOIC)

F) Sabaragamuwa Province

20. Kegalle STD clinic	
Address	STD clinic, District General Hospital, Kegalle.
Email	stdunit.kegalle@gmail.com
Telephone	035-2231222
Fax	035-2231222
Contact persons	Dr. D.K. Nilanga Jeewani Jayasinghe (MO/IC)

21. Ratnapura STD clinic	
Address	STD clinic, Teaching Hospital Ratnapura.
Email	stdclinic.rathnapura@gmail.com
Telephone	045-2221561 (Venereologist)
	045-2226561
Contact persons	Dr Krishanthi Ubeysekara (Actg Venereologist)

22. Embilipitiya STD clinic	
Address	STD clinic, District General Hospital, Embilipitiya.
Email	stdclinic.embilipitiya@gmail.com
Telephone	047-2230261 (GH)
Fax	047-2230141
Contact persons	Dr. Nameendra Rajapaksha (MOIC)

G) Southern Province

23. Balapitiya STD clinic	
Address	STD clinic, Base Hospital, Balapitiya.
Email	stdbalapitiya@gmail.com
Telephone	091-2256822
Fax	091-2256410 (BH)
Contact persons	Dr. H.D. Fernando (MO/IC)

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

25. Tangalle STD clinic	
Address	STD clinic , Base hospital, Tangalle.
	sexualhealthclinicbhtangalle@gmail.com
Telephone	0473144194
Contact person	Dr Vishwajith Jayawardene (MO)

26. Hambantota STD clinic	
Address	STD clinic, General Hospital, Hambantota.
Email	stdclinic.hambantota@gmail.com
Telephone	047-2222247
Fax	047-2222247
Contact persons	Dr Inoka Munasinghe (Venereologist) Dr.L.K.H.M.Jayaruwan (MOIC)

27. Matara STD clinic	
Address	STD clinic, No 43, District General Hospital, Matara.
Email	stdmatara@gmail.com
Telephone	041-2232302
Fax	041-2232302
Contact persons	Dr Niroshan Jayasekara (Venereologist)

H) Uva Province

28. Badulla STD clinic	
Address	STD clinic, Room No 73, Daya Gunasekara Mawatha, Badulla.
Email	stdclinic.badulla@gmail.com
Telephone	055-2222578
Fax	055-2222578
Contact persons	Dr Chathurika Wickramarathne (Venereologist) Dr Chrishan Vethanayagam (MOIC)

29. Mahiyanganaya STD clinic	
Address	STD clinic, Room 22, Base Hospital, Mahiyanganaya.
Email	stdclinicmyg@gmail.com
Telephone	055-4936779
Fax	055-2223750
Contact person	Dr. Baratha Dissanayake (MO/IC)

30. Monaragala STD clinic	
Address	STD clinic, District General Hospital, Monaragala.
Email	monaragalastd@gmail.com
Telephone	055-2276826
Fax	055-2276700 (RDHS Office)
	055-2276912 (GH)
Contact person	Dr. Dilanka Nimalrathne (Actg. Venereologist) Dr R.K.G.M. Rajapaksha (MO)

I) Western Province

31. Avissawella STD clinic	
Address	STD clinic, Room 5, OPD Complex, Base Hospital, Avissawella.
Email	stdavissawella@yahoo.com/ stddgha@gmail.com
Telephone	036-2222003
	036-2222261/62 (BH)
	Ext: 228
Contact person	Dr. Priyanatha Weerasinghe (Venereologist)

32. Colombo Central STD clinic (NSACP)	
Address	29, De Saram Place, Colombo 10.
Web link	www.aidscontrol.gov.lk
Email	info@aidscontrol.gov.lk
Telephone	011-2667163 (Exchange)
Hot lines	011-2695420 (Female clinic), 011-2-695430 (Male clinic)
Fax	011-2665277
Contact persons	Dr. Janitha C M Tennakoon (Director)
	Dr. K.A. Manathunge Ariyaratne (Venereologist)
	Dr. Jayanthi. P. Elwitigala (Microbiologist)
	Dr. Sathya Herath (Community Physician)
	Dr. Umedha Jayasinghe (Venereologist)
	Dr. Janaka Weragoda (Community Physician)
	Dr. Nimali Jayasuriya (Venereologist) Dr. Prageeth Premadasa (Venereologist) Dr. Iruka Rajapaksha (Venereologist) Dr. Waruni Pannala (Venereologist) Dr Madhavi Gunathilaka (Epidemiologist) Dr Vino Dharmakulasinghe (Venereologist) Dr. Gayan Ariyadasa (Community Physician)

33. Gampaha STD clinic	
Address	STD Clinic, District General Hospital, Gampaha.
Email	stdclinic.gampaha@gmail.com
Telephone	033-2234383
Fax	033-2222179 (GH)
Contact persons	Dr. Gayani Nanayakkara (Venereologist) Dr Thilak Udayasiri (MOIC)

34. Homagama STD clinic	
Address	OPD Building, Base Hospital, Homagama.
Telephone	011-2855200
Contact person	Dr E.R. Mahesh Eriyagolla (MO)

35. Kalubowila STD clinic	
Address	STD clinic, Room 43, Sunandarama Road, Kalubowila.
Email	stdclinic.kalubowila@gmail.com
Telephone	011 -2763893
Fax	011 -2763893
Contact person	Dr. Nalaka Abeygunasekara (Venereologist)
	Dr M.Malcolm (MO)

36. Kalutara STD clinic	
Address	STD clinic, General Hospital, Nagoda, Kalutara.
Email	stdclinic.kalutara@gmail.com
Telephone	034-2236937
Fax	034-2236937
Contact persons	Dr Kokilanthi Dharmaratne (Venereologist)

37. Negombo STD clinic	
Address	STD clinic, District General Hospital, Negombo.
Email	stdclinic.negombo@gmail.com
Telephone	031-2239016, 031-2222261 (GH)
Contact persons	Dr. Manjula Rajapaksha (Venereologist)
	Dr Lal Arunasiri (MOIC)

38. Panadura STD clinic	
Address	STD clinic, Base Hospital, Panadura.
Telephone	038-2232261
Contact person	Dr. Kokilanthi Dharmaratna (Venereologist)

39. Ragama STD clinic	
Address	STD clinic, Room 70, Teaching Hospital, Ragama.
Email	stdclinic.ragama@gmail.com
Telephone	011-2960224
Fax	011-2960224, 011-2959266 (TH)
Contact persons	Dr Geethani Samaraweera (Venereologist) Dr Gayan Samarasinghe (MOIC)

40. Wathupitiwala STD clinic	
Address	STD clinic, Base Hospital, Wathupitiwala.
Email	stdcampaign.bswathupitiwala@yahoo.com
Telephone	033-2280261 Ext: 255
Fax	033-2280927
Contact person	Dr Mohomad Riyaz (MOIC)

Anex 01

Reported infectious syphilis cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	3	0	3	4	1	5	0	2	2
	Kandy	18	2	20	29	3	32	18	3	21
	Matale	3	2	5	8	3	11	8	4	12
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	3	2	5	0	0	0	1	3	4
Eastern Province	Ampara	3	1	4	10	1	11	4	1	5
	Batticaloa	10	4	14	4	2	6	6	3	9
	Kalmunai	1	0	1	2	1	3	2	0	2
	Trincomalee	3	1	4	4	0	4	6	4	10
North Central province	Anuradhapura	0	0	0	6	3	9	4	9	13
	Polonnaruwa	6	0	6	14	5	19	8	6	14
North Western Province	Chilaw	10	4	14	7	2	9	11	8	19
	Kuliyapitiya	0	0	0	1	1	2	4	0	4
	Kurunegala	9	3	12	9	6	15	13	5	18
	Puttalam	3	2	5	4	1	5	5	6	11
Northern Province	Jaffna	3	0	3	11	3	14	12	6	18
	Kilinochchi	3	2	5	3	0	3	5	4	9
	Mannar	0	0	0	1	1	2	1	2	3
	Mullaitivu	4	1	5	1	1	2	0	0	0
	Vavuniya	8	2	10	5	2	7	9	1	10
Sabaragamuwa Province	Embilipitiya	0	0	0	0	0	0	1	0	1
	Kegalle	5	0	5	15	1	16	11	6	17
	Ratnapura	3	1	4	5	9	14	11	2	13
Southern Province	Balapitiya	3	0	3	0	0	0	11	7	18
	Hambanthota	6	1	7	8	4	12	9	3	12
	Mahamodara	16	4	20	31	10	41	26	1	27
	Matara	2	1	3	4	1	5	15	5	20
	Tangalle	2	0	2	3	0	3	2	0	2
UVA Province	Badulla	6	0	6	14	2	16	10	4	14
	Mahiyanganaya	0	0	0	0	1	1	1	3	4
	Monaragala	2	3	5	4	2	6	2	4	6
Western Province	Avissawella	6	1	7	17	1	18	6	2	8
	Colombo	101	9	110	129	24	153	112	25	137
	Gampaha	51	6	57	28	5	33	37	9	46
	Homagama	4	2	6	4	1	5	4	0	4
	Kalubowila	60	5	65	49	6	55	38	5	43
	Kalutara	7	0	7	12	4	16	7	7	14
	Negombo	16	5	21	22	7	29	16	4	20
	Panadura	10	2	12	11	1	12	2	2	4
	Ragama	31	6	37	27	6	33	43	7	50
	Wathupitiwala	2	0	2	9	0	9	7	0	7
Total		423	72	495	515	121	636	488	163	651

Reported late syphilis cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	6	1	7	2	2	4	6	2	8
	Kandy	21	7	28	19	14	33	12	14	26
	Matale	6	2	8	7	8	15	2	4	6
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	3	3	6	4	4	8	1	3	4
Eastern Province	Ampara	8	0	8	4	6	10	8	4	12
	Batticaloa	12	8	20	20	6	26	10	6	16
	Kalmunai	6	0	6	1	0	1	3	1	4
	Trincomalee	6	6	12	8	1	9	6	2	8
North Central province	Anuradhapura	16	12	28	8	1	9	16	8	24
	Polonnaruwa	22	7	29	23	6	29	31	9	40
North Western Province	Chi law	9	11	20	4	5	9	5	4	9
	Kuliyapitiya	5	0	5	0	1	1	2	2	4
	Kurunegala	26	12	38	25	30	55	36	15	51
	Puttalam	2	0	2	0	3	3	1	0	1
Northern Province	Jaffna	29	19	48	47	18	65	18	11	29
	Kilinochchi	0	1	1	1	1	2	3	1	4
	Mannar	4	1	5	3	2	5	2	2	4
	Mullaitivu	0	0	0	0	0	0	0	0	0
	Vavuniya	3	2	5	4	3	7	7	5	12
Sabaragamuwa Province	Embilipitiya	6	0	6	4	1	5	1	2	3
	Kegalle	20	6	26	18	4	22	7	3	10
	Ratnapura	15	5	20	6	8	14	12	7	19
Southern Province	Balapitiya	3	4	7	3	5	8	0	0	0
	Hambanthota	21	15	36	22	13	35	19	2	21
	Mahamodara	23	9	32	18	7	25	22	8	30
	Matara	13	8	21	15	6	21	13	3	16
	Tangalle	3	1	4	5	3	8	0	0	0
UVA Province	Badulla	14	6	20	18	10	28	13	4	17
	Mahiyanganaya	2	3	5	3	3	6	0	0	0
	Monaragala	5	3	8	11	6	17	4	2	6
Western Province	Avissawella	4	1	5	5	1	6	2	2	4
	Colombo	180	56	236	108	46	154	40	9	49
	Gampaha	16	9	25	14	5	19	5	6	11
	Homagama	1	2	3	7	2	9	1	0	1
	Kalubowila	28	3	31	39	5	44	36	12	48
	Kalutara	22	16	38	19	7	26	24	17	41
	Negombo	14	7	21	24	5	29	22	10	32
	Panadura	18	3	21	9	2	11	8	2	10
	Ragama	23	14	37	35	10	45	24	8	32
	Wathupitiwala	8	2	10	14	0	14	6	0	6
Total		**623**	**265**	**888**	**577**	**260**	**837**	**428**	**190**	**618**

Reported gonorrhoea cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	0	1	1	7	1	8	7	2	9
	Kandy	20	0	20	31	1	32	19	2	21
	Matale	9	6	15	8	6	14	12	6	18
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	8	7	15	7	7	14	4	1	5
Eastern Province	Ampara	10	2	12	16	14	30	7	11	18
	Batticaloa	2	1	3	15	0	15	7	1	8
	Kalmunai	5	2	7	3	0	3	3	0	3
	Trincomalee	16	2	18	5	1	6	8	1	9
North Central province	Anuradhapura	29	3	32	8	2	10	12	1	13
	Polonnaruwa	20	19	39	28	6	34	10	1	11
North Western Province	Chilaw	12	7	19	12	0	12	13	0	13
	Kuliyapitiya	4	1	5	4	1	5	3	0	3
	Kurunegala	26	6	32	23	9	32	24	0	24
	Puttalam	12	28	40	7	11	18	8	1	9
Northern Province	Jaffna	24	2	26	33	2	35	24	0	24
	Kilinochchi	0	0	0	4	0	4	6	0	6
	Mannar	1	0	1	3	1	4	1	0	1
	Mullaitivu	0	0	0	0	0	0	0	0	0
	Vavuniya	26	12	38	24	12	36	6	1	7
Sabaragamuwa Province	Embilipitiya	13	1	14	6	1	7	7	2	9
	Kegalle	10	0	10	8	0	8	2	0	2
	Ratnapura	7	0	7	14	4	18	4	0	4
Southern Province	Balapitiya	1	2	3	7	11	18	1	0	1
	Hambanthota	13	7	20	11	1	12	11	3	14
	Mahamodara	11	2	13	20	0	20	5	0	5
	Matara	11	1	12	13	0	13	9	2	11
	Tangalle	10	0	10	1	0	1	0	0	0
UVA Province	Badulla	8	0	8	4	1	5	7	1	8
	Mahiyanganaya	1	0	1	11	0	11	3	2	5
	Monaragala	5	1	6	9	2	11	3	5	8
Western Province	Avissawella	9	3	12	15	5	20	15	0	15
	Colombo	305	38	343	258	32	290	154	17	171
	Gampaha	43	8	51	33	5	38	39	9	48
	Homagama	13	1	14	15	3	18	11	3	14
	Kalubowila	86	16	102	91	9	100	44	4	48
	Kalutara	15	4	19	18	4	22	10	0	10
	Negombo	52	4	56	26	2	28	31	4	35
	Panadura	26	3	29	17	2	19	16	6	22
	Ragama	60	11	71	54	4	58	36	10	46
	Wathupitiwala	5	1	6	5	1	6	14	2	16
Total		**928**	**202**	**1130**	**874**	**161**	**1035**	**596**	**98**	**694**

Reported non gonococcal cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	7	38	45	15	96	111	8	86	94
	Kandy	12	108	120	20	63	83	15	15	30
	Matale	10	96	106	8	233	241	3	232	235
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	0	61	61	3	102	105	2	10	12
Eastern Province	Ampara	0	14	14	13	11	24	13	12	25
	Batticaloa	0	0	0	0	0	0	2	0	2
	Kalmunai	0	2	2	3	0	3	2	0	2
	Trincomalee	1	5	6	0	0	0	1	0	1
North Central province	Anuradhapura	5	19	24	25	30	55	54	22	76
	Polonnaruwa	5	28	33	14	60	74	11	39	50
North Western Province	Chilaw	1	14	15	3	20	23	2	19	21
	Kuliyapitiya	0	1	1	1	1	2	5	6	11
	Kurunegala	25	205	230	33	408	441	31	368	399
	Puttalam	1	10	11	5	8	13	1	13	14
Northern Province	Jaffna	0	2	2	1	2	3	0	0	0
	Kilinochchi	0	0	0	1	0	1	3	1	4
	Mannar	1	3	4	0	2	2	0	2	2
	Mullaitivu	0	0	0	0	0	0	1	0	1
	Vavuniya	11	42	53	75	53	128	74	36	110
Sabaragamuwa Province	Embilipitiya	5	39	44	13	34	47	13	41	54
	Kegalle	1	3	4	10	15	25	10	3	13
	Ratnapura	1	1	2	1	6	7	7	6	13
Southern Province	Balapitiya	0	1	1	9	20	29	0	0	0
	Hambanthota	1	31	32	16	28	44	12	33	45
	Mahamodara	4	41	45	15	19	34	10	36	46
	Matara	12	56	68	7	78	85	5	91	96
	Tangalle	0	0	0	2	1	3	2	0	2
UVA Province	Badulla	6	63	69	35	73	108	95	55	150
	Mahiyanganaya	5	76	81	7	41	48	4	36	40
	Monaragala	11	47	58	8	63	71	2	15	17
Western Province	Avissawella	2	7	9	17	6	23	12	0	12
	Colombo	49	515	564	168	379	547	89	268	357
	Gampaha	15	124	139	18	130	148	30	144	174
	Homagama	1	43	44	28	25	53	16	31	47
	Kalubowila	27	200	227	103	199	302	64	228	292
	Kalutara	14	120	134	28	53	81	21	5	26
	Negombo	10	111	121	25	123	148	47	81	128
	Panadura	3	17	20	21	5	26	4	15	19
	Ragama	19	130	149	32	144	176	36	128	164
	Wathupitiwala	0	6	6	10	6	16	7	30	37
Total		**265**	**2279**	**2544**	**793**	**2537**	**3330**	**714**	**2107**	**2821**

Reported herpes cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	4	24	28	10	19	29	7	30	37
	Kandy	52	110	162	70	110	180	65	111	176
	Matale	15	34	49	23	24	47	19	39	58
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	4	19	23	8	16	24	7	23	30
Eastern Province	Ampara	10	46	56	28	37	65	34	35	69
	Batticaloa	2	4	6	9	14	23	2	15	17
	Kalmunai	1	3	4	0	6	6	3	7	10
	Trincomalee	8	19	27	8	15	23	4	8	12
North Central province	Anuradhapura	19	63	82	40	70	110	37	76	113
	Polonnaruwa	5	53	58	32	35	67	24	44	68
North Western Province	Chilaw	4	27	31	41	27	68	32	45	77
	Kuliyapitiya	4	16	20	16	26	42	33	39	72
	Kurunegala	17	92	109	57	67	124	60	64	124
	Puttalam	1	5	6	8	14	22	12	28	40
Northern Province	Jaffna	7	28	35	37	33	70	15	17	32
	Kilinochchi	2	8	10	6	8	14	7	7	14
	Mannar	1	3	4	3	10	13	3	4	7
	Mullaitivu	3	12	15	19	5	24	4	4	8
	Vavuniya	6	13	19	6	14	20	15	13	28
Sabaragamuwa Province	Embilipitiya	5	47	52	36	45	81	37	52	89
	Kegalle	10	48	58	26	38	64	12	21	33
	Ratnapura	11	64	75	40	45	85	18	6	24
Southern Province	Balapitiya	6	25	31	40	41	81	19	13	32
	Hambanthota	20	64	84	11	38	49	50	67	117
	Mahamodara	11	66	77	24	74	98	34	60	94
	Matara	11	41	52	24	41	65	40	43	83
	Tangalle	6	25	31	5	21	26	1	8	9
UVA Province	Badulla	3	55	58	22	19	41	26	56	82
	Mahiyanganaya	3	20	23	7	20	27	6	19	25
	Monaragala	9	29	38	10	32	42	11	34	45
Western Province	Avissawella	13	52	65	37	65	102	40	58	98
	Colombo	39	204	243	156	182	338	123	209	332
	Gampaha	8	48	56	31	56	87	47	61	108
	Homagama	4	24	28	44	39	83	21	42	63
	Kalubowila	23	101	124	96	122	218	96	113	209
	Kalutara	13	63	76	56	73	129	23	47	70
	Negombo	16	63	79	37	60	97	28	58	86
	Panadura	17	40	57	26	34	60	24	35	59
	Ragama	17	69	86	49	55	104	55	62	117
	Wathupitiwala	4	23	27	15	27	42	13	21	34
Total		**414**	**1750**	**2164**	**1213**	**1677**	**2890**	**1107**	**1694**	**2801**

Reported warts cases, 2023-2025										
Province	Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	13	7	20	16	18	34	8	17	25
	Kandy	62	65	127	48	41	89	55	50	105
	Matale	27	15	42	19	28	47	19	21	40
	Nawalapitiya	0	0	0	-	-	-	-	-	-
	Nuwara Eliya	8	7	15	11	8	19	8	13	21
Eastern Province	Ampara	17	25	42	20	32	52	13	22	35
	Batticaloa	7	9	16	18	5	23	12	8	20
	Kalmunai	5	4	9	2	4	6	0	2	2
	Trincomalee	6	6	12	4	8	12	2	2	4
North Central province	Anuradhapura	39	33	72	64	44	108	60	57	117
	Polonnaruwa	43	30	73	42	42	84	45	41	86
North Western Province	Chilaw	28	33	61	31	19	50	34	22	56
	Kuliyapitiya	27	15	42	19	22	41	26	22	48
	Kurunegala	61	65	126	52	41	93	6	15	21
	Puttalam	6	6	12	10	8	18	12	14	26
Northern Province	Jaffna	14	12	26	21	19	40	26	14	40
	Kilinochchi	6	2	8	4	6	10	7	3	10
	Mannar	0	0	0	5	3	8	2	0	2
	Mullaitivu	4	2	6	2	1	3	2	0	2
	Vavuniya	15	9	24	19	7	26	7	7	14
Sabaragamuwa Province	Embilipitiya	15	17	32	19	6	25	19	13	32
	Kegalle	51	34	85	33	23	56	16	8	24
	Ratnapura	26	23	49	32	38	70	9	2	11
Southern Province	Balapitiya	10	11	21	37	39	76	10	7	17
	Hambanthota	42	30	72	42	37	79	40	23	63
	Mahamodara	43	43	86	50	39	89	45	47	92
	Matara	19	27	46	72	42	114	66	47	113
	Tangalle	10	7	17	12	3	15	3	4	7
UVA Province	Badulla	43	47	90	14	16	30	24	9	33
	Mahiyanganaya	9	14	23	6	7	13	12	5	17
	Monaragala	15	25	40	14	23	37	20	26	46
Western Province	Avissawella	21	25	46	37	35	72	34	42	76
	Colombo	316	150	466	259	133	392	229	108	337
	Gampaha	41	24	65	36	56	92	37	47	84
	Homagama	14	23	37	28	21	49	18	24	42
	Kalubowila	74	60	134	125	79	204	127	88	215
	Kalutara	118	74	192	57	52	109	31	34	65
	Negombo	50	35	85	45	35	80	69	49	118
	Panadura	24	20	44	25	12	37	25	12	37
	Ragama	91	61	152	84	55	139	67	61	128
	Wathupitiwala	14	15	29	23	15	38	20	19	39
Total		**1434**	**1110**	**2544**	**1457**	**1122**	**2579**	**1265**	**1005**	**2270**

Reported trichomonasis cases, 2023-2025										
Province	STD Clinic	2023			2024			2025		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Central Province	Dambulla	0	0	0	0	0	0	0	0	0
	Kandy	0	1	1	0	0	0	0	0	0
	Matale	0	0	0	0	0	0	0	2	2
	Nawalapitiya	0	0	0	-	-	-	-	-	0
	Nuwara Eliya	0	0	0	0	0	0	0	0	0
Eastern Province	Ampara	0	0	0	0	0	0	0	0	0
	Batticaloa	0	1	1	0	0	0	0	0	0
	Kalmunai	0	0	0	0	0	0	0	0	0
	Trincomalee	0	0	0	0	0	0	0	0	0
North Central province	Anuradhapura	0	0	0	0	1	1	0	0	0
	Polonnaruwa	0	0	0	0	0	0	0	0	0
North Western Province	Chilaw	0	0	0	0	1	1	1	1	2
	Kuliyapitiya	0	2	2	0	1	1	0	0	0
	Kurunegala	0	3	3	0	1	1	0	1	1
	Puttalam	0	0	0	1	1	2	0	0	0
Northern Province	Jaffna	0	1	1	0	0	0	0	0	0
	Kilinochchi	0	0	0	0	0	0	0	0	0
	Mannar	0	0	0	0	0	0	0	0	0
	Mullaitivu	0	0	0	0	0	0	0	0	0
	Vavuniya	0	0	0	0	0	0	0	0	0
Sabaragamuwa Province	Embilipitiya	0	1	1	0	0	0	0	0	0
	Kegalle	0	0	0	0	2	2	0	1	1
	Ratnapura	0	1	1	1	3	4	0	1	1
Southern Province	Balapitiya	0	1	1	0	0	0	0	0	0
	Hambanthota	0	0	0	0	0	0	0	0	0
	Mahamodara	0	0	0	0	0	0	0	0	0
	Matara	0	0	0	0	0	0	0	0	0
	Tangalle	0	0	0	0	0	0	0	0	0
UVA Province	Badulla	0	1	1	5	12	17	0	1	1
	Mahiyanganaya	0	0	0	0	0	0	0	0	0
	Monaragala	0	0	0	0	1	1	0	0	0
Western Province	Avissawella	0	2	2	0	1	1	0	1	1
	Colombo	3	12	15	2	9	11	0	7	7
	Gampaha	1	1	2	0	0	0	0	0	0
	Homagama	0	3	3	0	1	1	4	2	6
	Kalubowila	1	3	4	0	3	3	0	0	0
	Kalutara	0	3	3	5	31	36	0	0	0
	Negombo	0	0	0	0	0	0	0	0	0
	Panadura	0	1	1	0	0	0	0	1	1
	Ragama	1	2	3	1	3	4	0	0	0
	Wathupitiwala	4	2	6	0	0	0	0	0	0
Total		10	41	51	15	71	86	5	18	23

Anex 02

Number of clinic attendees and details of clinic attendances for STD clinics during 2025							
		New patients registered			Total new patients with STIs	Total clinic visits by STD patients	Total visits by others
		Male	Female	Total			
Central Province	Dambulla	120	279	399	211	1,253	517
	Kandy	555	574	1,129	521	2,737	4,370
	Matale	217	397	614	436	1,474	1,170
	Nuwara Eliya	176	324	500	217	789	450
Eastern Province	Ampara	201	227	428	299	1,484	1,229
	Batticaloa	139	186	325	77	383	5,036
	Kalmunai	30	52	82	6	81	344
	Trincomalee	84	89	173	44	272	994
North Central Province	Anuradhapura	471	654	1,125	528	2,420	10,061
	Polonnaruwa	348	332	680	295	2,033	1,258
North Western Province	Chilaw	270	273	543	340	2,833	673
	Kuliyapitiya	203	225	428	208	1,008	535
	Kurunegala	2,261	1,905	4,166	725	3,919	5,042
	Puttalam	153	249	402	161	802	819
Northern Province	Jaffna	204	117	321	196	732	2,711
	Kilinochchi	138	108	246	96	383	3,829
	Mannar	20	29	49	29	80	2,754
	Mullaitivu	129	84	213	10	240	1,776
	Vavuniya	172	99	271	225	1,072	3,681
Sabaragamuwa Province	Embilipitiya	108	175	283	155	812	1,238
	Kegalle	653	617	1,270	510	2,077	1,386
	Ratnapura	687	618	1,305	261	2,996	331
Southern Province	Balapitiya	209	248	457	195	97	641
	Hambanthota	419	355	774	391	2,618	3,008
	Mahamodara	469	355	824	412	5,071	1,125
	Matara	580	420	1,000	473	4,308	1,875
	Tangalle	64	44	108	37	228	80
UVA Province	Badulla	1,099	843	1,942	1,126	2,659	250
	Mahiyanganaya	163	164	327	55	575	70
	Monaragala	182	219	401	184	1,014	2,489
Western Province	Avissawella	196	173	369	238	2,424	680
	Colombo	4,290	2,577	6,867	2,502	18,175	2,424
	Gampaha	473	371	844	617	3,614	1,103
	Homagama	186	200	386	147	749	237
	Kalubowila	718	518	1,236	734	5,903	3,061
	Kalutara	429	516	945	269	693	11,142
	Negombo	369	390	759	558	2,599	2,969
	Panadura	334	272	606	183	2,010	202
	Ragama	844	567	1,411	666	4,845	1,188
	Wathupitiwala	254	267	521	210	551	884
Total		**18,617**	**16,112**	**34,729**	**14,547**	**88,013**	**83,632**

Reason for attendance among New STD clinic attendees in 2025					
Province	Clinic	Contact of patients	Voluntarily	Referral from magistrate/court	Others
Central Province	Dambulla	8	214	88	97
	Kandy	52	322	93	635
	Matale	38	238	30	309
	Nuwara Eliya	30	70	99	317
Eastern Province	Ampara	35	125	61	207
	Batticaloa	12	13	91	209
	Kalmunai	2	24	32	23
	Trincomalee	3	54	44	22
North Central province	Anuradhapura	50	549	177	349
	Polonnaruwa	42	163	111	354
North Western Province	Chilaw	34	242	71	199
	Kuliyapitiya	23	171	67	232
	Kurunegala	61	341	171	154
	Puttalam	22	183	77	131
Northern Province	Jaffna	22	84	33	183
	Kilinochchi	14	0	5	222
	Mannar	5	0	14	31
	Mullaitivu	1	13	0	81
	Vavuniya	17	55	57	142
Sabaragamuwa Province	Embilipitiya	9	145	94	35
	Kegalle	12	190	35	273
	Ratnapura	17	152	51	99
Southern Province	Balapitiya	16	245	88	104
	Hambanthota	28	189	200	357
	Mahamodara	85	252	153	332
	Matara	26	437	108	417
	Tangalle	7	28	24	47
UVA Province	Badulla	17	151	95	1543
	Mahiyanganaya	13	138	47	76
	Monaragala	22	113	115	151
Western Province	Avissawella	13	96	22	238
	Colombo	213	2532	88	2011
	Gampaha	78	360	35	371
	Homagama	11	170	9	196
	Kalubowila	96	593	60	487
	Kalutara	19	149	117	662
	Negombo	32	246	128	352
	Panadura	22	130	49	405
	Ragama	67	500	158	688
	Wathupitiwala	2	84	38	204
Total		**1276**	**9761**	**3035**	**12945**

Number of patients with confirmed syphilis diagnoses completing treatment during 2025					
Province	STD clinic	Number of diagnosed with syphilis	Number completed treatment	No. of pregnant women diagnosed with syphilis	No. of pregnant women completed treatment
Central Province	Dambulla	10	3	0	0
	Kandy	44	44	4	4
	Matale	17	17	1	1
	Nuwara Eliya	9	9	4	4
Eastern Province	Ampara	17	13	0	0
	Batticaloa	25	24	7	7
	Kalmunai	3	3	0	0
	Trincomalee	20	20	3	3
North Central province	Anuradhapura	20	20	2	2
	Polonnaruwa	66	65	4	4
North Western Province	Chilaw	26	26	4	4
	Kuliyapitiya	5	4	0	0
	Kurunegala	90	54	6	6
	Puttalam	9	9	2	2
Northern Province	Jaffna	53	33	7	7
	Kilinochchi	13	8	1	1
	Mannar	7	7	0	0
	Mullaitivu	0	0	0	0
	Vavuniya	25	25	1	1
Sabaragamuwa Province	Embilipitiya	3	3	1	1
	Kegalle	21	21	0	0
	Ratnapura	77	67	8	7
Southern Province	Balapitiya	16	16	2	2
	Hambanthota	33	33	0	0
	Mahamodara	57	47	3	1
	Matara	39	38	3	3
	Tangalle	2	2	0	0
UVA Province	Badulla	22	8	0	0
	Mahiyanganaya	3	3	0	0
	Monaragala	11	11	4	4
Western Province	Avissawella	13	13	0	0
	Colombo	188	188	11	11
	Gampaha	52	52	2	2
	Homagama	3	2	0	0
	Kalubowila	90	90	1	1
	Kalutara	57	43	7	7
	Negombo	53	47	6	6
	Panadura	16	16	0	0
	Ragama	77	68	8	6
	Wathupitiwala	13	6	0	0
Total		**1305**	**1158**	**102**	**97**

Samples screened for HIV infection during 2025										
Province	Clinic	No. screened for HIV (ELISA,PA,RAPID)				No. confirmed HIV positive				
		STD pt. samples	Antenatal samples	Pre emp. samples	Other samples	STD pt. samples	Antenatal samples	Pre emp. samples	Other samples	Total
Central Province	Dambulla	257	5	38	-	1	-	-	-	1
	Kandy	1,834	13,896	860	11,182	20	-	-	26	46
	Matale	1,000	5,586	544	2,421	12	-	-	-	12
	Nuwara Eliya	217	2,036	90	644	-	-	-	-	-
Eastern Province	Ampara	216	950	57	904	3	-	-	-	3
	Batticaloa	324	9,403	-	2,108	5	-	-	-	5
	Kalmunai	110	6,960	15	927	-	-	-	-	-
	Trincomalee	331	7,258	487	605	3	-	1	6	10
North Central province	Anuradhapura	2,870	8,028	1,423	5,608	4	-	-	-	4
	Polonnaruwa	1,149	4,645	556	11,528	1	-	1	3	5
North Western Province	Chilaw	1,586	10,092	544	768	2	-	-	7	9
	Kuliyapitiya	702	-	3	242	1	-	-	-	1
	Kurunegala	4,525	14,361	1,012	1,727	40	1	-	-	41
	Puttalam	761	33	-	476	2	-	-	1	3
Northern Province	Jaffna	332	7,061	778	4,433	2	-	-	-	2
	Kilinochchi	242	2,699	260	776	-	-	-	1	1
	Mannar	49	2,033	33	491	-	-	-	-	-
	Mullaitivu	95	720	140	82	-	-	-	-	-
	Vavuniya	656	2,000	433	972	4	1	-	-	5
Sabaragamuwa Province	Embilipitiya	659	65	269	596	-	-	-	-	-
	Kegalle	2,208	7,663	23	3,414	16	-	7	2	25
	Ratnapura	3,423	10,863	1,224	7,098	-	-	-	-	-
Southern Province	Balapitiya	723	2,472	197	1,261	-	-	-	-	-
	Hambanthota	1,031	6,823	962	3,631	10	1	-	2	13
	Mahamodara	2,983	4,685	544	2,614	30	-	-	-	30
	Matara	1,549	6,874	886	1,600	22	-	-	1	23
	Tangalle	154	12	24	67	1	-	-	-	1
UVA Province	Badulla	2,814	6,327	367	1,275	9	-	-	-	9
	Mahiyanganay	210	1,551	63	61	-	-	-	-	-
	Monaragala	627	6,380	461	5,761	1	-	-	5	6
Western Province	Avissawella	502	14	137	277	4	-	-	-	4
	Colombo	19,941	25,774	12	49,955	228	3	-	667	898
	Gampaha	1,673	7,187	747	787	24	2	-	2	28
	Homagama	432	23	9	108	2	-	-	1	3
	Kalubowila	1,918	90	1,262	1,958	23	-	-	9	32
	Kalutara	2,557	12,753	-	1,585	37	-	-	-	37
	Negombo	1,118	4,814	187	2,035	15	-	-	2	17
	Panadura	807	3	3	189	3	-	-	-	3
	Ragama	2,534	5,786	315	1,280	80	-	-	9	89
	Wathupitiwala	324	173	377	273	2	-	-	-	2
Total		**65,443**	**208,098**	**15,342**	**131,719**	**607**	**8**	**9**	**744**	**1,368**

Samples screened for syphilis - 2025									
Province	Clinic	Number screened for syphilis				Number TPPA/TPHA tested			
		STD	ANC	Pre-Emp.	Other	STD	ANC	Pre-emp.	Other
Central Province	Dambulla	259	5	38	0	233	0	1	0
	Kandy	1905	13871	1226	4843	445	19	0	59
	Matale	1001	5546	533	1920	348	25	10	496
	Nuwara Eliya	190	2028	90	644	30	6	0	6
Eastern Province	Ampara	218	2	57	291	157	952	0	8
	Batticaloa	324	9403	728	0	91	3	0	0
	Kalmunai	105	7639	112	599	71	120	0	52
	Trincomalee	347	7309	445	328	88	636	43	78
North Central province	Anuradhapura	2862	8028	1423	4410	852	14	0	34
	Polonnaruwa	1092	4645	556	8796	640	12	0	2858
North Western Province	Chilaw	2031	9727	348	299	548	33	2	23
	Kuliyapitiya	639	0	281	55	521	0	8	13
	Kurunegala	3312	14361	1485	433	1515	1	0	1
	Puttalam	111	7	0	24	0	0	0	0
Northern Province	Jaffna	332	7061	778	4433	332	36	2	121
	Kilinochchi	242	2699	260	776	177	0	1	0
	Mannar	49	2033	235	325	8	0	0	0
	Mullaitivu	0	0	0	0	23	720	0	0
	Vavuniya	656	738	0	0	347	1	0	0
Sabaragamuwa Province	Embilipitiya	405	52	269	352	203	0	0	157
	Kegalle	2128	7663	45	462	550	10	0	2
	Ratnapura	4301	10853	1204	5628	1339	28	3	929
Southern Province	Balapitiya	723	2472	197	607	723	1	0	4
	Hambanthota	1126	6823	962	3884	1099	24	25	3272
	Mahamodara	1862	2767	845	414	927	2614	8	25
	Matara	1524	6874	882	271	804	5	10	121
	Tangalle	159	12	24	54	161	12	24	41
UVA Province	Badulla	2194	4229	138	752	282	2	0	12
	Mahiyanganaya	0	0	0	0	0	511	0	0
	Monaragala	619	6380	514	5558	384	9	1	26
Western Province	Avissawella	567	9	171	84	388	1	3	28
	Colombo	13690	25774	1048	14320	5947	51	385	3361
	Gampaha	1858	7637	747	554	789	6	0	12
	Homagama	426	22	80	72	117	5	2	24
	Kalubowila	2249	90	1262	553	1033	18	8	226
	Kalutara	1463	12753	1633	0	793	4	0	0
	Negombo	1506	4814	295	435	576	21	0	167
	Panadura	771	3	63	73	677	2	57	66
	Ragama	2414	5786	461	645	2005	21	4	632
	Wathupitiwala	326	173	377	186	299	5	5	69
Total		**55986**	**200288**	**19812**	**63080**	**25522**	**5928**	**602**	**12923**

Samples tested for cervical cytology (PAP smears) during 2025					
Province	**Clinic**	**Number screened for cervical cytology**	**Total number of reports received**	**Number satisfactory for reporting**	**Number reported as CIN-1 or above**
Central Province	Dambulla	0	0	0	0
	Kandy	0	0	0	0
	Matale	88	100	99	0
	Nuwara Eliya	0	0	0	0
Eastern Province	Ampara	5	1	1	0
	Batticaloa	2	2	0	0
	Kalmunai	0	0	0	0
	Trincomalee	0	0	0	0
North Central province	Anuradhapura	2	1	0	0
	Polonnaruwa	99	144	126	18
North Western Province	Chilaw	12	7	0	0
	Kuliyapitiya	2	2	1	0
	Kurunegala	35	31	29	0
	Puttalam	0	0	0	0
Northern Province	Jaffna	0	0	0	0
	Kilinochchi	0	0	0	0
	Mannar	0	0	0	0
	Mullaitivu	0	0	0	0
	Vavuniya	0	0	0	0
Sabaragamuwa Province	Embilipitiya	13	0	0	0
	Kegalle	16	11	11	0
	Ratnapura	38	23	23	0
Southern Province	Balapitiya	0	0	0	0
	Hambanthota	2	2	2	0
	Mahamodara	99	114	105	0
	Matara	13	12	12	0
	Tangalle	0	0	0	0
UVA Province	Badulla	0	0	0	0
	Mahiyanganaya	0	0	0	0
	Monaragala	7	3	2	0
Western Province	Avissawella	41	41	41	0
	Colombo	92	47	47	6
	Gampaha	90	58	43	0
	Homagama	0	0	0	0
	Kalubowila	253	254	253	20
	Kalutara	19	19	13	0
	Negombo	34	32	18	0
	Panadura	8	8	4	1
	Ragama	45	20	16	1
	Wathupitiwala	15	13	13	0
Total		**1030**	**945**	**859**	**46**

Condom and lubricants distribution 2023-2025							
Province	Clinic	2023		2024		2025	
		Number of condoms	Number of lubricants	Number of condoms	Number of lubricants	Number of condoms	Number of lubricants
Central Province	Dambulla	2,604	70	7,772	960	18,016	5,050
	Kandy	62,342	10,200	85,472	14,600	67,856	13,200
	Matale	37,365	1,269	64,467	1,091	75,907	2,810
	Nawalapitiya	-	-	-	-	-	-
	Nuwara Eliya	19,784	1,000	16,856	100	7,200	-
Eastern Province	Ampara	12,558	-	21,921	4,650	44,433	14,950
	Batticaloa	4,823	800	3,735	2,480	4,608	2,635
	Kalmunai	6,624	-	7,768	2,200	26,640	5,300
	Trincomalee	1,546	376	3,004	1,784	720	-
North Central province	Anuradhapura	111,166	19,100	6,928	2,600	206,432	12,500
	Polonnaruwa	73,521	800	110,841	4,181	120,683	2,460
North Western Province	Chilaw	23,832	7,900	26,880	13,400	30,124	9,500
	Kuliyapitiya	1,804	150	4,468	980	7,350	1,570
	Kurunegala	57,381	11,600	118,765	21,700	105,887	25,470
	Puttalam	3,152	1,940	13,414	360	8,848	1,584
Northern Province	Jaffna	44,053	18,486	29,718	12,845	29,807	10,407
	Kilinochchi	6,100	100	3,680	400	11,748	3,500
	Mannar	3,744	244	288	288	1,152	788
	Mullaitivu	1,600	100	1,100	-	100	50
	Vavuniya	3,206	100	4,350	2,000	3,130	440
Sabaragamuwa Province	Embilipitiya	2,282	660	3,966	665	3,258	785
	Kegalle	28,235	10,070	21,848	8,650	36,702	20,575
	Ratnapura	14,056	3,000	29,297	16,500	38,229	21,900
Southern Province	Balapitiya	4,588	-	10,980	1,900	19,960	4,000
	Hambanthota	37,666	12,075	34,715	17,533	61,273	10,817
	Mahamodara	121,995	11,712	89,174	17,011	52,536	10,816
	Matara	25,851	5,805	37,756	11,497	27,083	5,874
	Tangalle	271	72	380	110	160	-
UVA Province	Badulla	36,438	1,719	40,076	1,174	45,047	4,445
	Mahiyanganaya	5,556	300	2,460	160	2,016	-
	Monaragala	8,683	190	7,853	1,990	5,972	1,671
Western Province	Avissawella	2,041	185	5,760	20	7,032	80
	Colombo	18,484	21,300	95,446	36,619	71,827	54,598
	Gampaha	5,254	645	11,790	1,670	11,010	3,410
	Homagama	560	-	525	-	688	-
	Kalubowila	35,428	4,282	49,482	6,016	37,288	4,522
	Kalutara	15,690	6,600	48,218	13,850	24,041	5,590
	Negombo	8,918	3,338	13,000	2,450	5,966	840
	Panadura	555	620	622	395	419	295
	Ragama	8,169	2,365	6,727	2,500	8,428	5,215
	Wathupitiwala	8,074	449	2,416	1,472	1,627	949
Total		**976,486**	**158,346**	1,043,918	228,801	1,231,203	268,596

HIV Testing and Counselling for Key populations-2025 -1							
Province	Clinics	Sex Workers		MSM		Transgender	
		Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y	Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y	Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y
Central	Dambulla	13	85	4	4	0	0
	Kandy	57	184	61	125	0	0
	Matale	12	301	27	29	0	0
	Nuwara Eliya	0	0	0	0	0	0
Eastern	Ampara	5	6	5	4	0	0
	Batticaloa	0	38	0	15	0	0
	Kalmunai	0	1	0	0	0	0
	Trincomalee	0	16	0	0	0	0
North Central	Anuradhapura	18	86	2	9	0	0
	Polonnaruwa	14	86	15	41	0	0
North Western	Chilaw	13	63	1	2	0	0
	Kuliyapitiya	5	18	1	6	0	1
	Kurunegala	6	22	8	37	0	0
	Puttalam	0	0	0	0	0	0
Northern	Jaffna	1	6	15	150	0	18
	Kilinochchi	0	0	0	0	0	0
	Mannar	2	0	0	0	0	0
	Mullaitivu	0	0	0	0	0	0
	Vavuniya	0	0	0	7	0	0
Sabaragamuwa	Embilipitiya	2	25	1	3	0	0
	Kegalle	49	53	61	147	4	10
	Ratnapura	0	0	0	0	0	0
Southern	Balapitiya	5	80	0	40	0	0
	Hambanthota	8	93	28	52	0	0
	Mahamodara	15	15	154	385	0	0
	Matara	7	32	9	20	0	0
	Tangalle	0	0	0	0	0	0
UVA	Badulla	0	8	0	4	0	0
	Mahiyanganaya	0	0	0	0	0	0
	Monaragala	0	10	3	6	0	0
Western	Avissawella	15	44	38	61	0	0
	Colombo	195	1192	559	1448	1	8
	Gampaha	4	17	10	21	0	0
	Homagama	0	0	0	0	0	0
	Kalubowila	33	234	110	300	1	7
	Kalutara	1	3	1	3	0	0
	Negombo	5	14	5	35	1	1
	Panadura	3	17	5	3	2	1
	Ragama	33	92	88	154	2	2
	Wathupitiwala	2	18	15	43	0	0
Total		**523**	**2,859**	**1,226**	**3,154**	**11**	**48**

Cont., HIV Testing and Counselling for Key populations-2025-2									
Province	Clinics	Beach boys		PWID or Drug users		Prisoners		Others	
		Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y	Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y	Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y	Total tested for HIV by STD_outreach <25 y	Total tested for HIV by STD_outreach >=25 y
Central	Dambulla	-	-	-	1	-	-	-	-
	Kandy	-	-	-	4	318	1,040	-	-
	Matale	-	-	-	-	-	-	4	66
	Nuwara Eliya	-	-	-	-	-	-	149	701
Eastern	Ampara	-	-	-	-	-	-	1	3
	Batticaloa	-	-	-	-	153	282	3	205
	Kalmunai	-	-	-	-	-	-	-	-
	Trincomalee	-	-	-	-	-	32	-	-
North Central	Anuradhapura	-	-	-	-	495	514	-	-
	Polonnaruwa	-	-	18	117	230	1,263	-	-
North Western	Chilaw	4	6	-	-	-	-	-	-
	Kuliyapitiya	-	-	-	-	-	-	9	78
	Kurunegala	-	-	-	-	85	312	-	-
	Puttalam	28	34	-	-	-	-	65	90
Northern	Jaffna	-	-	7	6	179	282	-	-
	Kilinochchi	-	-	1	4	-	-	-	-
	Mannar	-	-	-	-	-	-	-	-
	Mullaitivu	-	-	-	-	-	-	-	-
	Vavuniya	-	-	226	12	35	260	-	-
Sabaragamuwa	Embilipitiya	-	-	-	-	1	138	-	-
	Kegalle	-	-	-	-	555	504	1,623	154
	Ratnapura	-	-	-	-	80	1,027	-	-
Southern	Balapitiya	-	15	-	-	-	-	27	570
	Hambanthota	1	-	1	-	89	754	151	617
	Mahamodara	15	37	1	8	137	766	29	73
	Matara	-	-	-	-	48	354	4	239
	Tangalle	-	-	-	-	-	-	-	-
UVA	Badulla	-	-	-	-	407	1,467	-	-
	Mahiyanganaya	-	-	-	-	-	-	-	-
	Monaragala	-	-	-	-	233	1,144	296	1,424
Western	Avissawella	-	-	2	1	-	-	-	1
	Colombo	-	-	18	119	646	4,036	919	3,625
	Gampaha	-	-	15	36	-	-	-	-
	Homagama	-	-	-	-	-	-	-	-
	Kalubowila	-	-	-	3	51	159	429	1,713
	Kalutara	6	13	-	-	85	530	-	2
	Negombo	-	-	-	-	253	2,085	35	43
	Panadura	-	-	5	39	-	-	-	-
	Ragama	-	-	-	5	238	1,710	-	-
	Wathupitiwala	-	-	17	42	-	29	15	43
Total		**54**	**105**	**311**	**397**	**4,318**	**18,688**	**3,759**	**9,647**

Details of the awareness programmes conducted by STD clinics in 2025							
Province	Clinic	Lectures		Exhibitions		Workshops	
		Number of Programmes	Number of participants	Number of Programmes	Number of participants	Number of Programmes	Number of participants
Central Province	Dambulla	127	5,310	-	-	-	-
	Kandy	17	1,931	1	3,000	-	-
	Matale	85	4,859	-	-	11	682
	Nuwara Eliya	39	2,227	2	5,520	1	45
Eastern Province	Ampara	32	3,644	1	150	2	175
	Batticaloa	212	6,617	-	-	-	-
	Kalmunai	37	1,660	-	-	-	-
	Trincomalee	36	1,236	-	-	-	-
North Central province	Anuradhapura	23	3,191	1	-	5	301
	Polonnaruwa	127	6,552	-	-	-	-
North Western Province	Chilaw	75	2,566	-	-	9	673
	Kuliyapitiya	9	1,150	-	-	2	125
	Kurunegala	40	6,026	3	1,080	-	-
	Puttalam	38	2,130	-	-	1	63
Northern Province	Jaffna	37	1,725	-	-	2	100
	Kilinochchi	12	795	-	-	-	-
	Mannar	28	845	-	-	1	45
	Mullaitivu	25	887	-	-	1	124
	Vavuniya	22	1,454	-	-	-	-
Sabaragamuwa Province	Embilipitiya	10	1,050	-	-	-	-
	Kegalle	26	2,105	1	175	19	891
	Ratnapura	55	5,736	-	-	-	-
Southern Province	Balapitiya	19	1,330	1	100	1	100
	Hambanthota	72	11,094	-	-	1	50
	Mahamodara	11	955	-	-	-	-
	Matara	34	4,831	-	-	-	-
	Tangalle	2	80	-	-	-	-
UVA Province	Badulla	100	8,230	-	-	3	52
	Mahiyanganaya	15	1,726	-	-	2	80
	Monaragala	49	3,961	2	220	2	95
Western Province	Avissawella	4	100	-	-	2	60
	Colombo	38	993	8	5,100	17	1,385
	Gampaha	18	7,946	1	5,000	1	40
	Homagama	-	-	-	-	-	-
	Kalubowila	21	1,253	-	-	1	30
	Kalutara	99	5,605	-	-	1	39
	Negombo	1	40	-	-	-	-
	Panadura	5	311	1	100	-	-
	Ragama	13	1,230	-	-	-	-
	Wathupitiwala	18	2,584	-	-	3	144
Total		**1,631**	**115,965**	**22**	**20,445**	**88**	**5,299**

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Sri Lanka

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