DEMOCRATIC SOCIALIST REPUBLIC OF

SRI LANKA

NATIONAL AIDS PREVENTION AND CONTROL PROGRAMME

REPORT OF THE EXTERNAL

PROGRAMME REVIEW

MINISTRY OF HEALTH AND WOMENS' AFFAIRS IN

COLLABORATION WITH WHO AND OTHER MINISTRIES

29TH NOVEMBER - 17TH DECEMBER 1993

TABLE OF CONTENTS

ANNEXURES

EXECUTIVE SUMMARY

Since the establishment of the National AIDS Task Force in 1986 much progress has been made in STD/AIDS prevention in Sri Lanka. During the final year of the current Medium Term Plan an external review of the National AIDS Control Programme was conducted by a 7 member team. The team noted that there is enhanced political commitment to the Programme, AIDS Committees are established at national, provincial and divisional levels, and to some extent there has been integration of STD and AIDS control activities.

Various sectors other than health are beginning to be involved in AIDS prevention and the involvement of NGOs in AIDS prevention is on the increase, particularly at the provincial level.

There is a significant improvement in AIDS awareness in the general population as a result of the programme's efforts. Condoms have been provided to patients attending STD clinics and to sex workers and the number of outlets where condoms are available to the general public has been increased. Great progress has been made in ensuring blood safety, as 99.9% of blood is being screened for HIV prior to transfusion. Cost saving strategies such as testing of pooled sera have been implemented. HIV sentinel surveillance has been started with testing of population groups at four sites in the country, namely, Colombo, Galle, Ratnapura and Kandy. Two rounds of surveys have so far been completed.

In spite of these achievements, numerous constraints remain to be overcome if Sri Lanka is to remain a low prevalence country.

These include :

- continuing complacency among the general population and policy makers regarding the potential threat posed by AIDS;
- an inadequate response from various Government Ministries;
- insufficient financial and manpower support from the Government with current over dependence of the Programme on external support;
- the unwieldy structure of the National AIDS Committee and its inability to meet regularly to provide adequate monitoring and advisory support to the Programme; and
- religious and cultural barriers related to sexual matters hampering the Programme's ability to convey clear and unambiguous messages regarding AIDS prevention and, in particular, to promote condom use for HIV prevention.

The Programme has not yet planned and implemented intervention programmes among high risk behaviour groups, particularly commercial sex workers, in an organized and systematic manner. Unfortunately, in some areas, there are examples of ill-conceived programmes of arresting and charging commercial sex workers and testing them for HIV which have forced them underground, so undermining what preventive and educational work that is in progress.

In addition to focusing on high risk behaviours the Programme should be making every effort to ensure that information and education reaches all young people, both in and out of school. So far sexual health education, including STD/AIDS prevention, has not been included in the school curriculum. Focussing on high risk behaviour and on informing and educating the young are two activities of crucial importance for Sri Lanka where the epidemic is still at an early stage and the prevalence of HIV infection is still low in the general population.

Furthermore, in spite of the high incidence of STDs in certain populations and the continuing deficiencies in the present STD services provided by categorical clinics (first established in 1951), the Programme is yet to embark on implementation of the new syndromic approach to STD control at the primary health care level advocated by WHO.

There is inadequate staff to carry out programme activities. However, there is scope for improving management of existing staff by delegating specific responsibilities to them.

On the question of NGO involvement in AIDS prevention, there is room for improvement in the relationship between them and the Programme. In the past this has, at times, bordered on "mutual distrust", hampering effective NGO involvement in AIDS prevention efforts.

The constraints and weaknesses outlined above should not overshadow the very real achievements in AIDS prevention that have already occurred in Sri Lanka. Neither should they detract from the great potential there is for a highly effective STD and AIDS prevention and control programme in a non-stigmatising and non- discriminatory atmosphere which could serve as a model for the Region. The willingness of all sectors to work together and their commitment to the Programme was well illustrated by the successful two day Consensus Workshop that took place during the course of this Review. (See Annex IX).

The Review Team believes that by implementing the recommendations in this report and by building on the work that has already taken place and on Sri Lanka's excellent health and education infra-structures, the country can avoid the devastating effects of the epidemic being witnessed in other countries in South East Asia.

The Team's major recommendations are listed below. These, and others of a more technical nature, are incorporated in the body of the Report.

RECOMMENDATIONS

1) The National AIDS Committee (NAC) should be made more effective/operative by reducing the size from 37 at present to 18-20 and should include private sector representation as well. The Committee should be upgraded and be chaired by the Secretary, Health & Womens' Affairs, with DGs of various Ministries included as members. Important issues should be put before the National Health Council to mobilize multisectoral support. The role of the Steering Committee is ambiguous and should be abolished.

2) The Government should adopt coordinated multisectoral response to STD and AIDS prevention as a national policy and the Programme should actively promote and involve other sectors in AIDS prevention efforts including all Government Ministries, NGOs particularly community based groups and the private sector. Each sector namely all Ministries, NGOs and the private sector must identify the individual to function as focal point to plan and coordinate prevention activities. Furthermore, the programme must develop a mechanism leading to a more healthy and constructive collaboration with NGOs.

3) The Programme should develop, in consultation with all concerned sectors, a need-based comprehensive annual plan of action, and develop a mechanism for monitoring, supervision and evaluation of programme activities.

4) In order to ensure sustainability of the programme and also to demonstrate national commitment, all Government and local Ministries should budget for AIDS prevention activities to be carried out by each Ministry.

5) At central and peripheral level there should be formal integration of the National STD Control Programme and the National AIDS Control Programme, both administratively and operationally. The integrated Programme should be known as the National STD/AIDS Control Programme (NSACP), any reference to the "Anti-VD Campaign" being abandoned.

6) An organizational structure with clear definition of responsibility of Programme team members must be established as soon as possible. The Programme Manager should delegate responsibility and authority to each team member to maximise their effectiveness.

7) The Programme should be delegated the responsibility of budget approval and disbursement of funds.

8) Priority areas in STD/AIDS Prevention in Sri Lanka should be:

- Developing and implementing targetted interventions

among individuals engaging in high risk behaviours;

- The provision of STD/AIDS education to children and young people (both in and out of school);

- Ensuring the widespread availability of good quality, affordable condoms and the promotion of their use;

- Improvement of services for the treatment of STDs at the primary health care level.

9) The patient with HIV infection should be treated as a part of the general health services in the same way as other patients and not in "Special" hospitals or wards.

1. BACKGROUND

The Government of Sri Lanka established the National AIDS Task Force in May 1986. This was chaired by the Director General of Health Services and was made up of members from the Ministry of Health with representation from the Ceylon Tourist Board and the Police. Important landmarks in the AIDS Control Programme are:

May	1986 -	Establishment of National Task Force for Prevention and Control of AIDS
September	1986 -	Detection of first case of AIDS in Sri Lanka
July	1987 -	Formulation of short term plan of action
February	1988 -	Expansion of the National Task Force to form the multisectoral National AIDS Committee
September	1988 -	Formulation of Medium Term Plan for upgrading of STD services
October	1988 -	Formulation of Medium Term Plan for Prevention and Control of AIDS
October	1989 -	Approval of Medium Term Plan for Prevention and Control of STD/AIDS by the Committee of Secretaries
March	1990 -	Approval of the Medium Term Plan by the Cabinet of Ministers with the proviso that it should be cleared by Ministry of Finance
July	1990 -	First round of Sentinel Surveillance
November	1990 -	Medium Term Plan approved for funding by Ministry of Finance
August	1991 -	Signing of tripartite agreement by UNDP, WHO and Government of Sri Lanka for funding of Medium Term Plan
September	1992 -	Tripartite review
December	1993 -	External Review & Consensus Workshop in preparation for the second Medium Term Plan to be formulated and implemented early in 1994.

SITUATION ANALYSIS

As of 1 December 1993, a total of 119 persons have tested positive for Human Immunodeficiency Virus (HIV). Of these 33 have developed AIDS and 26 have already died. It is now evident that heterosexual contact is the predominant mode of transmission in the country. Transmission through drug users sharing injecting equipment is not a problem at present. However, there are an estimated 30,000 drug users in the country and, although only a small proportion of these inject, the experience of other countries in the WHO South East Asia Region has shown drug using habits can change quickly.

The above reported numbers, however, consist only of those who were detected as HIV positive and represent considerable underestimation of the actual situation. The NACP estimates that there are already more than 3500 persons in Sri Lanka who are infected with HIV.

Although surveillance data show that Sri Lanka is presently a low prevalence country, the risk factors exist which are likely to facilitate rapid spread of HIV in the country. For example, it is estimated that there are around 200,000 persons infected with sexually transmitted diseases each year, of which only a small proportion seek treatment in the Government sector. Behavioural studies confirm that risk behaviours for HIV are prevalent as exemplified by widespread female prostitution in many areas of the country. Furthermore, STD clinic data show an increase in the proportion of genital ulcer disease among patients attending these clinics. Given this background of prevalent high risk behaviour and high incidence of STDs, it is clear that the problem requires urgent and serious attention.

PROGRAMME REVIEW

Under the Medium-Term Plan, an external review had been planned to take place during the 3rd year of the programme. This review was carried out by a 7 member team represented by the Ministries of Education, Higher Education and Cultural Affairs; Policy Planning; Health and Women's Affairs; and by WHO with Dr. R. C. Rajapakse as the Chairman. Terms of reference of the review and members of the team are at Annex I and II.

The review team examined relevant documents and reports which were made available, held interviews with concerned individuals/officials within the Government sector both in health and non-health and with NGOs and UN and other donor agencies. To assess the programme activities at the provincial and divisional levels, field visits were made to Ratnapura, Galle, Negombo and Kandy.

A consensus workshop was held on 9 and 10 December 1993 to review existing policies and interventions related to HIV/AIDS and strategies needed for the next 3-5 years. The workshop was attended by representatives from various Ministries, NGOs, private sector and UN and bilateral agencies, and statements of commitment were made by the representatives for activities to be carried out by their respective organizations. (Consensus report in Annex IX).

2. REVIEW FINDINGS

2.1 PROGRAMME MANAGEMENT

The Government response to the challenge of AIDS, began with the establishment of a national Task Force for prevention and control of AIDS in 1986. This was later expanded into a national AIDS Committee with multidisciplinary and multisectoral representation. In January 1988, AIDS prevention activities were initiated under a short-term plan funded by WHO. A Medium-Term Plan (MTP) was developed in September 1988. This was approved by the Cabinet of Ministers in 1990 and implementation of programme activities began the same year. An AIDS Project Office was established during the MTP resulting in an improvement in the performance of AIDS control programme and in a higher rate of programme implementation. The present Director, STD/AIDS Control Programme has been designated the AIDS Programme Manager, but the STD programme and the AIDS Programme are not formally integrated.

ACHIEVEMENTS

The teams noted that much progress has been made by the programme in enhancing political commitment to HIV/AIDS prevention, in establishing AIDS Committees at the national, provincial and divisional levels, and to some extent in integrating STD and AIDS control activities. STD/AIDS focal points have been identified in some provinces. However, the present mechanism for ensuring coordination, support and supervision from the central level needs to be further strengthened.

Various sectors other than health-sector are beginning to be involved. For example, Ministry of Education is contemplating inclusion of STD/AIDS education as a part of the School Curriculum. The Ministry of Information has agreed to allocate free time for AIDS edutation messages on television and radio. The Tourist Board conducts seminars to educate those involved in the tourist industry as well as sections of the general population. The involvement of NGOs in AIDS prevention is also on the increase, particularly at the provincial level. This indeed offers great potential for further NGO involvement in many critical areas of the programme. Examples of such areas are education and other interventions targeted towards individuals with high risk behaviour and care of persons with HIV/AIDS and

their families.

There is also a general overall improvement in the level of awareness in the general population about AIDS as a result of the Programme's efforts. Condoms have been provided to patients attending STD clinics and to sex workers. Great progress has been made in ensuring blood safety as 99.9% of blood is screened for HIV prior to transfusion. Cost saving strategies such as testing of pooled sera have been implemented. HIV sentinel surveillance has been started with testing of population groups at four sites in the country namely Colombo, Galle, Ratnapura and Kandy. Two rounds of surveys have so far been completed.

CONSTRAINTS

In spite of these achievements, much more needs to be done in adequately responding to this emergency and the constraints listed below have to be overcome as soon as possible.

Among major constraints that the Programme is confronted with include :

* Complacency prevalent both among the general population and policy makers regarding the potential threat posed by AIDS;

* Inadequate response from various Government Ministries;

* Ministry of Health not having fulfilled its obligations as stated in the Medium Term Plan to provide financial support for building and staff to work in the AIDS Control Programme. Hence, insufficient financial and manpower support from the Government has led to current over dependence of the Programme on external support;

* Unwieldy structure of the National AIDS Committee and its inability to meet regularly to provide adequate monitoring and advisory support to the Programme; and

* Religious and cultural barriers related to sexual matters hampering the Programme's ability to convey clear and unambiguous messages regarding AIDS prevention and, in particular, to promote condom use for HIV prevention in risk situation.

* Given the stage of the epidemic and the data on HIV transmission, the first priority of the NACP should be to focus on prevention of sexual transmission. Although the risk behaviour mapping has been completed. The Programme has not yet planned and implemented intervention programmes among high risk behaviour groups particularly commercial sex workers in an organized and systematic manner, nor has sexual health education including STD/AIDS prevention been included in the school curriculum. These two activities are of crucial importance for a country like Sri Lanka

where the epidemic is still at an early stage and the prevalence of HIV infection is still low.

* The Programme is yet to embark on implementation of the new public health approach to STD control advocated by WHO which is based on providing STD services as a part of primary health care, using the syndromic approach to diagnosis and the provision of effective drugs to patients at the first contact with health services.

* From the Programme Management point of view, there is inadequate staff to carry out programme activities. The staff working in the STD Programme, continue to carry out clinical services as before and have not been assigned specific responsibilities on AIDS prevention and care.

* There is in general no delegation of responsibilities and surprisingly many STD staff do not know of their exact roles as their job descriptions related to the AIDS control activities have yet to be prepared. The review team was however informed that a proposal for establishing a management structure within the Programme has been submitted to the Secretary, Health & Women's Affairs for approval.

* Clear policy guidelines on AIDS prevention have not been conveyed to provincial health authorities and workplans for activities to be carried out in 1994 at provincial and divisional level are yet to be developed.

* The unsatisfactory relationship between NGOs and the Programme often bordering on "mutual distrust" has hampered effective NGO involvement in AIDS prevention efforts.

* There are examples also of ill-conceived activities undertaken by police which has led to pushing sex workers underground by raiding and arresting them, using their possession of condoms as evidence against them. Experience worldwide shows that such measures are counterproductive and may only facilitate HIV transmission.

* Overall, there appears to be a generally unfavourable perception of the programme effectiveness both among NGOs and international donors.

RECOMMENDATIONS

1) The National AIDS Committee (NAC) should be made more effective/operative by reducing the size from 37 at present to 18-20 and should include private sector representation as well. The Committee should be upgraded and be chaired by the Secretary, Health & Womens' Affairs, with Heads of Departments of various Ministries included as members.

Important issues should be put before the National Health Council to mobilize multisectoral support. The role of the Steering Committee is ambiguous and should be abolished.

The present sub-committees should be restructured according to the various programme areas, namely programme management and coordination; education and interventions; clinical care; surveillance and laboratory; legal and ethical aspects.

2) The Government should adopt coordinated, multisectoral response to STD and AIDS prevention as a national policy and the Programme should actively promote and involve other sectors in AIDS prevention efforts including all Government Ministries, NGOs particularly community based groups and the private sector. A mechanism should be developed to co-ordinate and sustain this multisectoral response. Each sector must identify focal points to plan and coordinate prevention activities. The Programme should in particular provide technical, moral, material and financial, where appropriate, support to NGOs. Furthermore, the Programme must develop a mechanism leading to a more healthy and constructive collaboration with NGOs. Activities to be carried out by various sectors should be considered as complementary and not in competition with each other.

3) The Programme should develop, in consultation with all concerned sectors, a need-based comprehensive annual plan of action, including priority strategies, interventions and activities to be carried out by NGOs as well as by various Ministries at the Central, Provincial and Divisional levels. The plan should be endorsed by the National Health Council to ensure multisectoral commitment and be monitored by the NAC on a regular basis. These plans should be discussed with donors for resource mobilization. With expansion of programme activities at all levels, there is a need to develop a mechanism for monitoring, supervising and for evaluation of programme activities.

4) In order to ensure sustainability of the Programme and also to demonstrate national commitment, all Government and local Ministries should budget for AIDS prevention activities to be carried out by each Ministry. As a minimum sign of commitment, the Government must provide for a building to house the National AIDS Control Programme and recruit adequate staff to mount a more effective and sustainable response to the AIDS epidemic. Such a commitment is likely to attract more donor support.

5) At central and peripheral level there should be formal integration of the National STD Control Programme and the National AIDS Control Programme, both administratively and operationally. The integrated programme should be known as the National STD/AIDS Control Programme (NSACP), any reference to the "Anti-VD Campaign" being abandoned.

6) An organizational structure with clear definition of responsibility of programme team members must be established as soon as possible. The Programme Manager should delegate responsibility and authority to each team member to maximise their effectiveness. The staff presently working in the STD Control Programme must be given specific assignments related to the AIDS Control Programme (proposed organogram is annexed). The Programme should put more effort and time for planning of activities and to build up better rapport with concerned persons in the Government and Non-Governmental Organizations.

7) The Programme should be made more independent and be given more authority and responsibility to carry out AIDS control activities with the urgency that these deserve. The Ministry of Health should therefore delegate the responsibility of budget approval and disbursement of funds to the Programme. The Programme must assume a more pro-active advocacy role to mobilize adequate national response and the Ministry of Health should provide maximum support morally, financially and administratively in this effort.

8) Priority areas in STD/AIDS Prevention in Sri Lanka should be:

- Developing and implementing targeted interventions among individuals engaging in high risk behaviours including education, promoting use of condoms and ensuring treatment for other STDs.

- The provision of education on all aspects of sexual health to children and young people (both in and out of school), and so encouraging adoption of safer sexual practices early, before risk-taking patterns of behaviour have developed.

- Ensuring the widespread availability of good quality, condoms at an affordable cost and the promotion of their use to prevent sexually transmitted disease by adopting the World Health Organization's "social marketing" strategy including the use of all media.

- Improvement of services for the treatment of STDs by ensuring the provision of effective diagnosis and treatment of STDs at the primary health care level by training Physicians and Assistant Medical Officers in the syndromic approach advocated by the World Health Organization. The present STD clinics should be upgraded to function as referral centres.

9) The Programme must also ensure that stigmatisation of people with HIV infection, and discrimination against them, at all levels of society is eliminated. Health care workers in particular must recognise that people with HIV infection have the same rights to privacy, care and support as other patients and that discrimination and

stigmatisation in the health care setting only serves to drive the disease underground to the detriment of the public health. The patients with HIV infection should be treated as a part of general health services in the same way as other patients and not in "Special" hospitals or wards.

2.2 PREVENTION OF SEXUAL TRANSMISSION OF HIV

2.2.1 INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Given the main ways by which HIV spreads, IEC continues to offer the most effective means of responding to the problem. IEC activities to create awareness were commenced in the mid 80's and conducted more on an ad hoc basis rather than in a systematic manner until 1992, when, following the development of an operational plan by the Health Education Bureau, the activities were implemented and are continuing to be implemented according to the plan.

The primary responsibility for implementation of IEC activities lies with the Health Education Bureau of the Ministry of Health. The activities of the Ministry are complemented and supported by those of the NGOs and other government sectors.

ACHIEVEMENTS

1) Both the print and the electronic media have been utilized to create awareness among the public, by the government as well as the non-government sector.

   * Production and telecasting of 3 TV spots over a period of 3 months.

   * Production and telecasting of a teledrama titled "Induru Dora" in six episodes of 30 minutes each.

   * Production of a TV documentary titled "Sathutaka Nimawa" of 25 minutes duration.

   * Allocation of 30 seconds of free TV time, twice daily, three times a week.

   * Broadcasting of radio spots for a continuous period of three months, each spot being of 30 seconds duration.

   * Broadcasting of two radio dramas each comprising of 28 episodes. Each weekly episode was of 30 minutes duration.

   NGOs have also used the different formats of the print and electronic media to create awareness among the public.

2) Action has been initiated to develop modules on HIV/AIDS for students of years 6 - 12 in the school system, with the objective of including it in the curricula.

3) While existing NGOs have generally begun to get increasingly involved in IEC activities related to HIV/AIDS, a few NGOs have been formed for the specific and exclusive purpose of supporting IEC activities of the NACP.

4) Links have been established and activities initiated to reach out-of-school youth through collaboration with the National Youth Services Council.

CONSTRAINTS

* Poor co-ordination between the Government sector and the NGOs is further compounded by the lack of co-ordination among the NGOs themselves, resulting in overlap of activities, failure to reach important groups, and lack of uniformity of messages given.

* Religious and cultural barriers have been a serious constraint in the implementation of IEC activities in support of HIV/AIDS.

* Absence of monitoring and evaluation of IEC activities.

* Lack of sufficient funds.

RECOMMENDATIONS

1) The Government should recognize the role of NGOs in HIV/AIDS prevention and control activities by

   a) increasing the provision of technical support, expertise, financial, human and material resources to NGOs, and,

   b) by organizing workshops to share information and experiences in relation to work carried out by NGOs.

   c) By organizing training programmes.

2) Greater attention needs to be paid to targetted communication approaches (including peer education) and materials, particularly to those engaged in high risk behaviours.

3) Institutes of learning such as schools, colleges and universities should be utilized to impart information about HIV/AIDS through appropriate curricula, peer education and other planned activities.

4) Since youth are a category at great risk of getting HIV/AIDS, formal and informal organizations and peer groups

should provide a forum to communicate messages on HIV/AIDS.

5) The Programme should promote and support STD/AIDS education in the work place both in the public and private sector.

6) AIDS IEC activities carried out by the governmental as well as non-governmental sectors should have in-built monitoring and evaluation processes.

2.2.2 CONDOM PROCUREMENT AND DISTRIBUTION SYSTEM

At present imports into Sri Lanka for family planning purposes amount to about 8 million condoms i.e. Family Planning Association of Sri Lanka (6 million) and Family Health Bureau of the Ministry of Health and Womens' Affairs (2 million).

The Population Division of the Ministry of Health has determined that the 1991 annual requirement of 6.8 million condoms would increase to 8.5 million by the year 2000.

Government supplied condoms are available through institutions and public health staff and costs SRL 5 cts (US$ 0.001) to the user. UNFPA supplies condoms to the Government but from 1993, the supplies would be reduced by 17% annually, till eventually all needs are supplied by the Government. This inevitably would result in an upward revision of the price of a condom.

The FPASL has a well organized condom distribution/marketing programme through about 6000 retail outlets and about 800 pharmacies (excluding Northern and Eastern Provinces). Several varieties of condoms are marketed at prices ranging from Rs. 2/- to Rs. 8/33 (US$ 0.04 to US$ 0.17) per condom.

Since the end of 1992, the NACP has been distributing condoms through STD Clinics, Divisional Directors of Health, Armed Services, brothels and massage parlours in and around Colombo mainly for promotional purposes. Average monthly issues during the past year are approximately 20,500.

All condoms supplied by WHO/UNFPA are obtained from approved sources to guarantee quality. However, the sources from which other distributors obtain their supplies are not known.

ACHIEVEMENTS

1) There is an existing social marketing programme for condoms for family planning purposes.

2) The NACP has been successful in initiating a scheme for distribution of condoms free of charge through STD clinics and to the commercial sex industry though on a limited

scale. The Programme will expand its distribution gradually to areas outside Colombo to cover persons engaged in the sex industry and those who continue to engage in risk activities.

CONSTRAINTS

1) Presently the Health Ministry programme for promotion of condoms is only for family planning with the emphasis on distribution through Public Health Midwives.

2) Funds available for purchase of condoms for the programme are insufficient to meet the future needs.

3) No data is presently available on the priority prevention indicators, particularly regarding condom availability at central level, condom access at peripheral level and condom use in relationships of risk, to determine condom requirements and distribution systems.

4) There is a reluctance among individuals to purchase condoms from their local retail outlets such as pharmacies, shops etc.

RECOMMENDATIONS

1) The Health Ministry should not only promote condoms for family planning but also as an intervention for prevention of transmission of STD/AIDS. The Ministry should also involve Public Health Inspectors in this activity as many clients are reluctant to obtain their condom requirements from Public Health Midwives.

2) As only the WHO is presently providing funds for condom procurement for the NACP, the Ministry of Health should explore the possibility of obtaining funds through other sources as emphasized in the report of the Presidential Task Force on formulation of a National Health Policy for Sri Lanka.

3) To maintain quality control, all condoms should be obtained from approved sources. A mechanism should be developed for randomly selecting condoms from outlets and testing them at recognized centres.

4) A survey should be carried out in certain randomly selected areas to obtain estimates regarding the priority prevention indicators.

5) Widespread availability of condoms through multiple channels should be promoted and provision of condoms through vending machines at selected places be explored.

2.2.3 PROVISION OF DIAGNOSIS AND EARLY TREATMENT OF STD

The STD Control Programme was established in 1951 consequent to a WHO sero survey which revealed a high sero prevalence of syphilis. With considerable support from the WHO, the programme developed steadily and reached its peak in the mid seventies, after which it went into a period of decline. This decline was arrested and a period of rehabilitation instituted in the mid eighties. Presently the programme is in a better position than it was a decade ago, but has yet to reach the zenith it had achieved in the mid seventies.

ACHIEVEMENTS

The programme has been successful in partially overcoming the acute shortage of medical officers opting for a career in Venereology.

Inspite of the prevailing unsettled situation in the North and East of the country, two new clinics were established in Batticaloa and Polonnaruwa. S.T.D. clinics are presently conducted at the following stations- Matara, Galle, Colombo South, Colombo, Colombo North, Kurunegala, Anuradhapura, Jaffna, Katugastota, Kegalle, Ratnapura and Badulla.

All Medical Officers conducting these clinics are trained in Colombo and a reasonable level of competence is maintained.

CONSTRAINTS

Since the devolution of the clinics to the Provincial Councils, STD services have deteriorated somewhat as adequate funds were not made available through the decentralized budget.

The physical plant is inadequate and in a few instances rooms allocated for provision of STD services have been taken away by the Director of the Hospital. The system of conducting Branch Clinics (or satellite clinics centred round a Provincial Referral Clinic) has broken down partly due to non availability of vehicles.

Laboratory services have not kept pace with developments in other parts of the world. The facilities available at present are adequate for public health purposes but will be inadequate when called upon to serve as referral centres. In particular, the technical capabilities of the central laboratory needs updating.

Motivation of some of the paramedical staff leaves room for improvement. Several staff who have had problems during their service have been transferred to the central STD Clinic. This has created problems for the Director STD/AIDS and for the service in general.

The control aspect of the programme rests largely on the efficiency of Public Health Inspectors. At present very junior Public Health Inspectors who lack experience and commitment are assigned to the programme resulting in a high turnover of officers which is not in the best interests of the service.

The non availability of some drugs like acyclovir have proved to be a constraint and has led to loss of credibility in the service.

The present clinical record forms and data collection system dates back to the early nineteen fifties and should be modified to suit present day requirements.

The present system of categorical S.T.D. clinics provides services for an estimated 10% of those infected, exposing a vast majority of STD infected persons to sub standard treatment elsewhere.

Several patients with STD seek treatment from General Practitioners (GP's). These GP's have not had any training or updating of their knowledge through an organized system of continuing medical education. Thus, it is likely that a vast number of STD patients were not being treated on modern STD management protocols.

The Medical Officers and other staff in Provincial Referral Clinics are not being involved in the AIDS Prevention and Control Programme activities to any significant extent.

The present view of the WHO is that STD's should be treated at the PHC level using a syndromic approach. National Guidelines are not available for this purpose.

The recent changes in the system of training of specialist medical officers in STD are likely to deliver Consultants with very little experience.

RECOMMENDATIONS

1) STD services should be made available at PHC level and all hospital clinics. By appropriate training and use of management protocols based on a "syndromic" approach, it would be possible to deliver a satisfactory service without over dependence on a laboratory.

2) Uniform treatment should be provided through guidelines and management protocols.

3) All patient records and surveillance data collection forms should be revised and be made computer compatible.

4) All PHIs attached to health care facilities providing STD services should be trained in counselling and should carry out this function.

5) Information and Educational material related to STDs should be made available at all Health Care facilities providing such services.

6) Improvement of the physical plant of the central clinic and other clinics which have been identified for upgrading to referral level is an urgent necessity.

7) Laboratory services at the centre need to be upgraded and those at the Provincial and Base Hospital level should be equipped to perform the VDRL test.

8) The present categorical STD clinics should be upgraded to the level of referral clinics.

9) A system of training of GPs in management of STDs should be instituted.

2.3 PREVENTION OF TRANSMISSION THROUGH BLOOD AND BLOOD COMPONENTS

2.3.1 PROMOTION OF SAFER BLOOD SUPPLY AND THE RATIONAL USE OF BLOOD AND BLOOD COMPONENTS

ACHIEVEMENTS

The National Blood Transfusion Service (NBTS) of Sri Lanka was established in the early 1960s and has as its main objective the supply of safer blood to all patients who need it. The service is a decentralized unit of the Ministry of Health and is in charge of a full time Director.

The NBTS network consists of a central blood bank (which also serves as a centre of excellence and training facility) and 47 regional blood banks. In 1992, 87500 donors were bled. Out of this supply, nearly 99% was utilised by the public sector hospitals and the rest by private hospitals. The Review Team heard conflicting accounts of the rational use of blood. Some Clinicians felt that blood and blood components are now used rationally, others did not.

Blood is collected from voluntary non remunerated donors, with relatives and friends of patients being encouraged to help replenish stocks of blood (i.e. by replacement, voluntary donation). In addition, donations are also obtained by public appeals and campaigns organized by the NBTS through their own donor recruitment programmes.

A donor self-deferral system is in place and donated blood is tested for syphilis, HIV, Hepatitis B and Malaria.

All donated blood is now being tested for HIV antibodies. Forty five percent of the HIV Antibody tests for the blood collected by the NBTS is performed for them by the laboratory of the STD/AIDS Control Programme. The balance 55% of the HIV Antibody tests are handled by the Blood Bank laboratories. The larger blood banks use the particled agglutination tests while the smaller units use rapid diagnostic tests which are more economical when blood samples are tested occasionally in small numbers. Since prevalence is low, costs are minimised by pooling samples.

CONSTRAINTS

- The dependence on foreign funds for the provision of test kits.
- Absence of a donor recall system.
- Non distribution of guidelines on appropriate use of blood and blood components.

RECOMMENDATIONS

Every effort must be made to ensure that in the future testing for HIV antibodies in donated blood is funded by the Government rather than Donors.

A donor recall system should be developed.

The WHO document "Guidelines for the Appropriate Use of Blood" should be circulated to all clinicians. Training programmes on the rational use of blood and blood components should be established for all medical staff and undergraduates.

2.3.2 INJECTING DRUG USERS

It is admitted that there is a growing problem of substance abuse in Sri Lanka but at present much of this is through inhalation. However, it is known that some injecting occurs but it is believed that the incidence of this is low.

It is the view of the NACP that transmission through sharing injecting equipment is not a problem at present and that prevention work in this area is of low priority.

CONSTRAINTS

There is no harm reduction programme for drug users.

Given the experience of other countries, notably Thailand, where drug using habits changed quickly, the Government, in collaboration with NGOs should consider the need for a more active prevention and care programmes for drug users.

2.3.3 PREVENTION OF TRANSMISSION IN THE HEALTH CARE SETTING

ACHIEVEMENTS

Both health care workers and the general public have good knowledge of the risk of transmission through unsterilised syringes, needles and other skin piercing equipment.

The team was impressed by the way infection control nurses have been recruited and trained, and those the team met were dedicated and enthusiastic about their work.

Comprehensive Infection Control Guidelines are in the final stages of preparation.

CONSTRAINTS

Disposable equipment is in very short supply and stocks of reusable syringes and needles etc. are limited. One consequence is that in busy clinics adequate sterilisation by boiling may not be achieved.

There is no policy on the safe disposal of sharps in the health care setting. In addition, hospitals and clinics have a problem with the disposal and destruction of used disposables, as clinics and hospitals do not have incinerators nor access to them. Safe sharps bins are not generally available.

Protective equipment is in short supply although latex gloves are now more widely available. However, these often have to be recycled and their poor quality does not permit this.

The infection control nurses are often frustrated by lack of supplies. The reluctance of some medical staff to observe current good infection control practice has undermined the lessons taught to other health care workers.

RECOMMENDATIONS

At present, and for some time to come, most hospitals and clinics will be using reusable equipment. The Ministry of Health should ensure that reusable skin piercing equipment should be of good quality and available in adequate supply. Every effort must be made to establish Central Sterile Supply Departments.

Disposable sharps should be collected in sharp disposal bins and

incinerated. Clinical waste should be similarly disposed of.

All staff, including senior medical and nursing staff, medical and nursing students, should be educated about current good infection control practices, including recognition of the need to apply universal precautions to all patients, not just to those known to be infected with HIV. The prevalence of Hepatitis B in Sri Lanka makes this essential.

2.3.4 LABORATORY SUPPORT

ACHIEVEMENTS

Most ELISA testing is done at the Central Laboratory of the STD/AIDS Control Programme. ELISA testing is also performed at two centres, Kandy and Galle. Quality control sera from CDC and WHO are tested by these centres every quarter. At present seropositives are confirmed by Western Blot test.

In 1992 the central laboratory in Colombo performed more than 72,000 tests, including tests carried out on donated blood. The number of tests performed daily is increasing, partly due to increased blood donations.

CONSTRAINTS

At present test kits is to a large extent funded by WHO/UNDP.

The present HIV testing laboratory in Colombo is cramped, protective gloves are in short supply and there are no facilities for staff to change into protective overalls.

Most laboratory technicians are refusing to perform any tests on sera etc. once it is known that the patient is HIV positive. The majority of them have not had any education and training on HIV/AIDS.

A number of private laboratories are known to test for HIV antibodies using rapid diagnostic tests. It is expected that increasing numbers will do so because of the need for HIV free certificates for migrant workers travelling (mainly to Middle Eastern countries) and for seafarers whose contracts often stipulate HIV testing.

In the time available the team was unable to visit any private laboratories but learned that the programme has no control over them and that there is no system of certification. They do not participate in quality control exercises.

There are examples of private laboratories mixing samples and giving erroneous information to clients.

RECOMMENDATIONS

The Ministry of Health should provide adequate funding required for HIV antibody testing.

All medical laboratory technologists and students should be provided with education and training on HIV/AIDS.

It is recommended that all private laboratories undertaking HIV antibody testing be subject to inspection including quality control and certification.

The WHO strategies on HIV testing as described in WHO Wkly. Epidem. Rec., No 20, 1992, pp. 145-149, should be circulated to clinicians and laboratory staff.

2.4 REDUCTION OF PERSONAL AND SOCIAL IMPACT OF HIV INFECTION

2.4.1 REDUCE HEALTH IMPACT FOR HIV INFECTED PERSONS AND THEIR FAMILIES

I) Provision of access to Health Care Services for HIV infected persons.

Health Policy requires that all health care facilities should provide care for HIV infected persons. However due to irrational fear of HIV, an 8 bed unit was established at the Infectious Diseases Hospital, Angoda, to serve as a safety net, should any person with HIV be denied health care.

ACHIEVEMENTS

1) Initial resistance has been overcome and nurses have been trained in the management and care of HIV infected persons.

2) Counselling services for patients and health care providers are available in Colombo and will be extended to the other provinces by 1994.

3) Plans are being instituted for patients' needs in a community based health care system to be provided by the AIDS Foundation and other NGOs.

CONSTRAINTS

1) Some medical and nursing staff, both in the public and private sector are presently reluctant to care for people with HIV infection. In response to this the 8 bed unit for

AIDS patients mentioned in paragraph (I) was established. However, there is a danger that the existence of this unit will further reinforce the fears of health care workers.

2) Inadequate exposure of the medical, paramedical and nursing staff to education and training on management of HIV/AIDS.

3) Lack of protective clothing and equipment needed for "Universal Precautions".

4) Limited availability of counselling services outside Colombo.

5) Non availability/non affordability of drugs for treatment of HIV related opportunistic infections, and equipment and material for patient management.

6) Non availability of CD 4 counts and other investigations necessary for management and follow up of persons with HIV/AIDS.

7) Communities have not been involved in the care of HIV infected persons to any significant extent.

RECOMMENDATIONS

1) The curricula in undergraduate training and in training schools should be revised to ensure adequate training on HIV/AIDS of medical, paramedical and nursing personnel. Inservice training should also be intensified.

2) Guidelines on HIV/AIDS clinical management should be distributed to all clinicians.

3) Medical Research Institute (MRI) should be strengthened to provide laboratory support to clinicians managing HIV infected persons.

4) Provide adequate material, equipment and drugs for management of opportunistic infections in HIV infected persons.

5) Facilities providing care for STD/AIDS patients should be provided with condoms for distribution free of charge.

6) All health and health related workers and others interested in working with HIV infected individuals should be provided with basic skills in counselling. Counselling activities should be urgently implemented in the health care facilities.

7) Care of HIV infected persons in the community should be promoted and supported through involvement of community members including NGOs.

2.4.2 REDUCE SOCIAL IMPACT

I) PROMOTION OF ACTION TO PROTECT THE RIGHTS OF INDIVIDUALS.

ACHIEVEMENTS

1) Persistent demands for mandatory testing from several individuals were successfully dealt with and it has been possible to obtain a Policy decision from the Government that there would be no mandatory testing.

2) Due to misinformation and myths about the mode of transmission of HIV, there was a demand from several sectors of the public that movements of HIV infected persons be restricted. Through successful educational programmes it was possible to defeat such a move.

3) Even though AIDS is notifiable, measures have been adopted to safeguard confidentiality.

4) It is a policy decision of the Government that unlinked anonymous testing of blood samples be the preferred methodology for public health surveillance.

5) The Government has made several policy decisions to protect the rights of individuals infected with HIV viz. provision of care for orphans of AIDS patients, guaranteeing that education, employment and housing would not be denied purely on the individual being HIV positive, and the provision of Anonymous Clinics.

CONSTRAINTS

1) There have been instances where patients were denied access to their own homes.

2) Reluctance of some health care institutions to provide labour room facilities for not only HIV positive women but also for uninfected spouses of infected partners.

3) There are ill-conceived programmes of arresting and charging commercial sex workers and testing them for HIV which has resulted in driving them underground.

RECOMMENDATIONS

1) Create a positive social environment through education to prevent discrimination, guarantee land and property rights and rights of women.

2) Existing Government policies be enforced both in the public and private sector to safeguard against discrimination at the work place based on HIV status.

II) PROVIDE ACCESS TO SOCIAL SERVICES

Social services are well organized in Sri Lanka. Negotiations have been made with the social services department to provide services for HIV infected persons.

ACHIEVEMENTS

The Social Services Department has agreed to provide the same type of financial support presently provided to tuberculosis, leprosy and cancer patients. They would also consider favourably any request to extend this facility to surviving family members of HIV infected persons, if a justification could be made.

CONSTRAINTS

Whenever Government funds are disbursed there is a statutory requirement to sign on a voucher. This would jeopardise the confidentiality of the patient. Inadequate community support is also a major constraint.

RECOMMENDATIONS

1) Social support as for above listed patients be provided by the social services department through a NGO (e.g. AIDS Foundation) to overcome the government requirement of a signature on a voucher for any payment made.

2) Social/community support should be extended to surviving members of the family.

3) Counselling facilities to HIV infected persons and their families be provided by the Government and the NGO sector.

III) HELP COMMUNITIES PROVIDE SOCIAL SUPPORT TO INDIVIDUALS AND FAMILIES

ACHIEVEMENTS

1) A Non-Governmental Organization established for prevention and control of AIDS called AIDS Foundation of Sri Lanka has

taken up the challenging task of establishing a "halfway house" in Colombo. It is yet in the preliminary stage. The Social Services Department has expressed its willingness to contribute significantly to the running of these facilities - Hospices/Halfway Houses once they are developed/established by community based organizations.

2) Patients are being cared for in their homes where circumstances permit.

CONSTRAINTS

Provision of domiciliary care by family members is difficult because of the prevailing climate of stigmatization.

RECOMMENDATIONS

1) Provide substantial inputs from the state through Health & Social Services Departments to provide home care.

2) Encourage the Non-Governmental Organizations to provide Hospices or Halfway Houses when circumstances warrant provision of such facilities.

2.5 STD, HIV/AIDS SURVEILLANCE AND RESEARCH

BACKGROUND

Sentinel surveillance for HIV infection was initiated in 1990. However, this survey did not yield useful information. This activity, based on a revised protocol was carried out in 1993 at 6 monthly intervals in four sentinel sites representing four of the nine provinces in Sri Lanka. Sentinel populations representing high (STD patients and female prostitutes), medium (tuberculosis patients) and low risk behaviours (blood donors) were screened, and only 0.5% of tuberculosis patients in Kandy and 0.24% of female prostitutes in Colombo were found to be HIV positive.

STD surveillance is carried out using active reporting from all the STD clinics. An increase in genital ulcer disease syndrome has been noted, particularly from the Central Clinic in Colombo during 1993. VDRL screening of ante-natal clinic attendees and those requiring a pre-employment medical examination also constitute an important part of surveillance for STDs.

ACHIEVEMENTS

An ongoing surveillance system has been established in the major cities in 4 of the 9 provinces and groundwork has already been completed to include two more sites to represent two additional provinces from 1994.

Studies on knowledge, attitude and behaviour have been carried

out in 1988 and 1992. In addition, a study on risk behaviour mapping was completed in 1992.

Laboratory staff have been trained in testing of pooled plasma which has helped to reduce the cost of HIV testing.

CONSTRAINTS

1) Inability to enrol recommended sample size from the sentinel populations within the specified time period was a major draw back.

2) Voluntary confidential method has been used to collect blood from STD clinic patients. This has led to participation bias.

3) Absence of a comprehensive reporting and surveillance system for STD, HIV/AIDS.

4) At present VDRL screening of pregnant women is not conducted in many Ante-natal Clinics. Poor motivation of health care providers as well as difficulties with transportation and storage of blood samples were contributory factors.

5) Data collection, collation and analysis were carried out manually which has proved to be cumbersome and time consuming.

RECOMMENDATIONS

1) Conduct sentinel surveillance once a year and to extend the period of screening up to 3 months in those sites where few persons in the respective sentinel groups are seen.

2) Provide training in sentinel surveillance methodology to the relevant staff.

3) Method of blood collection from all sentinel groups to be on an unlinked anonymous basis.

4) Guidelines to be issued regarding AIDS case definition and these guidelines to be made available to all public and private sector physicians and health institutions.

5) A comprehensive reporting and surveillance system for STD, HIV/AIDS to be established.

6) Improve coverage of ante-natal VDRL screening through increased motivation of health workers and through provision of necessary facilities. There should be more coordination between the MCH services and the STD/AIDS Control Programme.

7) Establish a computerised STD, HIV/AIDS data base to improve uniformity, accuracy and efficiency of the surveillance system.

Annex I

TERMS OF REFERENCE

PROGRAMME REVIEW

1) To review the present management structure of the programme with particular reference to its adequacy in view of the decentralization of activities to the periphery within the Ministry of Health, the proposed involvement of other government sectors in MTP II and greater involvement of non-governmental organizations and non-state sector institutions in the MTP II.

2) To review sustainability of the programme with special reference to accommodation for office, staffing and mobilization of funds locally.

3) To review the procedures adopted in approval of project proposals, training programmes, workshops etc., with a view to streamlining and minimizing bureaucratic delays while retaining precautions against possible misuse of funds.

4) To review the current interventions as to their adequacy and relevance with regard to prevention of sexual transmission of HIV with particular reference to IEC counselling and condom promotion.

5) To review adequacy of provision of facilities for management of sexually transmitted diseases.

6) To review the policies on legal and ethical issues with particular reference to safeguarding of confidentiality, human rights, protection of employment and destigmatization of HIV/AIDS

Annex II

LIST OF REVIEW TEAM MEMBERS

1)	Dr. R.C. Rajapakse	-	Former DDG, Teaching Hospitals & Womens' Affairs and Director, Sri Jayewardenepura General Hospital & Chairman, Review Team
2)	Dr. J.P. Narain	-	Team Leader, GPA/WHO/SEARO/New Delhi
3)	Dr. Peter D. Exon	-	WHO/GPA/Geneva
4)	Ms. W.A.S. Mahawewa	-	Deputy Director, Human Resource Development Div., Dept. of National Planning, Ministry of Policy Planning & Implementation
5)	Dr. T.S.R. Peiris	-	Medical Officer, Epidemiological Unit
6)	Dr. R.M. Fernando	-	Director, Health Education Bureau, Ministry of Health & Womens' Affairs
7)	Mr. D.A. Dharmasena	-	Deputy Director of Education Ministry of Education & Cultural Affairs

RESOURCE PERSONS

1)	Dr. G.N. Jayakuru	-	Director, STD/AIDS Prevention & Control Programme
2)	Dr. T. Arulanantham	-	Venereologist, Central VD Clinic, Colombo
3)	Dr. K. Senanayake	-	Venereologist, Central VD Clinic, Colombo
4)	Dr. I.Abeyewickreme	-	Venereologist, Central VD Clinic, Colombo
5)	Dr.A.V.K.V.de Silva	-	National Programme Co-ordinator AIDS Project

Annex III

SCHEDULE OF ACTIVITIES

Venue of Meeting - AIDS Project Office
7, Palmyrah Mawatha, Colombo 3

29 NOVEMBER - MONDAY

10.30 a.m.	-	INAUGURATION
11.00 a.m.	-	Briefing of team members
	-	Address by Acting WHO Representative for Sri Lanka
	-	Briefing on National AIDS Programme by Dr. G.N. Jayakuru, Programme Manager
12 Noon - 1.00 p.m.	-	**LUNCH BREAK**
1.00 p.m.	-	Overview of Review Plan Division of responsibilities to teams and planning of field visits

30 NOVEMBER - TUESDAY

Morning	-	Working Sessions - Collection of data at Central level
Afternoon	-	Working Sessions - Collection of data at Central level

01 DECEMBER - WEDNESDAY

	-	Working Sessions - Collection of data at Central level

02 DECEMBER - THURSDAY

	-	Field Visits

03 DECEMBER - FRIDAY

	-	Field Visits

04 DECEMBER - SATURDAY

	-	Discussion of field reports

05 DECEMBER - SUNDAY - No Sessions

06 DECEMBER - MONDAY

- Preparation of draft Summary Report

07 DECEMBER - TUESDAY

- Preparation of draft Summary Report

08 DECEMBER - WEDNESDAY

- Finalise Summary Report for presentation at Consensus Workshop

09 DECEMBER (THURSDAY) AND 10 DECEMBER (FRIDAY)

- Consensus Workshop at Colombo Marriott Hotel, Lotus Road, Colombo 3

13TH, 14TH, 15TH DECEMBER

- Preparation of draft of Review Report

16TH AND 17TH DECEMBER

- Finalisation of Review Report

PERSONS MET

DATE	TEAM I	TEAM II	TEAM III
30.11.93	Project Office : - Mr. M.M. Azzed Programme Assistant Medical Supplies Division: - Dr. Ajith Mendis Director/MSD Health Education Bureau : - Dr. Marcus Fernando Director/HEB	General Hospital : - Dr. S D Atukorale Clinical Microbiologist Central Blood Bank Colombo : - Dr. N de Zoysa Director/NBTS Central STD Clinic Colombo & Laboratory: - Dr. M Fernando Actg. MOIC - Dr. K. Kulatunga MO/Laboratory	MRI : - Dr. U.T. Vitharana Director Fever Hospital : - Dr. N K Fernando Consultant Physician - Dr. Pathirana, MOIC Social Services : - Mr. N.W.E. Wijewantha Director Health Education Bureau : - Dr. Marcus Fernando Director
01.12.93	Ministry of Health : - Dr. Susantha de Silva DDG (Planning)	Ministry of Health : - Directors Nursing, (Medical/Education/ Public Health) USAID : - Ms. T. Dharmawardena Programme Officer	CVDC : - Dr. K. Senanayake, MOIC FPASL : - Mr. Daya Abeywickrema Executive Director CFPA : - Mr. Shirley Tissera President NDDCB : - Mr. Y Ratnayake Asst. Director

PERSONS MET

DATE	TEAM I	TEAM II	TEAM III
02.12.93	PDHS Ratnapura : - Dr. R Arulanantham, PD - Dr. D A B Dangolle, MO/MCH General Hospital/Blood Bank VD Clinic, Ratnapura : - Dr. Sankaranarayan, Director Hospital - Dr. D. Perera, Blood Bank - Dr. Abeyratne, MO/VDC Ferguson Girls High School: - Ms. Rupa Gnanawathie Vice Principal - Group of 5 teachers teaching 5-14 year classes Office of the Red Cross Society, Ratnapura : - Mr. B Pragnaratne, Vice Chairman - Mr. R K H Ranchagoda, Programme Officer - Mr. M H M Yehiya, Treasurer RCS	General Hospital, Kandy: - Dr. A.M.L. Beligaswatte, Director, GHK - Dr. C. Thalgahagoda Deputy Director - MOIC/Blood Bank - Infection Control Nurse/GHK STD Clinic : - Dr. P. Wedisinghe, Venereologist	Visit to Galle : - Dr. Dula de Siiva Provincial Director (SP) - Dr. P.H.U. Soysa Regional Director of Health Services - Health Education Officers - Dr. V. de S. Ginige, MO/VD Clinic/PHI - MO/Blood Bank - Infection Control Nurses

PERSONS MET

DATE	TEAM I	TEAM II	TEAM III
03.12.93	Department of External Resources : - Ms. N Madanayake Additional Director WHO Office : - Dr. S Abdullah Actg. WR	SLAVSC, Kandy : - Dr. R.B. Adikari PDHS, Kandy : - Mr.H.M.R.Pilapitiya, PDHS - Epidemiologist - Health Education Officers	ADIC : - Ms. Kushlani Amarasuriya SLANA : - Mr. Kumar Nadesan Red Cross : - Mr. M W Premawardena Sarvodaya : - Mr. K P Chandrasekera
06.12.93	NGO Sub-Committee : - Prof. A H Sheriffdeen UNICEF : - Dr. H Wijemanne	NORAD : - Mr. Henry de Mel Programme Officer PDHS, Western Province : - Dr. N. Jayatilleke RDHS, Gampaha : - Dr.H.R.U.Indrasiri Negombo - Dr. P.Sivaraja, DMO - Dr. S.Piyadigama, MOH	CDS : - Ms. Kamanee Hapugalle AIDS Foundation : - Mr. Mahen Ambani Ministry of Information : - Mr. K S Gunasekera Secretary Ministry of Education : - Mr. R T Alles State Secretary
07.12.93	Ceylon Tourist Board : - Mr. Wimaladharma Ekanayake, Chairman		

Annex IV

NATIONAL AIDS COMMITTEE

TERMS OF REFERENCE

- Advise Government on policy regarding prevention and control of AIDS.
- Facilitate intersectoral co-ordination.
- Monitor the implementation of activities related to the National STD/AIDS Control Programme.
- Bring to the notice of the NHC any difficulties in programme implementation or of any dramatic changes in the situation.

	NAME	DESIGNATION	ADDRESS
1.	Dr. George Fernando	Chairman/NAC DGHS	Ministry of Health "Suwasiripaya" 385, Deans Road Colombo 10
2.	Dr. G N Jayakuru	Secretary/NAC Director/AVDC	STD/AIDS Control Programme P.O.Box 567 De Saram Place Colombo 10
3.	Dr.H M S S D Herath	DDG (PHS)	Ministry of Health
4.	Prof. Dulitha Fernando	Head/Dept. of Community Medicine	Dept.of Community Medicine, Kynsey Road, Colombo 8
5.	Prof. N Kodagoda	Dean	Faculty of Medicine Kynsey Road Colombo 8
6.	Prof.A H. Sheriffdeen	Medical Director FPASL	Dept. of Surgery Faculty of Medicine Kynsey Road, Col.8
7.	Dr.R.S.B. Wickremasinghe	Consultant Bacteriologist	MRI Colombo 8
8.	Dr.Lalith Mendis	DDG(LS)	Ministry of Health
9.	Dr. N.de Zoysa	Director	NBTS, General Hospital, Colombo
10.	Dr.R M Fernando	Director	Health Education Bureau, Colombo 8

11.	Dr.W S Jayakuru	Epidemiologist	Epidemiological Unit 231, De Saram Place Colombo 10
12.	Dr. U T Vitarana	Director	MRI, Colombo 8
13.	Dr. L Weerasena	Representative COGP	371, Galle Road Colombo 3
14.	Dr. S D Atukorale	Representative SLMA	Dept. of Pathology General Hospital Colombo
15.	Ms I. Sugathadasa	Director	Women's Bureau Deans Road Colombo 10
16.	Dr. V Ariyaratne	Medical Officer	Sarvodaya Shramadana Sangamaya 98, Rawatawatte Moratuwa
17.	Mr. Ignatius Canagaratnam	DIG/Crimes & Public Order	Police HQ
18.	Mr. C S Ranhoti- gamage	Deputy Commissioner	Indo/Sri Lanka Citizenship Division P.O. Box 586 Galle Buck, Colombo 1
19.	Mr. Samith E de Silva	Senior State Counsel	Attorney General's Dept., Hultsdorf Colombo 12
20.	Mr. C T Jansz	Representative SLAPSW	88/2, Anderson Road Dehiwela
21.	Dr. K G Chandrasena	Director	Central Ayurvedic Hospital, 325, Dr. N M Perera Mawatha, Colombo 8
22.	Dr. N Pathmanathan	Senior Asst. Secretary	Ministry of Reconst. Rehabilit. & Social Welfare, 1 Alfred House Gardens, Colombo 3
23.	Ms.Swarna Boralessa	Director	Ceylon Tourist Board 73, Steuart Place Colombo 3
24.	Vacant	Snr. Asst. Sec.	Ministry of Public Administration & Provincial Councils

25.	Mr. N H Pathirana	Snr. Asst. Sec.	Ministry of Youth Affairs, 4th floor, Inland Revenue Bldg. Colombo 2
26.	Mr.Lionel Jayasinghe	Admin.Officer	NDDCB 54/1 Australia Bldg. York Street Colombo 1
27.	Ms. H Kumarapperuma	Director	Ministry of Education "Isurupaya" Sri Jayawardenepura Battaramulla
28.	Mr. W A S Perera	Snr. Asst. Sec.	Ministry of Cultural Affairs & Information
29.	Dr.C Pitigala	Director	Respiratory Diseases Control Programme Chest Hospital Welisara
30.	Dr.M de Silva	Director	MCH 231, De Saram Place Colombo 10
31.	Prof.S P Lamabadusuriya	-	Dept. of Paediat. Faculty of Medicine Colombo 8
32.	Prof. Harsha Seneviratne	-	Dept. of Obstet. & Gynaecology Faculty of Medicine Colombo 8
33.	Dr. Susantha de Silva	DDG (P)	Ministry of Health
34.	Ms.M Suriyarachchi	D/Nursing	Ministry of Health
35.	Dr. Neil Abeysekera	Chairman	GPs Sub-Committee Horagasmulla Divulapitiya
36.	Dr. Reggie Gunatilleke	Representative	Governmental Dental Surgeons' Assoc. Professional Centre 275/75 Bauddaloka Mw. Colombo 7
37.	Mr. Mahen Ambani	AIDS Foundation	1B, 6th Lane Colombo 3

Annex V

PROPOSED TERMS OF REFERENCE AND COMPOSITION OF NATIONAL AIDS COMMITTEE

TERMS OF REFERENCE

- Advise Government on policy regarding prevention and control of AIDS.
- Facilitate intersectoral co-ordination.
- Monitor the implementation of activities related to the National STD/AIDS Control Programme.
- Bring to the notice of the NHC any difficulties in implementation of any drastic change in the situation.

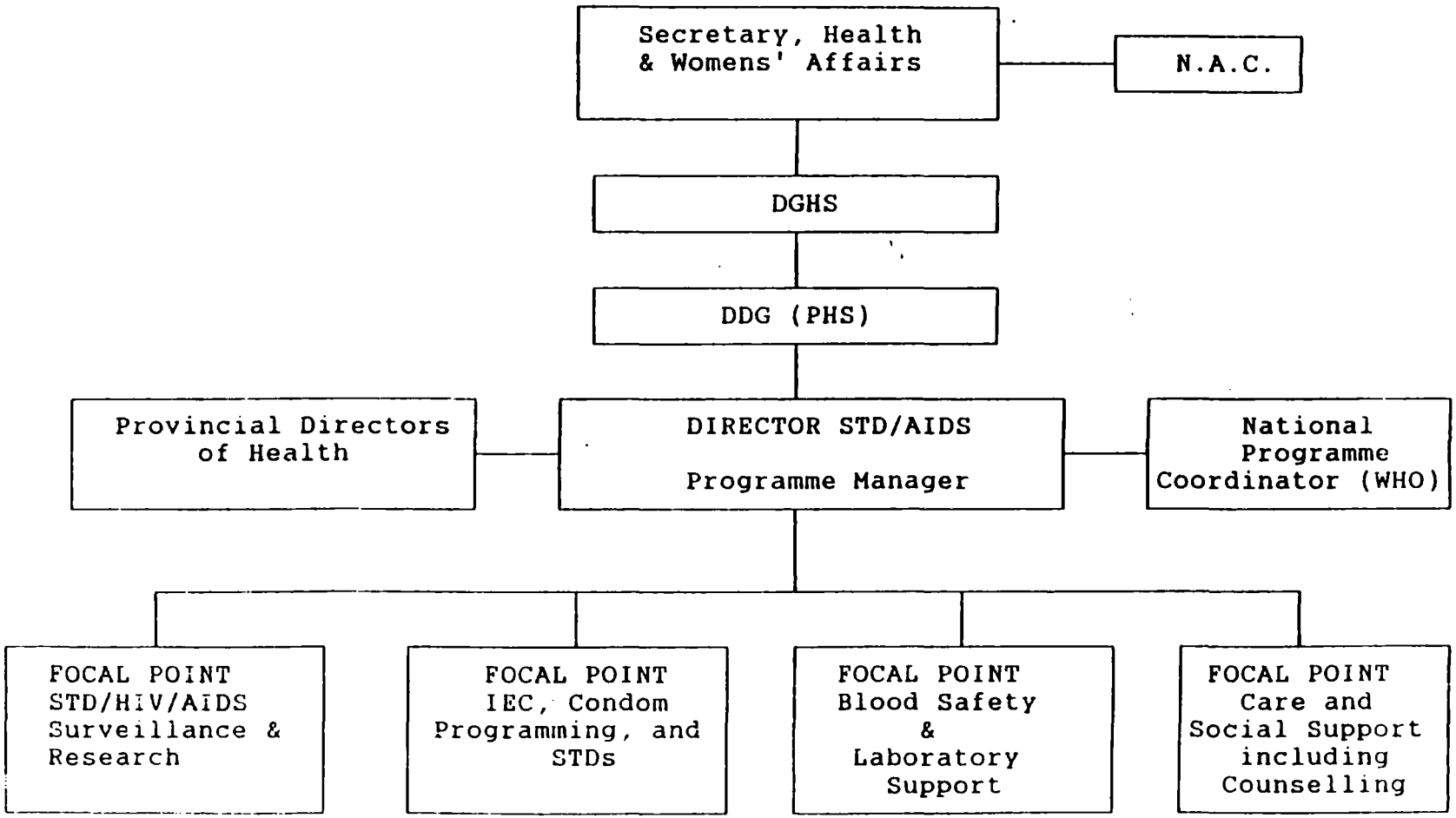
PROPOSED COMPOSITION OF NAC

1. Secretary/Health & Womens' Affairs - Chairman
2. Inspector General of Police
3. Director General of Education
4. Director, Department of External Resources
5. Director General, Department of Information
6. Controller, Department of Immigration & Emigration
7. Solicitor General, Attorney General's Department
8. Commissioner of Labour, Department of Labour
9. Director, Department of National Planning (Human Resources Development Division), Ministry of Policy Planning & Implementation
10. Senior Assistant Secretary (Policy), Ministry of Public Administration, Provincial Councils and Home Affairs
11. Director, Social Services, Department of Social Services
12. Director General, Ceylon Tourist Board
13. Director, National Youth Services Council
14. Director General of Health Services, Ministry of Health and Womens' Affairs
15. Deputy Director General (PHS), Ministry of Health and Womens' Affairs

- Two representatives from the private sector
- Two representatives of NGOs
- A representative from General Practitioners
- Director, National STD/AIDS Control Programme - Secretary/NAC
- Observers as needed

ANNEX VI

PROPOSED ORGANOGRAM OF THE NATIONAL STD/AIDS CONTROL PROGRAMME



Annex VII

EXISTING GOVERNMENT POLICIES RELATED TO HIV/AIDS

1) Notification of HIV infection/AIDS will be ensured through procedures designed to safeguard confidentiality.

2) Unlinked anonymous testing of blood samples will be the preferred methodology for public health surveillance.

3) Use of condoms to ensure safe sex will be promoted. Further, availability of condoms would be ensured. Local manufacture of condoms will be promoted and supported, particularly in the private sector. Besides, the SAARC mechanisms will be used for easy availability of condoms produced in other member countries, at low cost.

4) Information of STD, HIV infection and AIDS will be introduced into the curriculum (sex/health education) of Secondary Schools, Universities and other higher education institutions. Information will be provided to high risk groups.

5) Mass media will be used to create public awareness about the dangers posed to Sri Lankan population by AIDS pandemic. Media will provide prime time space for this purpose free of charge. Any controversy with regard to the content of messages will be resolved by an independent, competent body.

6) The Government with active involvement of Non-Governmental Organizations, will be responsible to provide care for orphans of AIDS patients.

7) Every health care worker, either public or private, receiving a needle stick injury or such other exposure to infection from a known HIV positive or from a body fluid sample, will receive the best available prophylaxis at the expense of the state.

8) No individual will be denied education or employment or housing or health care in any institution or any other normal need on the ground of being HIV positive.

9) In order to ensure that HIV infection/AIDS programme is sustainable, sufficient personnel and material resources backed up by adequate funding from the national budget, will be provided so as to replace, in a phased manner, the external resources available for the programme.

10) "Anonymous Clinics" will be promoted for serving HIV positive persons and AIDS patients and for providing counselling and psycho-social support services.

11) A model centre with all facilities for training, service and research on AIDS will be developed.

12) An integrated programme for the prevention and control of AIDS will be developed with close collaboration with other programmes such as drug addiction.

Annex VIII

CONSENSUS STATEMENT

The consensus meeting, expressing concern over HIV/AIDS epidemic globally and particularly in the South East Asia Region, and recognizing the potential for rapid HIV spread in Sri Lanka, urges the Government to urgently intensify its efforts on prevention of HIV transmission and on provision of care and support to persons with HIV/AIDS and their families. All sectors of society including various Ministries, NGOs and the private sector must contribute constructively to the national effort. Such a coordinated multisectoral response, along with enhanced Government commitment both at the central and provincial levels, and a more open discussion on methods of HIV prevention including greater promotion of condom use, are imperative to minimise the health, social and economic consequences of AIDS epidemic and to ensure sustainability of the programme in Sri Lanka.

The time to act is now!

Annex IX

REPORT ON CONSENSUS WORKSHOP

09 - 10 DECEMBER 1993

DAY 1

The workshop was inaugurated on 9th December and was chaired by Dr. Joe Fernando, Secretary Health and Womens' Affairs.

Dr. George Fernando, Director General of Health Services and Chairman, National AIDS Committee, expressed his appreciation of the work done by the Programme Manager, and the Review Team. He also thanked the participants for their presence.

Dr. Aung Myint, WHO Representative for Sri Lanka, briefly traced the global and regional situation with regard to HIV/AIDS. He stated the strategies available for the prevention of transmission of HIV/AIDS. He also mentioned the Honourable Prime Minister's enthusiasm in effecting this as part of a National Health Strategy. The contributions from donor countries towards activities in MTP II were especially addressed.

Mr. Robert England, Resident Representative, UNDP, spoke of the impact of HIV/AIDS in a country like Sri Lanka, specially stressing the need for action at a time when the prevalence is yet low. He also spoke of the social and economic impact of HIV/AIDS and the study that is being carried out by the UNDP. He requested the Government to consider the necessary budgetary allocation for HIV/AIDS control activities in view of the dwindling international resources.

Dr. Joe Fernando, Secretary Health & Womens' Affairs, observed that control of HIV/AIDS should not be the sole responsibility of the Ministry of Health, and appealed to other sectors to join his Ministry's efforts.

The vote of thanks was proposed by the Director, STD/AIDS Control Programme, Dr. G. N. Jayakuru.

The working session was chaired by Dr. George Fernando, DGHS and Chairman, NAC.

Dr. T. Arulanantham, Venereologist, made a short presentation on STD, HIV/AIDS epidemiology focussing on the increasing incidence of genital ulcer disease syndrome.

Prof. N. Ratnapala, Professor of Sociology and Anthropology made a presentation based on his study of sexually high risk groups in Sri Lanka. In his study he had elicited some rarely perceived

facts of their behaviour which had helped him to formulate techniques to encourage non-penetrative sex as part of safe sex, while also promoting the condom.

Dr. Saroj Jayasinghe, member of the UNDP research team on economic implication of the HIV/AIDS epidemic, presented the preliminary findings of the study which showed that personal cost amounted to US$ 420 - 780 (life) as compared to US$ 658 Thailand and US$ 4225 in Korea.

Dr. George Fernando presented a short review of the present policies adopted by the Government on HIV/AIDS which were recommended by the Presidential Task Force on National Health Policy.

Dr. G. N. Jayakuru next presented the strategies, approaches and interventions for prevention and control of HIV/AIDS.

Dr. R. C. Rajapakse, Chairman of the Review Team presented the preliminary findings of the review.

The post lunch session consisted of working groups.

Working Group I on Policies
Working Group II on Interventions

The groups were chaired by Mr. Daya Abeywickrema of the FPASL and Mr. V. Sabanayakam, DDG, Ministry of Education, Higher Education and Cultural Affairs.

Both groups came out with recommendations.

DAY 11

The sessions were chaired by Mr. Daya Abeywickrema and Group I report on policies was presented by Mr. Mahen Ambani.

Group II report on prioritized strategies was presented by Dr. Saroj Jayasinghe. (Relevant documents are attached).

The presentation of statements of commitment by the participants attending the meeting followed.

1) Mr. Daya Abeywickrema (FPASL) traced its organization's origin, its affiliation and its present role in

   a) condom marketing
   b) training of health workers, volunteers on HIV/AIDS
   c) counselling for HIV testing

   Mr. Abeywickrema agreed to continue the support of FPASL to the Programme.

2) The Sri Lanka Red Cross represented by Mrs. Perera outlined the existing activities in relation to HIV/AIDS control.

and she promised to extend it to cover condom promotion in their next biennial.

3) The National Dangerous Drugs Control Board represented by Mr. Y. Ratnayake presented their current role in drug control activities, and agreed to extend their co-operation for the Programme.

4) Mr. Shirley Tissera representing Community Front for Prevention of AIDS gave an account of the activities carried out in the areas of IEC and expressed their commitment to provide support to the Programme in the field of counselling.

5) Mr. Mahen Ambani of the AIDS Foundation stated that their objective was care of the HIV affected. He stressed that his organization would be carrying out AIDS prevention activities in support of the Government. Their main area of activity would be in the provision of palliative care to HIV infected persons.

6) Mrs. Mahawewa, Deputy Director, Dept. of National Planning also stressed the need for prior planning, and extended support in budgeting and finance.

7) Mr. A. Abeygoonesekera, Deputy Director, Department of External Resources, recognized HIV/AIDS as a national problem and extended full co-operation in foreign resources for this programme.

8) The Defence Ministry/Police was represented by Mr. Sathiyan (ASP - Crimes/HQ) and he agreed to extend police co-operation for the Programme. Mr. Sathiyan assured the participants that in the future that being in possession of condoms would not be grounds for arrest.

9) The Information Ministry announced that it has already given free air time under educational activities for health promotion including HIV/AIDS.

10) In their presentation, the Ministry of Tourism outlined the activities carried out and demonstrated their commitment

11) The representative of the Ministry of Education, Higher Education and Cultural Affairs, Mr. V. Sabanayakam, Deputy Director General, stated that through the National Institute of Education, the Ministry has taken action to conduct orientation courses on HIV/AIDS for Health Science Master Teachers and develop modules for students of years 6-12 in the school system. An intensive programme on HIV/AIDS education in schools is also planned for 1994.

The final session was chaired by Dr. George Fernando when the consensus statement was discussed and agreed upon. Dr. George Fernando thanked all participants.

PROPOSED POLICIES - CONSENSUS WORKSHOP

1) Infection control will be effected through sterilization or the use of disposables where appropriate, moving towards the establishment of appropriate infection control/ universal precautions and effective sharps disposal policy

2) Unlinked anonymous testing of blood samples will be the preferred methodology for public health surveillance.

3) Use of condoms to ensure safe sex will be promoted. Further, availability of condoms would be ensured and made available at low cost.

4) Education on STD, HIV infection and AIDS will be introduced into the curricula of middle and secondary schools.

5) Mass media, both in the state and private sector, will be used to create public awareness about the dangers posed to the Sri Lankan population by the AIDS pandemic.

6) No individual will be denied education, employment, housing or health care in any institution, or any other normal need purely on the grounds of his or her HIV status.

7) In order to ensure that HIV/AIDS programme is sustainable, sufficient personnel and material resources, backed by adequate funding from the national budget will be provided so as to replace in a phased manner, the external resources available for the programme.

8) All voluntary confidential testing should be done with pre and post test counselling.

9) An integrated programme for the prevention and control of AIDS will be developed in close collaboration with other relevant programmes.

10) Notification of HIV infection and AIDS will be ensured through procedures designed to safeguard confidentiality.

11) All blood and blood components will be screened for HIV antibodies prior to transfusion.

12) No person will be confined to an institution against his/her wishes purely on account of HIV seropositivity.

13) Prevention and control of sexually transmitted diseases including AIDS will be a single programme.

14) All HIV infected persons requiring institutional care will be looked after in the general wards.

15) HIV infected persons who knowingly expose others to HIV infection will be liable for prosecution.

16) All ministries and provincial councils should make adequate budgetary allocations for HIV/AIDS preventative activities.

17) Adequate support should be made available to all health care workers who become infected with HIV while on duty.

18) The current policies and regulations with respect to abortion should be reviewed in the context of the problems posed by HIV infection.

* All the above policies be made applicable to both public and private sector institutions, where appropriate.

PROPOSED STRATEGIES - CONSENSUS WORKSHOP

1. Prevention of HIV infection

1.1 Prevention of sexual transmission.

* Promotion of safer sexual behaviour through IEC and counselling.
* Easy availability, accessibility and affordability of condoms.
* Early diagnosis and treatment of STD patients by providing treatment at all health care facilities including at PHC level.

1.2 Prevention of transmission through blood and blood components.

* Promotion of safer blood supply. If necessary bring in legislation to cover the private sector.
* Education of drug users.
* Provide for universal precautions.
* Education on rational use of blood and blood components.

1.3 Prevention of perinatal transmission.

* Provision of information and education on HIV to all pregnant women.
* Provision of health care to HIV infected pregnant women.
* Prevent transmission of HIV infection through good infection control in obstetric practices.

2. Reduce personal and social impact

2.1 Reduce health impact by :

* Providing access to good care.
* Education of health care workers.
* Provision of community care by mobilizing NGOs.

2.2 Reduce social impact by :

* Protecting the rights of HIV infected individuals.

* Providing social and financial support to HIV infected persons and their dependants

2.3 Reduce impact on society through IEC.

3. **Mobilise support for HIV prevention activities and unify all such efforts.**

3.1 Mobilize support for HIV prevention activities and unify all such efforts by promoting intersectoral coordination within the government, and close collaborations with NGO, private sector and funding agencies.

ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ADIC	-	Alcohol and Drug Information Centre
AVDC	-	Anti-Venereal Diseases Campaign
CDS	-	Community Development Services
COGP	-	College of General Practitioners
CVDC	-	Central Venereal Diseases Clinic
DG	-	Director General
DGHS	-	Director General of Health Services
DDG (MS)	-	Deputy Director General (Medical Services)
DDG (PHS)	-	Deputy Director General (Public Health Services)
DDG (P)	-	Deputy Director General (Planning)
DIG	-	Deputy Inspector General of Police
DMO	-	District Medical Officer
ELISA	-	Enzyme Linked Immuno Solvent Assay
FPASL	-	Family Planning Association of Sri Lanka
GPs	-	General Practitioners
GPA	-	Global Programme on AIDS
HIV	-	Human Immunodeficiency Virus
HEB	-	Health Education Bureau
HQ	-	Headquarters
IEC	-	Information, Education, Communication
MO	-	Medical Officer
MOH	-	Medical Officer of Health
MOIC	-	Medical Officer in charge
MRI	-	Medical Research Institute
MTP	-	Medium Term Plan
MCH	-	Maternal and Child Health
MSD	-	Medical Supplies Division

NDDCB	-	National Dangerous Drugs Control Board
NGO	-	Non-Governmental Organization
NAC	-	National AIDS Committee
NSACP	-	National Sexually Transmitted Diseases & AIDS Control Programme
NACP	-	National AIDS Control Programme
NAP	-	National AIDS Programme
NHC	-	National Health Council
NBTS	-	National Blood Transfusion Service
PHC	-	Primary Health Care
PD	-	Provincial Director
PDHS	-	Provincial Director of Health Services
PHI	-	Public Health Inspector
SLANA	-	Sri Lanka Anti Narcotics Association
SLAPSW	-	Sri Lanka Association of Professional Social Workers
SLAVSC	-	Sri Lanka Association for Voluntary Surigical Contraception
SLMA	-	Sri Lanka Medical Association
STD	-	Sexually Transmitted Diseases
UNDP	-	United Nations Development Programme
UN	-	United Nations
UNFPA	-	United Nations Fund for Population Activities
VD	-	Venereal Diseases
VDC	-	Venereal Diseases Clinic
VDRL	-	Venereal Diseases Research Laboratory
WHO	-	World Health Organization

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