

# Joint HIV Assessment Mission of Conflict-affected Populations in Sri Lanka

February 2008



**Joint HIV Assessment  
Mission of  
Conflict-affected  
Populations in  
Sri Lanka**

**5th February to 15th of February 2008**

Participating Agencies:  
UNHCR, UNAIDS, UNICEF, UNDP Regional Centre,  
UN Resident Coordinator's Office,  
IOM, FPA-Colombo,  
OfERR, World Vision, HelpAge

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# List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
CDO	Chief District Officer
CHAP	Common Humanitarian Action Plan
FGD	Focus group Discussion
FPA	Family Planning Association
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
KII	Key Informant Interview
LTTE	Liberation Tigers of Tamil Eelam
MARP	Most-at-risk Population
MSM	Men who have Sex with Men
IASC	Inter Agency Steering Committee
ICAAP	International Congress on AIDS in Asia & Pacific
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organization for Migration
NSACP	National STI and AIDS and Control Programme
NGO	Non-Governmental Organization
PLWH	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SLA	Sri Lanka Army
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFAO	United Nations Food and Agriculture Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJTA	UN Joint Team on AIDS
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office of Drugs and Crime
UNRC	United Nations Resident Coordinator
UNV	United Nations Volunteers
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
WB	World Bank
WFP	United Nations World Food Programme

# Executive Summary

In February 2008, a joint mission led by UNHCR and the UNAIDS Secretariat, was undertaken to assess the measures to prevent and respond to HIV among conflict-affected populations in Sri Lanka. Participants were from five UN agencies, international and national NGOs. The National STI and AIDS Control Program was involved in the planning and fully approved of and supported the assessment.

The assessment was undertaken in two sites – Batticaloa and Trincomalee Districts. The populations in both districts have endured the effects of the long standing civil war between the Government of Sri Lanka and the LTTE, a separatist militant organization fighting for the creation of an independent state in the Northeast Province of Sri Lanka.

Batticaloa and Trincomalee Districts differ slightly in ethnic mix but little in socioeconomic profiles; both were severely affected by the 2006-2007 intensification of the conflict. In Batticaloa the presence of armed

non-state factions complicates the local political and security scene. Both districts were affected by the 2004 tsunami suffering significant degrees of destruction and loss of life.

Sri Lanka is experiencing a low-level HIV epidemic with HIV prevalence rates low even in most-at-risk populations. However, it was evident in both sites that the long standing conflict contributed to an increase in the population's vulnerability to HIV though the assessment did not demonstrate an increase in HIV transmission.

The nearly thirty-year conflict has had a devastating impact on the population causing mass displacement, sometimes on multiple occasions. Many factors - often interrelated - exacerbated the population's vulnerability to HIV. Poverty and lack of livelihoods, food insecurity, marginalisation of certain population subgroups and disruption of family units, compromised social support and community safety networks all contributed, in some instances, to

women adopting coping strategies that place them at risk of HIV infection, such as sex work and transactional sex. Women that were most vulnerable were widows and other female heads of households and former LTTE recruits.

Alcohol misuse has increased as a result of the conflict and was associated with an increase in domestic violence, forced sex and - in some communities - a breakdown in law and order. There are few interventions to address the harms associated with alcohol misuse in the north-east. Alcohol use is indirectly associated with HIV as it impairs decision-making about safe behaviour, including sexual behaviour.

Sexual and gender-based violence is reportedly very common. It is related, inter alia, to poverty, culture, loss of traditional male roles and alcohol use. Though no individual reported direct experience of rape it was reportedly common and was a source of fear for many women. Though a number of initiatives are in place to prevent and respond to SGBV the coverage is still uneven.

An increase in external migration amongst Tamils was largely attributed to the conflict. Men travelling and working overseas

are more likely to engage in casual relationships including with sex workers, while female migrants are at risk of sexual exploitation and abuse. Despite these vulnerabilities HIV prevention in migrants pre-departure was inadequate.

Conversely, some factors associated with the conflict may have been protective against HIV. Some villages were displaced almost in their entirety and community structures and families remained relatively intact; those displaced from rural areas to towns reported better access to health care and education. Furthermore, displacement had increased the availability of HIV-related information for those in camps in Batticaloa where access to Ministry of Health and NGO services was better; finally the humanitarian response was noted to be strong and effective in some sites. Related to the above factors, variations in vulnerability according to the stage of displacement were evident in some areas.

The most urgent gap in HIV programming in the conflict-affected areas is the lack of interventions with most-at-risk populations, such as sex workers and men who have sex with men. Though this is a feature of HIV programming elsewhere in Sri Lanka, it is exacerbated in the

conflict-affected areas due to poor civil society participation in HIV programming and the heavy security presence.

The assessment demonstrates that the factors that influence HIV vulnerability and risk in conflict are multisectoral, underscoring the importance of a coordinated and interagency response even in a low prevalence setting. Within humanitarian emergencies involving IDPs, sector leads (cluster leads where applicable) must ensure that HIV considerations are incorporated into the response in all relevant sectors. The IASC Guidelines on HIV/AIDS Interventions in Emergency Settings provide guidance on minimum interventions. Though conflict-affected areas should be fully integrated into the national response special measures will need to be taken to ensure that the HIV-related needs of this population are met. In particular, the assessment highlights the importance of strengthened protection mechanisms for women and children (including livelihood assistance to vulnerable women) in reducing HIV vulnerability and the need for systematic and comprehensive HIV services in uniformed personnel. Furthermore, there is a pressing need for better coverage of HIV prevention activities in

most-at-risk populations including involvement of community-based organisations and NGOs and consideration of the use of respondent driven sampling to enhance behavioural and biological surveillance. Lastly, special consideration should be given to the care and support needs of those already living with and affected by HIV, residing in conflict affected areas and how best to meet these needs in a confidential and supportive way.

Once Sri Lanka enters the post-conflict phase and peace is restored additional factors that affect HIV vulnerability may be introduced. This phase may be characterised by increased mobility of the affected population, opening up of transport networks and improved incomes all of which will add other dimensions to HIV vulnerability. Effective interventions now will help to reduce vulnerability in the recovery phase.



# 1. Background

## 1.1 Context

Sri Lanka has an estimated population of 19.7 million.<sup>1</sup> Its ethnically diverse population is 81.9 percent Sinhalese, 9.4 percent Tamil, (5.1 percent of whom are Indian Tamils) and 8.0 percent Moor Muslims. The population living in the north-east are estimated to be 65.3 percent Tamil (Sri Lankan and Indian Tamils), 19.1 percent are Moors, 15.1 percent are Sinhalese, with the remaining 0.5 percent comprised of Burghers, Malays and others.

Since independence in 1948, Sri Lanka has suffered ethnic unrest between the Sinhalese majority and the Tamil minority. From 1983, there has been an intermittent civil war fought mainly in the northeast of the country that has caused an estimated 70,000 deaths and one of the worst internal displacement crises in Asia.<sup>2</sup> Current estimates

suggest that 187,850 persons were displaced internally after 2006, while 312,712 internally displaced persons (IDPs) remain in displacement from before 2002.<sup>3</sup>

There is a dearth of information on risk and vulnerability to HIV from the conflict-affected districts.<sup>4</sup> In order to better understand these risks and vulnerabilities an assessment mission took place from 5th February to 15th February 2008. Batticaloa, Trincomalee and Vavuniya were the three districts selected for field work but due to insecurity, the mission to the Vavuniya district was cancelled.

## 1.2 Objectives

The objectives of the assessment were as follows:

1. Describe the epidemiology (including prevalence, risk behaviours and

1 Department of Census and Statistics. Estimated mid year population by sex and age, 2003 - 2005.

2 [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/9415B89D69E597E2C125735C003BF9EF?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/9415B89D69E597E2C125735C003BF9EF?OpenDocument).

3 UNHCR December 2007.

4 WHO (2006) Review of the National Response to Sexually Transmitted Infections and HIV/AIDS in Sri Lanka.

vulnerabilities) relating to HIV in conflict-affected communities.

2. Describe and assess current HIV and AIDS interventions and response with regards to policy and strategy, coordination, protection, prevention, care and treatment, surveillance, monitoring and evaluation, and funding.
3. Provide quantitative and qualitative information to guide the development of UNAIDS's HIV programming in Sri Lanka.
4. Develop recommendations to reduce vulnerability and risk associated with HIV among conflict-affected populations and respond to the needs of those infected and affected.

### **1.3 History and manifestation of the conflict in Sri Lanka**

Sri Lanka's armed conflict has emerged out of a long history of political and socio-economic grievances, exclusions and issues between the Sinhalese majority and the Tamil minority populations. The prolonged conflict has been a culmination of ethnic politics that emerged in the early twentieth century and intensified after the country

received political independence in 1948. In post-independence years, the conflict evolved around the Tamil minority's demand for regional autonomy and the rejection of that demand by the governments dominated by the representatives of the Sinhalese majority. The conflict remained within the framework of parliamentary politics until the early 1980s.

Essentially, the war has been between the government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE), a separatist militant organization fighting for the creation of an independent state in the north-east where Sri Lankan Tamils form a majority. The war has gone through three phases each more intense than the previous and interspersed with ceasefires and peace negotiations. During the first phase between 1983 and 1987 a large number of Sri Lankan Tamils were internally displaced or left the country as refugees, (mainly to Southern India). The second phase in 1991 and the third in 1995 were characterized by a significant intensification in tactics and increase in military capacity. However, as both the Government and the LTTE fought for territories in the north and the east, many civilians became victims and were forced to flee,

sometimes being displaced several times.

A significant violation of international law has been the LTTE's use of child soldiers, some as young as 9 years of age.<sup>5</sup> Apart from the direct human cost of the conflict, landmines and explosive debris have left large areas of land uninhabitable. The fighting has laid waste to agricultural land contributing to child malnutrition. Finally, all manner of social services including disruption of health facilities and human resource availability has adversely impacted community welfare and development.

Since 1983 there have been a number of failed attempts to address the conflict through negotiations. With the signing of a cease fire in 2002, negotiations lead to IDPs and refugees being resettled or returned to their homes. While the ceasefire was the longest period of political engagement without war since the inception of the conflict there were many violations to the agreement. In 2006 the government launched an offensive to clear the LTTE from the east, restricting their access and dominance to the north.

Many people were displaced yet again, but started to return after fighting ceased and security in the east improved. In January 2008 the government withdrew from the ceasefire agreement and intensified military activities against the LTTE around its remaining strongholds in the north.

## **1.4 HIV situation in Sri Lanka**

Sri Lanka is experiencing a low-level epidemic with HIV prevalence rates low even in most at risk populations (MARPs).<sup>6</sup> However, Sri Lanka is vulnerable to the development of a concentrated HIV epidemic. Female sex workers (FSW) are found in most of the major towns and cities, and there are networks of men who have sex with men (MSM), who have multiple partners including paying clients. Sri Lanka also has a high number of heroin users and although few of them currently inject drugs, a substantial change in drug-use patterns to more injecting drug use could result in the increase in the number of people who are likely to be exposed to HIV.<sup>7</sup>

UNAIDS estimates that the

5 [www.unicef.org/infobycountry/sri\\_lanka](http://www.unicef.org/infobycountry/sri_lanka) Accessed on the 22nd of February 2008.

6 UNAIDS: HIV and AIDS Situation Response Analysis Update 2006 Sri Lanka.

7 UNAIDS Sri Lanka Country page (Accessed on 22nd of February 2008).

number of people living with HIV in Sri Lanka is 5,000<sup>8</sup> (i.e. less than 0.1% prevalence). The National STD/AIDS Control Program (NSACP) report 923 cases of HIV and cumulative AIDS deaths of 172 by the end of December 2007.<sup>9</sup> The northeast was not included in the national surveillance system until 2002.

Of the cases reported, heterosexual sex (85%) is the primary mode of infection with some infections due to male to male sex (11%), perinatal transmission and through infected blood products; only one case of HIV transmission attributed to injecting drugs has been reported (in 2004).<sup>10</sup> The male to female ratio of reported HIV cases is 1.3:1; HIV prevalence is 0.01% among women screened in antenatal clinics (n=116,000); 0.1% among FSWs (n= 2,633); and 0.06% among sexually transmitted infection (STI) clinic attendees (n=4,875) and TB patients (n=3,184).<sup>11</sup>

Sri Lanka is characterised by high literacy levels, relatively high status of women and good access

to health care services for the majority of the population, all of which are considered protective against HIV. However, conflict and associated displacement, high mobility of military, separation of spouses related to internal and external migration<sup>12</sup> are also present and increase vulnerability to HIV transmission.

## 1.5 National Response

The national response is coordinated by the National AIDS Committee (NAC), chaired by the Minister of Healthcare and Nutrition. The NSACP is responsible for planning, monitoring and implementation of the National HIV/AIDS Strategic Plan, and provision of technical guidance at decentralized levels. Key stakeholders contributing towards the national HIV response include several health and non-health, government and non-government agencies as well as the private sector.

The UN system in Sri Lanka supports the national response on HIV and AIDS through the UN

8 UNAIDS 2007, The range is estimated to be between 3,500 and 8,500.

9 National STD/AIDS control programme. <http://www.aidscontrol.gov.lk> (Accessed on 22nd of February 2008)

10 <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/SriLanka/index.asp> (Accessed on 22nd of February 2008).

11 UNAIDS: HIV and AIDS Situation Response Analysis Update 2006 Sri Lanka.

12 In 2001, 48% of HIV cases were among women who sought employment (housemaids) abroad. However this may be a reflection of access to testing (overseas labour migrants are often required to undergo HIV testing) than increased numbers of cases in this group. <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/SriLanka/index.asp> (Accessed 21st of February 2008).

Joint Team on AIDS (UNJTA), consisting of twelve different organisations (ILO, UNFPA, WFP, UNICEF, WHO, World Bank, UNDP, UNHCR, UNV, FAO, UNODC, IOM). A Division of Labour for the HIV/AIDS work of the UN has been agreed through the UNJTA and a Joint Support Programme has been developed of which this assessment is a key component.

The response to the humanitarian situation in Sri Lanka is being implemented through a collaborative approach with sector leads in the areas of protection, shelter, food, water and environmental sanitation, food aid, nutrition, health, education, food security, economic recovery and infrastructure, and logistics. Roles and responsibilities have been assigned for the various sectors, with sector lead agencies accountable for delivering services to the targeted population with the support of partner agencies. Coordination among sectors is fostered through inter-agency coordination structures. Attention to HIV in any of the sectors has been minimal to nonexistent with agencies citing the low HIV prevalence and other priorities.

In 2006 an External Review of the National Response was completed where it was noted that conflict-

affected populations were especially vulnerable to HIV but no specific recommendations were made to address this. Similarly, conflict-affected populations were recognized as vulnerable in the 2002-2006 National HIV Strategic Plan but no measures were offered in the plan to address this vulnerability.<sup>13</sup> The Common Humanitarian Action Plan (CHAP) 2006 mentioned HIV twice, however described very limited activities to respond to HIV while the 2007 CHAP does not mention HIV at all. In the 2008 CHAP HIV is mentioned twice under individual agency objectives and outcomes but no activities relating to HIV are specified. Currently the National HIV/AIDS Strategic Plan for 2007-2011 is in effect and an operational plan is developed annually by the government and key stakeholders. However, the lack of information available on risks and vulnerabilities of conflict-affected populations has limited the recommendations and activities in this population.

## **1.6 Defining HIV Vulnerability and Risk**

Risk and vulnerability are often incorrectly used interchangeably. An understanding of these terms is essential to the understanding of the dynamics of HIV and conflict.

13 National Response to the challenge of HIV/AIDS 2006 [www.aidscontrol.gov.lk/me/PMIS/popups/NationalResponse.jsp](http://www.aidscontrol.gov.lk/me/PMIS/popups/NationalResponse.jsp)

Risk of HIV is the likelihood that a person will become infected with HIV either due to his or her own actions or due to another person's action. Unprotected sex with multiple partners and sharing contaminated needles are risky activities that increase the probability of HIV infection.

Vulnerability to HIV is a person's or a community's inability to control their risk of infection. It may be attributed, inter alia, to poverty, disempowering gender roles or migration.<sup>14</sup>

Conflict can impact the degree of interaction between communities with differing levels of risk behaviour and HIV prevalence. Depending on the context greater isolation may decrease exposure opportunity to HIV, while increased mobility may increase the likelihood of exposure.<sup>15</sup>

14 UNAIDS (1998) Expanding the global response to HIV/AIDS through focused action: reducing risk and vulnerability. Geneva, UNAIDS Best Practice Collection: Geneva

15 Mock et al. (2004) Conflict and HIV: a framework for risk assessment to prevent HIV in conflict-affected settings in Africa. *Emerging Themes in Epidemiology*, 1:6.

## 2. Methodology

The rapid assessment was carried out in two districts in the east of Sri Lanka by two teams. The data collection period lasted five days and the entire assessment was completed over ten days. Information was collected from a variety of sources using a qualitative approach and standardized tools:<sup>16</sup>

- a review of existing national and district-specific data on HIV
- key informant interviews (KII) with, inter alia, affected population groups, government and non-governmental organization (NGO) staff, uniformed forces, youth representatives and service providers, such as teachers and health staff
- focus group discussions
- observations of health facilities.

The assessment tool used for this study was developed by UNHCR and UNAIDS using the input received from multi-agency assessment missions in Côte d'Ivoire, the Democratic Republic of Congo, Nepal and the UNHCR-organised first global consultation on HIV and internally displaced persons held in April 2007. However, they were modified to the country context based on the HIV situation, the manifestations of the conflict and cultural sensitivities.

In Trincomalee, a team of eight investigators conducted 25 interviews with key informants and 19 focus group discussions and in Batticaloa, eight investigators completed 45 interviews and six focus group discussions.

Data analysis began in the field during the period of data collection with teams meeting to discuss findings and determine if emerging themes needed further

16 UNHCR and UNAIDS. HIV-related Needs in Internally Displaced Persons and Other Conflict-affected Populations: A Rapid Situation Assessment Tool.

exploration or triangulation. The data collected was collated into broad themes by each interviewer in a matrix. Each site team met together over two days at the end of the data collection period and discussed, refined and summarised the main themes to have emerged. This was then compiled into a site report by each team leader.

## 2.1 Limitations

As in all studies of this design it is recognized that qualitative approaches provide in-depth information about individuals and communities but conclusions cannot be generalized to other conflict-affected areas of Sri Lanka. Furthermore, this rapid assessment was performed at a time and in an environment of intensifying conflict in both districts which may have inhibited open discourse on sensitive and personal issues. Imminent local council elections in Batticaloa were also thought to have possibly discouraged forthright discussions, consequently limiting the information that was able to be collected. For example, sexual violence and transactional sex were reported as happening to others but no individual reported direct experience. As a result

these experiences were difficult to verify or quantify.

Qualitative methods will not provide population-based estimates of the proportion of the population affected by areas of interest such as forced sex or transactional sex or of the level of HIV-related knowledge. Population-based surveys are needed to obtain quantitative data on these key issues.

Due to the heightened insecurity in Sri Lanka and travel restrictions the initial two-day briefing and orientation of all team members planned had to be shortened to one day. As a result some team members needed more support to familiarize themselves with the data collection tools once field work started.

There was a limited opportunity to meet with groups and individuals considered most at risk, such as sex workers and men who have sex with men due to the illegality and stigma associated with their activities. As a result a valuable source of information was lost. Finally due to ethical considerations, teams did not meet with children under the age of 18 therefore not capturing the perspective, knowledge and needs of young adolescents.<sup>17</sup>

17 However agencies working with children were interviewed.

Finally as this was a rapid assessment the time spent collecting data was relatively short and did not allow for in-depth research and analysis. Nevertheless, it has provided an overview of the HIV risks and vulnerabilities and highlights areas where further research would be beneficial.



## 3. Findings

### 3.1 Batticaloa

#### 3.1.1 General situation

The population of Batticaloa District is 579,469.<sup>18</sup> The demographic breakdown in 2005 was Tamil (Hindus and Christians) 73.4%, Muslims 25.6%, Burghers 0.7%, Sinhalese 0.2% and others 0.05%. The population are predominantly farmers, fishermen and labourers. In August 2006 there was an intensification of the longstanding conflict when the government undertook a major offensive to recapture LTTE-held areas, which continued into early 2007, leading to widespread displacement within the district, including large numbers of IDPs moving into Batticaloa town. During the height of displacement there were 160,000 newly-generated IDPs in Batticaloa of whom approximately 20% came from Trincomalee District. At the time of the assessment most IDPs had already returned, while

approximately 16,000 persons remained displaced, the majority in camps. The district was also affected by the 2004 tsunami and significant tsunami relief was provided in the Government-controlled, coastal areas. However, there has been little investment in infrastructure and/or development in LTTE-controlled areas since the conflict intensified in the 1990s.

There is a heavy security force presence (SLA in the northern part of the District; the Special Task Force (STF) in the southern part of the District, including resettled areas of Batticaloa West) as well as non-state armed groups.

Key indicators demonstrate that the health and nutrition status of the district is generally worse than the national average. The crude mortality rate in Batticaloa District is 5.2/1000<sup>19</sup> (national average 6.1),<sup>20</sup> infant mortality rate 20.1/1000 live births (national

18 Census information from the Batticaloa District Planning Secretariat, 2005

19 [www.apacph.org/downloads/healthchallenges-srilanka.ppt](http://www.apacph.org/downloads/healthchallenges-srilanka.ppt)

20 UN Population Division 2005

average 12.0)<sup>21</sup> and global acute malnutrition 27% (Vahari IDP camp 2007) compared with the national average of 16%.<sup>22</sup>

### **3.1.2 Overview of HIV and Sexually Transmitted Infections**

Although surveillance data are incomplete available information indicates that HIV prevalence is at a very low level in Batticaloa District at least in the general population. The STI Clinic at Batticaloa Hospital participates in the national surveillance system, however, this does not include MARPs and adequate sample sizes for STI clients have not been reached. As a result it is not possible to draw conclusions about HIV prevalence in those most at risk of HIV in the District. The Deputy Provincial Director of Health Services (DPDHS) reports that eight cases of HIV have been diagnosed in persons from the District. These were all diagnosed outside of the district and no information is available on age, sex, risk factors, mode of transmission or place of diagnosis.

STI data indicate that the most common infections proportionally are gonorrhoea, genital warts and

syphilis. However, these are all at a very low level with only five cases of both syphilis and genital warts and six of gonorrhoea confirmed in 2007 from the 1233 persons seen at the STI clinic. However, many STIs are seen in the private sector and are thus not captured.

HIV and STI services are very few and concentrated in the District Hospital with the District Health Office and the STI clinic conducting some community awareness in various groups.

### **3.1.3 Vulnerabilities relating to HIV infection**

#### 1. Poverty and lack of livelihoods

Poverty - often related to lack of livelihoods options - was exacerbated by the conflict eroding the community's coping strategies and in a number of ways increased the vulnerability of women and children to HIV and STIs. Poverty was cited by the majority of key informants as one of the principle impacts of the conflict on the community. Employment opportunities have been severely affected as a population that predominantly consists of fishermen and farmers have had to flee. Even those not displaced have been affected as

21 World Health Report 2006 (2004 data)

22 WFP. Sri Lanka Food Security Assessment. Final Report June 2007

insecurity has restricted their movements and access to land and fishing opportunities. This is also the case with many returnee communities.

Many displaced lost all their possessions, including their homes, while returnees face problems in re-establishing means of earning an income.

Loss of livelihood and the resultant poverty underpin a large proportion of other vulnerabilities to HIV and STI infection such as migration, disruption of families, and alcohol consumption. Young people perceived poverty as a major cause of crime, migration and risky behaviour, such as alcohol and drug use. It was also perceived as the major driving factor for women undertaking transactional sex.

## 2. Migration

It was reported that large numbers of people, particularly young men, had migrated overseas to work and that the conflict has led to an increase in migration amongst Tamils. In one village (population approx. 1300 people) nearly 50 persons – the vast majority being male – had left to work abroad. The main reason for males leaving was to

avoid recruitment but extreme poverty was also cited as associated with females' decision to migrate. In some instances children are migrating; the reason for this are fear of recruitment, educational opportunities and reintegration difficulties experienced by former -child soldiers.

In-country migration is also occurring but is usually more localised. For example, children may be sent to Batticaloa town as the education opportunities are better or sent to work as domestic labour; in some cases this involves girls as young as 14 years of age.

Migration is associated with an increased vulnerability to HIV for a number of reasons including separation from families and sexual partners and availability of money coupled with few recreational opportunities. Migrant women and children are particularly vulnerable to sexual abuse and exploitation.<sup>23</sup>

## 3. Displacement

Displacement can both increase and decrease vulnerability to HIV depending on, inter alia, the availability of services in the area of origin and the host areas, the

23 Weeramunda, A. 2004. No Safety Signs Here. Chapter 8. Research Study on Migration and HIV Vulnerability from Seven South and North East Asian Countries, Geneva: UNDP

length of time spent displaced and the degree and type of interaction with the host community. For example, prolonged displacement may influence the norms of the displaced group. An example of this was cited in relation to early marriage when people were displaced from rural to urban areas; early marriage decreased as the host community tended to marry later. This was more pronounced with prolonged displacement.

Conversely, some sites reported very strict community control when in LTTE-held areas that were “relaxed” upon displacement. Though not condoned by the community the upheaval associated with displacement and breakdown in community controls made sexual relations with other partners easier. Furthermore the living circumstances of the displaced (close and cramped quarters, shared bathing and latrine facilities and lack of privacy within shelters) provided more opportunity for mixing between the sexes and subsequent relationships, both forced and unforced.

Displacement could also have positive aspects as refugee returnees from India tended to have a greater exposure to HIV information and a higher level of

awareness. Persons moving from rural to urban areas also reported better access to health and education services which would reduce vulnerability to HIV.

#### 4. Disruption of families

The circumstances of conflict and subsequent displacement often lead to family separation and disruption. For example, there were an estimated 700 to 1000 separated children living in Batticaloa town at the height of the recent exacerbation of the conflict. Only 22 of these had been identified as in need of family tracing and reunification with the majority living in Batticaloa where they had been sent to stay in homes or host families as education services were perceived to be better, to avoid recruitment or because their families (often female-headed) were having difficulty supporting them. Similarly, on return IDP families may choose to leave their children behind in Batticaloa town where access to education was deemed to be better. Refugee returnees from India also reported leaving their children in India on their return because of security concerns. Children living alone or without a designated caregiver are vulnerable to exploitation and abuse, including of a sexual nature, placing them at risk of HIV and STIs.

This was not the experience of all displaced communities; sometimes almost entire villages moved together and families and certain community structures remained relatively intact.

### 5. Marginalisation

Persons marginalised from their community may be forced to seek shelter and other support elsewhere making them vulnerable to exploitation and abuse. Former female LTTE recruits who were released during the peace process in 2002 and 2004 found it difficult to reintegrate and were sometimes forced to leave their families and community and stay with host families in other communities. It was reported that some of these women had to engage in sex in exchange for shelter, food and other support.

### 6. Disruption in health and education services

The conflict also led to disruption in health and education services. For example, in Batticaloa town there was an additional burden placed on health services as at the height of the conflict large numbers of people were displaced into the town. It was

reported that at Batticaloa Hospital approximately 25-30% of patients were IDPs. Health services in Batticaloa are chronically understaffed for reasons relating to the conflict as it is difficult to recruit and retain certain cadres of staff, especially doctors and nurses. Currently, Batticaloa has 81 doctors on staff but vacancies for another 106. There were few shortages of drugs or supplies in Batticaloa Teaching Hospital but there was a shortage of blood supplies for transfusion during intense fighting in 2007; clinicians needed to start to use replacement donors and screen blood themselves rather than sending to the Regional Blood Bank in Ampara. Though all units were screened the use of replacement donors<sup>24</sup> and lack of quality assurance for HIV testing may have compromised blood safety.

Similarly, education services were disrupted for both the displaced and host community for several months. Many schools were closed as IDPs were living in them and the numbers of IDPs needing access to education services placed an additional demand on existing services (20% of school-aged children were from IDP communities).<sup>25</sup>

24 Replacement donors are generally relatives of patients requiring transfusion and are therefore less likely to admit recent risk behaviour on screening

25 UNICEF 121,853 maximum displaced and 23,268 IDP children in Batticaloa Town

Furthermore, displaced teachers did not necessarily settle in the main IDP locations; with the lack of teachers class sizes became very large.

However, the level of service provision in both education and health was reportedly better for those displaced from more isolated rural areas. For example, in Batticaloa IDPs reported that basic services were within four kilometres and tertiary care was available at the teaching hospital. Indeed better access to education services was a factor that led some families to leave children behind when they returned. Conversely, poor access to health services was noted to be a concern during flight for those from Trincomalee. In returnee areas health services are improving though access to them, particularly at night, was still reported as problematic.

## 7. Food insecurity

Lack of adequate food supplies was reported by many people to be a result of the conflict and this in turn was associated with a number of coping strategies some of which heightened vulnerability to HIV. People often reported that they and their families were

largely self sufficient prior to displacement and were now dependent on rations and needing to find the means to supplement their diet. Various coping strategies were reported including pawning and selling of assets, borrowing money and/or purchasing food on credit; and reducing food intake.

Women in IDP camps also reported that female heads of households who could not go out alone were dependent on traders who came to the camps to sell food and therefore subject to the high prices of the traders. In families affected by excess alcohol consumption the rations were sometimes sold to buy alcohol. The global acute malnutrition prevalence in under-fives in Vahari IDP camp in 2007 was reported as 27% indicating a crisis situation.<sup>26</sup> This indicates that at least for some of the population, food insecurity was significant.

Elsewhere food insecurity with poverty has been associated with transactional sex by women as one coping strategy.<sup>27</sup> Although interviewees reported to the assessment team that they knew of women and girls who had resorted to transactional sex in Batticaloa, it was not recognised

26 There is a severe nutritional emergency when the global acute malnutrition rate in under-fives is over 15% and over 10% with aggravating factors (e.g. an epidemic). UNHCR Handbook For Emergencies Second Edn.

27 Rollins N (2007) Food insecurity—A risk factor for HIV infection. *PLoS Med* 4(10): e301. doi:10.1371/journal.pmed.0040301

as a coping strategy in the food security assessment conducted in 2007.<sup>28</sup>

### 8. Gender-based violence

GBV is reportedly very common and is perceived almost as normal by the assessed population. It is related, inter alia, to poverty, culture and loss of traditional male roles.<sup>29</sup> GBV, particularly domestic violence, reportedly increased during the conflict; this was often related to increased alcohol consumption, which is in turn associated with conflict and displacement. However, this increase could not be verified with the available data. GBV, and particularly sexual violence, is rarely reported to public officials...

One form of GBV that was reportedly strongly associated with the conflict was child marriage. Though the legal age of marriage is 18 years other factors take precedence. Many interviewees associated this increase with the following: the tsunami (separate houses given if married); to escape forced recruitment (LTTE), to escape arrest and detention (SLA); and/o a lack of education services resulting in children leaving

school early. Some interviewees also indicated that marriage was perceived as a way to avoid harassment or arrest by the SLA after returning to cleared areas.

Isolation increases the likelihood of sexual and gender-based violence. In returnee areas women are often alone during the day as their husbands were now having to make their living further away. This was coupled with large numbers of armed males in returnee areas; under these circumstances women reported fear of coerced sex.

### 9. Alcohol misuse and other substance misuse

Alcohol and substance misuse is a major contributor to sexual harassment, forced sex, unsafe sex and gender-based and family violence. In Batticaloa District illicit alcohol is cheap and increasingly accessible as it is being made and sold by more people. It is increasingly an income generating activity for people (often reportedly widows) in some sites.

A number of respondents, including IDP camp leaders, believe that alcohol consumption, particularly but not exclusively amongst young people, has

28 WFP. Sri Lanka Food Security Assessment. Final Report June 2007

29 It was reported by one KI that there was a high sense of dependency developing in some camps – where up to 70% of men do not have regular work.

markedly increased due to the conflict. This was attributed to easy access and lack of other more positive coping mechanisms. In addition to family violence and social problems it was also a contributory factor to breakdown in law and order in communities.

Heroin use through inhalation is occurring in small networks of substance users and is reportedly increasing. One informant reported that his heroin use was associated with casual sex which was often coerced.

Substance use including alcohol is indirectly associated with HIV as it impairs decisions about safe behaviour, including sexual behaviour; in addition the poor availability and low use of condoms means that sex is often unprotected.

#### 10. Lack of correct information on HIV

Knowledge relating to HIV was extremely poor in most groups. This was more so in adult women and men; younger people often had a reasonable level of knowledge. Displacement had increased the availability of HIV-related information for those in camps in Batticaloa due to better access to Ministry of Health services and NGOs. Although interviewees may have been

aware of HIV, specific knowledge was often poor resulting in inadequate HIV prevention practices. Condoms were only seen as a family planning measure and not as a means to prevent HIV and STIs. A significant number of people had never heard of condoms; this may have been in part due to the fact that in former LTTE areas condoms, and indeed all methods of family planning, were discouraged as the policies were pronatalist.

#### **3.1.4. Risks relating to HIV infection**

##### 1. Unsafe / forced sex:

There were reports that transactional sex or sex in exchange for money, goods, services or protection had increased in association with the conflict. Although the team heard this from a number of interviewees it could not be quantified or verified.

Significantly, no female interviewee admitted to engaging in transactional sex herself. Security was cited as a reason that not much is known about sex work as it was perceived to be associated with the presence of the military and police. Again, this could not be verified by the assessment.

Despite the wide availability and

relatively high contraceptive uptake in Sri Lanka, unwanted and unplanned pregnancies still occur. The occurrence of such pregnancies is likely to be more frequent in the northeast where contraceptive uptake is lower than in other parts of the country, which is in turn indicative of poor access to certain reproductive health services. Though abortion is illegal one KI reported that it was a “thriving business” and others reported that demand was high.

Young male informants confirmed that sex work is occurring and believed that it had increased during the conflict. However, it was not possible to talk to sex workers as large scale arrests were occurring during the assessment.

A number of examples of situations where women and girls may be asked to exchange sex for goods or services were given. For example, women have reportedly provided sex to obtain release of husbands from detention, buyers may ask women to provide sex in exchange for purchasing their produce; shopkeepers reportedly ask women for sex in exchange for settling debt; and women or girls staying with host families are required to provide sex in exchange for shelter and basic survival needs.

Sexual violence and forced sex is rarely officially reported but the fear of sexual violence associated with the conflict was raised by a number of interviewees. There is not enough information to say forced sex and sexual violence has increased as a result of the conflict. However, given that forced sex is likely to be unprotected it is associated with an increased risk of HIV transmission. Particular categories of females who were reportedly more vulnerable to sexual violence and abuse were widows and other female heads of households (husbands arrested or detained or travelled abroad), former LTTE recruits, returnee women back in villages that are isolated during the day and young girls aged 13-15.

## 2. Injecting drug use

Injecting drug use is relatively uncommon amongst substance users in Sri Lanka but was reported by key informants to be taking place on a small scale in Batticaloa. There is no information available on sharing of needles and syringes as injecting drug users (IDUs) could not be contacted during this assessment. This group has the potential for being at high risk of HIV infection should injecting equipment be shared. Currently there are no NGO or government

interventions specifically targeting IDUs or substance users. Neither of the two (inhaling) heroin users interviewed were aware of any infection that could be acquired by sharing needles, demonstrating the low level of knowledge regarding transmission of HIV.

### 3. Blood transfusions and infection prevention in health care settings

Given the relatively good state of the health care system the risk of transmission of HIV and other blood borne infections in these settings appears extremely low. However, the conflict has affected the provision of a comprehensive safe blood supply with shortages of blood requiring the use of replacement donors (who are generally considered to be less safe) and no quality assurance for HIV testing in conflict-affected areas.

### 4. Most-at-Risk Populations

Key informants related that MARPs (sex workers, MSM, IDUs) are further marginalised by the conflict due to the strict security arrangements – making them difficult to reach and less likely to seek services.

## **3.1.5 Current response at local level**

### 1. Coordination

At local level the HIV response is seen as falling solely under the health sector; other sectors including education, military and police are not involved in HIV programming. As a result, there is very little coordination between health and other sectors or even within the health sector itself. This is largely due to the highly centralized structure of the NASCP but the conflict has also meant that more urgent and overt humanitarian needs have been prioritised.

### 2. Protection

A number of mechanisms to enhance protection of displaced vulnerable women and children exist. During the recent displacements registration of all IDP families occurred, including those staying with host families. The Probation Officer, with the support of agencies such as UNICEF and ICRC, followed up on separated children and instigated family tracing and reunification. However, there was little assessment of other vulnerabilities at registration and little systematic follow-up of female-headed households, child-headed households or other vulnerable children and no special

measures to monitor their needs if and when identified. There are a few initiatives to enhance livelihoods of female-headed households but the coverage is inadequate; the conflict also interfered with longstanding livelihood initiatives. Post-return was a period of heightened vulnerability for some. Returnee widows in one site reported that no additional assistance was availed to them making it difficult to meet their basic needs and those of their children.

### 3. Sexual and gender-based violence

Many initiatives are underway to prevent and respond to Sexual and Gender-based Violence (SGBV) but their coverage and quality was uneven and sub-optimal. The government plays a marginal role in service provision. The response, particularly to sexual violence, is geared towards prosecution<sup>30</sup> and not care and support; the wishes of the survivors are rarely considered. Health care providers are obliged by law to report survivors of sexual violence to the police, who subsequently interview the survivor. This is a barrier to reporting and care

seeking as programmes cannot advertise or promote confidential services - a cornerstone of quality GBV services. Not all components of the health response to sexual violence are in place: STI prophylaxis is not routine, hepatitis B immunization is not provided and there is no post-exposure prophylaxis for HIV. Psychosocial support is available through the Mental Health Unit.

The strength of NGO programs reportedly lies in awareness raising and advocacy but individual case management needs to be improved.

Young males in one FGD reported that raped women were condemned by the community. Their perception was that rape survivors' only option was to report to the police and that no other services were available. The lack of awareness of available services and the fear of community exclusion - or more serious repercussions - contributes to very low levels of reporting.

International NGOs and UN agencies<sup>31</sup> usually had codes of conduct against sexual exploitation and abuse in place

30 At the same time no successful prosecution of rape in Sri Lanka has been reported since 1995 when new laws were introduced with a minimum sentence of seven years; reportedly judges are reluctant to convict with what is viewed as a hefty sentence.

31 It was not possible to assess to what extent this had been implemented by agencies and how well it was understood by staff

but none of the national NGOs had taken such measures.

#### 4. Prevention

Blood safety is satisfactory. As of mid 2007 all blood units are screened at Batticaloa hospital for HIV, Hepatitis B and C, syphilis and malaria. Other aspects of infection prevention in health care settings were not able to be thoroughly examined. Merlin is supporting the Central Sterilizing Department at Batticaloa Hospital and the hospital did not report any shortage of gloves, needles or syringes in 2007.

#### Awareness/Behaviour Change Communication activities

The Batticaloa STI Clinic conducts community level and institutional level HIV awareness in some sites while limited HIV awareness programs have been delivered to some IDP sites by local clinics. HIV awareness and prevention programming directed to MARPs are almost non-existent. The participation of NGOs, which are the agencies best placed to deliver awareness and prevention programs, is limited. This may be due to a lack of initiative to engage NGOs to address this need.

Information, Education, Communication (IEC) materials in Tamil language are limited in

supply; IEC materials focus on the biomedical facts relating to HIV and poorly address behaviour change or stigma and discrimination. Of note there are no IEC materials to support activities in MARPs.

Condom programming in relation to HIV prevention is almost non-existent. Condoms were available in the STI clinic but these were not readily accessible or promoted except during STI consultations. Pharmacies sell condoms but young interviewees reported that they were shy to approach them. In the family planning service condoms are available through midwives and clinics but the uptake is very low and they are only given to married couples.

#### Voluntary counselling and testing

The only site providing Voluntary counselling and testing (VCT) in Batticaloa is the Teaching Hospital in the STI clinic. They provide services to an average five to ten people per week as either “walk in” clients or provider-initiated (usually due to an STI). The blood is tested using ELISA at the hospital but all specimens are also sent to Colombo; results are received in four to eight weeks. Same-day testing and results provision would encourage a higher rate of return by clients.

A large part of the work of the STI

clinic is syphilis screening and HIV screening as a component of pre-employment medical examinations. Staff providing VCT have not necessarily been trained in pre or post test counselling. No guidelines on HIV counselling were available and little supervision and monitoring of the quality of counselling was taking place. No IEC materials to support the counselling process were present in the clinic. Practitioners often lacked experience in the management of HIV positive persons.

A code is used when the specimen goes to the laboratory but in the register the HIV result is recorded next to the client's name, thus, it is easily associated with that client. Records were kept in a locked cabinet and staff did understand the importance of confidentiality but record keeping did not reflect best practice. Staff also reported that the conflict had affected their work as fewer people came for testing services due to the difficulty in travelling during periods of insecurity.

#### Sexually transmitted infections

STI services are centralized at Batticaloa Teaching Hospital although the majority of STIs are likely to be managed in the private sector. In 2007, 1,233 persons sought services at the STI clinic. Out of these there were

five confirmed syphilis, six confirmed gonorrhoea and five genital warts. There were no management protocols available. It was reported that management was syndromic but the record keeping did not verify this. Condoms were offered as part of the STI consultation but there were no penile models to demonstrate their use. Partner tracing was not systematically conducted. All persons with STIs are offered HIV counselling and testing which reportedly has a high uptake. As monitoring and evaluation were poor it was difficult to assess uptake of services and quality (partners tracing, condom distribution, and referral for VCT etc.).

#### Uniformed forces

Officials of the police or military were not interviewed in Batticaloa. There apparently is no regular HIV education programme for the uniformed forces although the DPDHS office had trained some members of both police and military but this was not a regular activity. Access to condoms for these groups could not be assessed.

#### Post exposure prophylaxis (PEP)

PEP is not available for survivors of sexual assault or in case of occupational exposure of health care workers.

## 5. Care and treatment

There was extreme fear associated with disclosure of HIV status. None of the reported eight cases of HIV from Batticaloa were diagnosed in Batticaloa Hospital or are seeking treatment or other services there.

“If people knew, we would have to leave.” Person living with HIV Batticaloa

Though the hospital clinic has never diagnosed HIV a newly diagnosed HIV positive person would automatically be referred to Colombo for ongoing care, support and treatment. There was no capacity to provide even basic HIV-related services; most services, including antiretrovirals (ARVs), are only available in Colombo. The eight-hour journey is an obstacle to maintaining regular appointments; this is compounded by the expense, insecurity, and frequent check points (where passengers may be searched with the result that persons living with HIV are reluctant to travel with anything that may reveal their status e.g. hospital medical record, IEC materials).

Persons living with HIV (PLHIV) also face economic hardship both due to ill health affecting their employment prospects and the costs associated with travel to Colombo. There is some support

provided for nutrition supplements and travel through the Salvation Army in Batticaloa, and WFP and Lanka+ (in Colombo).

## 6. Surveillance, monitoring and evaluation

The STI Clinic at Batticaloa Hospital participates in the national surveillance system. It should be noted that the conflict-affected north and east was excluded from the national surveillance system from 1993 until 2002. However, a weakness of the surveillance in Batticaloa and indeed in most of the northeast is that there are no data from MARPs; furthermore even though there was no HIV detected in STI patients in 2007 the sample size was inadequate (only 130 people when the target is 500). An attempt was made to compensate for the lack of surveillance data by undertaking surveillance in those seeking pre-employment medicals but, again, this does not give an indication of HIV prevalence in MARPs. Newly diagnosed tuberculosis patients are included in the surveillance system. Given the available information it is not possible to draw conclusions about HIV prevalence in MARPs or the prevalence of behaviours that place people at risk. Other indications outside of formal HIV surveillance include blood donor

data and HIV and AIDS case reporting. The former is not linked with the surveillance system.

STI surveillance is not incorporated into the surveillance system for HIV. For example, screening of antenatal women for syphilis is done routinely at Batticaloa hospital but not reported. The data from the STI clinic in Batticaloa Hospital is not reported syndromically but only on proven aetiology. For example of the 1,233 persons seen at the STI clinic in 2007 a diagnosis is only reported for less than 20 of these and only when a laboratory diagnosis is made. In a low level epidemic the emphasis should be on behavioural surveillance, especially in MARPs, but there are no behavioural data. The existing data collected are not being used in a coherent way that will assist managers and decision makers to monitor the stage of the epidemic and serve as an early warning mechanism. Though this is a nationwide problem it is exacerbated in the northeast due to the chronic understaffing and difficulty in attracting and retaining qualified personnel.

## 7. Capacity Building

There are few NGOs focusing on STI/HIV and none with the capacity to focus on MARPs. Staff working in HIV-related areas may not have the necessary training in counselling and care and support and there is a reliance on services in Colombo. Financial resources are scarce; this is compounded by the fact that funding is linked to staffing and many staff are not willing to come to conflict-affected areas.

## 8. HIV in the Workplace

Though most UN agencies and international NGOs had HIV in the workplace policies in place at global level these were poorly implemented, if at all, in Sri Lanka. Few NGOs or UN agencies had done staff training or had condoms available for staff. No NGOs met had PEP available for staff. None of the national NGOs met had HIV initiatives in the workplace in place.

## **3.2 Trincomalee**

### **3.2.1 General Situation**

Trincomalee District has a population of 412,432.<sup>32</sup> The ethnic composition is: Muslim 41%, Tamil 35%; and Sinhalese

24%. The region has suffered the impact of the long standing civil war between LTTE and the GoSL. As recently as 2006, parts of Trincomalee were under the control of the LTTE. Now the GoSL controls all areas but occasional military incidents occur. The district was affected by the 2004 tsunami with widespread destruction of homes and loss of lives.

The conflict resulted in significant displacement the largest of which occurred in April/May 2006 when up to 40,000 people were displaced within the district. In February 2008, official estimates were that 5,911 people were still displaced. This population is currently in various stages of return to either their place of origin or to an alternate location. It is difficult to determine the population that has left the district for other parts of the country or migrated overseas. Furthermore, it is estimated that over 20,000 people from Trincomalee fled to India as refugees; small numbers (~3,000) of this population have already returned.<sup>33</sup>

Health indicators are thought to

be generally poorer than the national averages but available data does not necessarily reflect this. The infant mortality rate is estimated at 7.5/1000<sup>34</sup> live births (national average 12.0),<sup>35</sup> maternal mortality ratio 92/100,000<sup>36</sup> live births (national average 92),<sup>37</sup> global acute malnutrition prevalence in <5yrs is 23%<sup>38</sup> with a national average of 16%.<sup>39</sup> Measles vaccine coverage is 89.6% in the district, compared to the 95% coverage reported nationally. The mortality rates for the district are facility-based and will not capture deaths that occur outside which may be higher in a conflict zone. Thus, care must thus be taken when comparing with national rates.

Trincomalee has strategic military significance due to its location on the world's second largest deep water harbour, and the presence of a major oil distribution facility, cement factory and flour factory. In addition the area hosts all ethnic groups and is potentially a flash point for ethnic and political rivalries and tensions; 12,000 military personnel are stationed in the district.

33 UNHCR Information Brief 2007

34 Trincomalee District Health services 2007

35 World Health Report 2006 (2004 data)

36 Trincomalee District Health services 2007

37 Reported by WHO 2006 (2000 data)

38 UNICEF Trincomalee, 2007

39 WFP. Sri Lanka Food Security Assessment. Final Report June 2007

### 3.2.2 Overview of HIV and STIs

There are six known HIV positive cases reported from the district. It is notable that these cases were diagnosed elsewhere and no information is available on demographics, risk factors, or mode of infection. The vast majority of STIs are diagnosed and treated on clinical presentation and very few cases are seen in the public health system (just 10 to 15 cases are seen monthly at the STI clinic at the Trincomalee Hospital). Most STI cases (estimated to be approximately 85%), are treated by private practitioners and thus are not captured in the district STI surveillance system.

Approximately 3-4,000 persons are tested for syphilis per year including pre-employment checks and routine ante-natal clinic screening. Patients presenting with any STI are encouraged to test for VDRL. Of those tested in 2007, six were confirmed positive for syphilis.

At the district level resource allocation for HIV is very limited and no funds are specifically allocated by the public sector to address HIV. District health services support the limited HIV activities through the core Ministry of Health STI funding. These activities include sexual health and HIV awareness raising at local schools.

### 3.2.3 Vulnerabilities Relating to HIV Infection

#### 1. Poverty and lack of livelihoods

Following the population's displacement, traditional male roles as the breadwinner altered significantly. The vast majority of displaced or recently displaced men are traditionally farmers and fishermen. Due to security concerns of the government, these sources of livelihood are no longer available as movement is restricted. This also restricts options for men to travel to seek employment. The loss of livelihood was cited as one of the main concerns of many respondents. "There are many trainings by NGOs on hygiene, gender and protection but there are no jobs".

Household income is minimal and most families are mainly or wholly dependent on relief.

Consequently men are often idle and turn to locally brewed alcohol for distraction. A few women have embraced small business opportunities as well as migration to gain employment overseas. Some women, especially single-heads of households, have reportedly engaged in commercial sex, both within the displaced camps or at times in nearby towns.

## 2. Migration

While no accurate figures exist a considerable number of displaced women and some men migrate to the Middle East and other countries for employment. Most of the women work in the domestic sector and many have experienced physical and sexual abuse, some returning with STIs.<sup>40</sup> Men separated from their families are more likely to engage with sex workers and other risky sexual behaviour. The absence of a partner likewise puts the remaining partner at risk with reports of both casual and long term relationships occurring amongst remaining spouses (both women and men); it was reported that men had often remarried after their wives had left for overseas.

## 3. Displacement and the Disintegration of the Family Unit

The fragmentation of family is due to a number of factors including displacement, death due to the conflict, abduction of family members by parties to the conflict and the migration of men or women for economic and security reasons. The absence of men from the family makes women vulnerable to HIV as pressure for sex may come from male members of the community who

perceive these women as available; furthermore women faced with limited economic support may be forced to resort to commercial sex as a means of survival. These women may have limited awareness of safe sex or ability to negotiate safe sex. Intergenerational sex was reported in a number of instances with males in their forties having relations with 16 and 17 year old girls and older women, whose husbands were overseas, having relations with boys and younger males. Rare cases of incest were reported.

There are several instances where families have been separated during flight due to the conflict. In many cases men stayed back in the original location during the first leg of displacement and families moved to a different location; in several cases men remarried, often several times.

## 4. Disruption in Health and Education Services

The conflict has driven nearly half the professional health care workers from the district resulting in inadequate numbers to service the population, especially IDPs in isolated locations. This is seen by district authorities as one of the greatest burdens on the health

40 Personal communication Trincomalee District Health Services

care system secondary to the conflict. In Trincomalee senior staff, at the STI clinic are female and the lack of male staff is viewed as discouraging some male clients from attending. Most district-based clinics have some form of health care volunteers visiting families and providing services such as family planning. However, the level of HIV related knowledge is very low. The small number of male health volunteers further limits the access to information for men. In some rural areas the lack of Tamil speaking health care workers is a barrier to accessing services and information, particularly with regards reproductive health. Insecurity and decreased staff numbers, have limited the hours of clinic operations. Doctors working in the public sector often also maintain a private clinic thus limiting their presence at the public facility. Limited mobility, distance and expense of transport combined with harassment at the multiple security checkpoints discourages and limits the population's access to Trincomalee and its more sophisticated diagnostic and treatment options for STIs as well as VCT for HIV.

Similarly, schooling was interrupted in many areas. One informant reported that in some cases the home guard had been

brought in to teach primary school children. Teachers reported that even after the reestablishment of schools absenteeism was noted to be very high, attributed mainly to the parents disinterest in enforcing their children's attendance. It has also been noted that at times of harvest attendance at school falls dramatically. In other cases the location of a school near a military base was threatening to the children and caused them to not attend school.

#### 5. Alcohol misuse and other substance misuse

It was consistently reported that alcohol was problematic within the community resulting in domestic abuse in more than half the households. While alcohol abuse has always occurred there has been a marked increase associated with the conflict. Alcohol abuse increases vulnerability as it impairs judgment, decision making and increases risk behaviour.

#### 6. Sexual and Gender-based violence

Verbal abuse and violence, including domestic violence, is reported to be commonplace in many communities marked by loud and at times violent quarrels.

Many areas surveyed had, until recently, been under LTTE control. Due to the LTTE's practice of forced conscription of children/youth and a dispensation for those married the phenomenon of early marriage increased. Often children would marry as young as 14 or 15 years. The usual age of marriage prior to the conflict was reportedly 20 years. While some reported that these early marriages have been sustained, more often they are of a limited duration with men having subsequent marriages and young women being perceived as sexually available. Again this change of traditional cultural norms has resulted in multiple marriages (both sequentially and concurrently) and multiple sexual partners increasing the risk of HIV transmission.

#### 7. Lack of correct information on HIV

Specific HIV-related knowledge was poor. While many had heard of HIV, fewer knew how it was transmitted and many others had no information or held significant misconceptions. Some still believed that HIV could be spread by talking or sharing a meal with an infected person.

"HIV can be transmitted even by touching and people with HIV must be isolated from the community".

35 year old male, Trincomalee District

IEC materials were available at times but were not always suitable for those with low levels of literacy, especially rural women. Some had received HIV information by NGOs but coverage was inadequate. One woman stated "foreigners and outsiders have AIDS, so if we control ourselves we can avoid it".

As in Batticaloa condoms were only seen as a family planning measure and not as a means to prevent HIV and STIs. Lack of knowledge increases an individual's vulnerability as they are unable to take the necessary measures to protect themselves.

#### Decreased Vulnerability

Some consequences of the conflict may have reduced vulnerability to HIV. Access and movement during the height of the conflict was strictly controlled thereby discouraging traders and transport workers from visiting.

"The communities were much more insulated than now".

Another factor that may contribute to a reduction in casual sex is the strict documentation of travellers' names in transit and particularly for hotel registration.

### **3.2.4 Risks Relating to HIV Infection**

#### 1. Unsafe sex/ forced sex:

Many displaced communities told the assessment team about sex being exchanged for goods, services or monetary gain. There was an indication that in those communities which were in temporary locations, or in transit, the community experienced a greater degree of social dysfunction (including the occurrence of SGBV) and tended to engage in higher risk sexual activities (multiple partners, transactional sex, and use of sex workers). Those groups who had re-established themselves in or near to their original homes appeared to largely maintain their traditional and thus low risk sexual behaviour.

Sexual activity was often unprotected. Knowledge of condom use was extremely limited in both males and females and the concept of dual protection non-existent. Women reported that as contraception was readily available they were not at risk of conceiving and were free to engage in multiple sexual relations without fear of the consequences. Traditional engendered roles and practices were also evident; most males reported they were not willing to use condoms as it interfered with

their pleasure and that contraception was the woman's responsibility. Thus, the low prevalence of condom use, multiple sexual partners including commercial sex are all significant risks existing in the conflict-affected community for the transmission of HIV. While premarital sex was said to be rare, the occurrence of abortions indicates that some women engaged in unprotected sex and either had no access to or inadequate knowledge of contraception..

While the incidence of rape was reportedly not uncommon it was rarely officially reported. NGOs consistently mentioned the occurrence of forced sex. The low reporting was due to, inter alia, the stigma associated with sexual assault and fear of repercussions. However, one small clinic reported up to 15 cases/year of sexual assault in its catchment area of approximately 14,000 people.

Though not able to be verified by the assessment it was reported that the presence of home guards and uniformed forces has led to an increase in commercial sexual activity; moreover, some military personnel while on leave were reportedly accessing sex workers in centres outside conflict-affected areas. Though relationships with the affected population were

forbidden it was reported by female respondents and key informants that sexual interaction occurred between uniformed personnel and women in the displaced camps. This includes transactional sex and was reported with some frequency. Furthermore, some male IDPs were reported to use the services of sex workers. Clearly with the low availability of condoms and low perception of need, these sexual interactions likely were unprotected and put both the client and sex worker at risk for HIV.

No respondent reported knowledge of male to male sex. Most respondents recognised that male to male sex may be occurring but it is very much hidden as it is highly stigmatised and is still illegal in Sri Lanka. This underscores the challenges in accessing this population with much needed HIV prevention services.

## 2. Unsafe injection practices amongst substance users

Smoking of heroin was reported in a number of FGDs and KII; however it was felt by the community and medical staff that no injecting drug use of any substance was taking place in the district. This is consistent with the low prevalence of injecting reported elsewhere in Sri Lanka.

## 3. Blood transfusions and infection prevention in health care settings

This was not able to be examined in detail but medical personnel relayed that they had been trained in infection prevention methods and that these were strictly practiced. Disposable needles and syringes were standard in all clinics.

### **3.2.5 Current response at local level**

#### 1. Coordination

As in Batticaloa, the HIV response in Trincomalee is largely under the health sector with no comprehensive multisectoral HIV program in place. The highly centralised NASCP, prolonged conflict and competing priorities in public health have meant that HIV has been neglected in terms of both personnel and financial resources. No budgetary support related to HIV is allocated to the District except for limited funding for World AIDS Day and other events, such as school poster competitions prior to the 8th ICAAP in 2007.

#### 2. Protection

The focus of protection programming in Trincomalee is on assisting the displaced population

in IDP camps and in areas of return. Activities include the following:

- Registration and documentation of special needs, protection issues during flight (e.g. human rights violations, loss of documents, possessions, family separations)
- Monitoring and addressing protection concerns in displacement sites and of IDPs living with host families (e.g. physical security, discrimination in the delivery of assistance, pressure to return).
- Monitoring and addressing protection concerns during organized movements such as return processes (e.g. family unity, transportation arrangements for persons with special needs, safety);

Mechanisms to enhance protection amongst the displaced included registration (of all the displaced population), shelter, material assistance to persons with specific needs and non-food items. A number of NGOs provide assistance to female headed households mainly in the form of livelihoods promotion but it was difficult to assess the coverage or the impact of these initiatives.

Family tracing and reunification of separated children was carried out by ICRC and UNICEF.

However, there were no specific measures to ensure that women/girls and unaccompanied children had access to relief items and food and little monitoring of the needs of separated and unaccompanied children once identified. Although there were few unaccompanied children as these were absorbed by others (grandparents, extended families) children that are in foster care are still very vulnerable to exploitation and abuse and need to be identified and monitored.

Codes of conduct prohibiting sexual violence and exploitation are in place in UN agencies, most international NGOs but few national NGOs. However, it was not possible to determine the level of knowledge of staff relating to the code of conduct or how effectively the code was implemented.

### 3. Sexual and gender-based violence

Measures to prevent and respond to SGBV are patchy and of variable quality. As elsewhere in the country the emphasis is on prosecution, particularly for sexual violence, and not care and support of the survivor. Standard operating procedures (SOPs) for

prevention of and response to SGBV are being established by UNHCR in Trincomalee and other districts. There is an identified need to build a prevention and awareness strategy at local level in IDP sites and return areas. The SOPs are at a preliminary stage and considerable work needs to be done to ensure that they are further developed and integrated into a broader protection monitoring strategy. In particular there is need to strengthen capacity of agencies at field level to improve service standards and accountability.

#### 4. HIV Prevention

Prevention of HIV transmission activities to date has been limited in scope.

##### Infection prevention in health care settings

Blood donations in the hospital are screened routinely for HIV, hepatitis B (not C), syphilis and malaria. No donated blood has been found to be HIV positive. Single-use syringes or auto disable syringes are in use both in the Trincomalee hospital and district clinics with appropriate sharps containers available for subsequent incineration. Approximately 20% of blood was still obtained through replacement donors; all donors

completed a screening questionnaire.

##### Awareness raising/Behaviour change

Primarily activities have focussed on raising HIV awareness. This activity has been through initiatives of the STI and divisional clinic managers visiting schools. There are a few NGOs working in HIV, however, their coverage is limited geographically and in scope and the level of awareness remains generally poor. In particular transitioning from awareness to promotion of behaviour change is weak. Condoms as a means of HIV prevention are poorly addressed.

No specific preventive initiatives target MARPs, such as sex workers or MSM. The military receive some information and education on HIV prevention during induction training; though written IEC materials are provided ongoing HIV prevention activities are limited to provision of condoms when going on leave.

To observe World AIDS Day, a poster competition is coordinated by the STI Division of the District Health Services but there are no coordinated efforts between these agencies and government.

A critical obstacle to raising awareness and education

regarding HIV prevention is the society's conservatism and reluctance to discuss sex and sexuality. A further fundamental obstacle to dissemination of information on prevention is the limited awareness and understanding amongst some of those most needing to be equipped with the knowledge, namely teachers and health care workers.

### Condom Programming

All public health clinics reportedly have condoms available free of charge but these may not be in a discreet location where they may be easily accessed in privacy by men and women. Condoms are not a popular method of contraception being the sixth most used method.<sup>41</sup> Within family planning services condoms are only made available for married couples. Unmarried women who obtain condoms from a pharmacy are discouraged by the negative reaction generated as it is against social norms. Despite the availability of free condoms at clinics, without the necessary associated behavioural change activities including counselling, use of condoms remains extremely low. The uniformed forces have made condoms available to personnel when

departing on leave. This, however, should be accompanied by ongoing education on HIV prevention.

### VCT

There is only one location in Trincomalee district where VCT is available and this is at the STI clinic on the hospital premises. Reportedly no clients come specifically for an HIV test. Clients who report for an STI are given the option to test and some pre-employment HIV tests are conducted.

To date no HIV positive cases have been detected through VCT or pre-employment screening, although only approximately fifteen tests are performed each quarter. Tests available for HIV testing in Trincomalee are rapid diagnostic tests and latex agglutination methods. A positive result found on screening would be confirmed in Colombo with Western Blot and Elisa, but these confirmatory tests have never been required. The results should be available from Colombo within two weeks and communicated by telephone. For reasons of anonymity many individuals choose to test outside of Trincomalee for both STIs and HIV.

41 Trincomalee District Health Services Fourth quarter Family Planning Report 2006

In addition it was reported that all uniformed forces deployed for overseas duty are screened for HIV on deployment and return.

#### Post exposure prophylaxis for HIV

As in Batticaloa post-exposure prophylaxis for HIV is not in place for occupational exposures or survivors of sexual violence. In the occurrence of a needle stick injury patients from whom the needle or instrument came will be tested for HIV, and Hepatitis B. Should there be a need for any treatment the staff member would be referred to Colombo.

#### 5. Care, Support and Treatment

Although there are six persons with HIV known to be from Trincomalee District none of these were diagnosed in Trincomalee nor are they accessing any HIV-related services there. The fear of stigma and concerns over lack of confidentiality mean that people prefer to access services in Colombo. Again, with many competing demands and budgetary limitations it is understandable that ARV therapy has not been decentralised. A Colombo based NGO, Lanka Plus, is reported to provide cash assistance and income generating opportunities to PLWH as well as facilitate travel to

Colombo when required. Measures are needed to establish social and health services for PLWH which will be confidential, appropriate and complementary to services provided in Colombo.

#### 6. Surveillance, monitoring and evaluation

Many of the observations made in Batticaloa are also relevant to Trincomalee and will not be repeated here. Of note the military reported that up to two hundred personnel were recently tested randomly and anonymously as part of a sentinel site survey. The HIV prevalence was reportedly 0% but again this sample size is too small for a low prevalence setting.

## 4. Discussion

The longstanding conflict in Sri Lanka and resultant large scale displacement has strained the coping mechanisms of both the population and the government, which, in a number of ways, has heightened the vulnerability of the population to HIV. Key factors, including the lack of livelihoods and subsequent poverty, disintegration of the family unit and traditional community support structures have led many to resort to negative coping mechanisms, some of which expose them to the risk of HIV. Generally, female heads of households more easily exhaust coping strategies that provide for the essential needs of their family and allow them to live with dignity; as a result women and girls are vulnerable to sex work or transactional sex to meet their needs. Specific measures are needed that provide for the safety and economic security of women and girls to enable them to make choices that are not generated out of fear or lack of alternatives. Programmes to prevent GBV and opportunities for income generation need to be availed to the most vulnerable as a priority.

The proximity of large numbers of uniformed personnel further exacerbates HIV-related vulnerability as it creates greater demand for sex work. Yet uniformed personnel are not being adequately reached by HIV prevention services. Increased civil-military interaction also means mixing of populations with different levels of risk of HIV transmission; though the impact of this on HIV prevalence in a low prevalence setting is likely to be minimal, it underscores the importance of comprehensive HIV prevention measures in uniformed personnel.

Problems relating to substance use, including alcohol, are prevalent in many conflict-affected populations and have received increased attention of late. Abuse of readily available home brewed alcohol was associated with an increase in domestic and community violence. Alcohol misuse indirectly heightens the vulnerability of affected individuals and families by impairing decision making and

leading to risk taking behaviour, promoting sexual and domestic violence and straining families' economic resources. A concerted effort should be made to address the harms associated with alcohol use in this population.

Though direct experience of sexual violence or forced sex was not admitted by any interviewee it was commonly reported as happening to others. Although it was not possible to verify the frequency of these reports is cause for concern. The government, international and national actors need to urgently develop a response that not only provides for legal recourse for a survivor, if they wish, but also includes comprehensive medical and psychosocial care as well as protective mechanisms to prevent and mitigate the occurrence and effects of all forms of gender-based violence.

Another factor increasing the conflict-affected population's vulnerability to HIV is the external migration that has been exacerbated by the conflict. Men travelling and working overseas are more likely to engage with sex workers or in casual relationships, while female migrants are at risk of sexual exploitation and abuse. Special efforts are required to equip these migrants with knowledge and skills to reduce their risk of HIV and greater legal

safeguards are needed to protect women.

A small number of refugees have already returned from Tamil Nadu in India, a state that is experiencing a generalised HIV epidemic. Returnee refugees generally had a higher level of knowledge compared to those that did not leave but there were still significant gaps and it appears they had limited access to HIV-related services whilst in India. Nevertheless, there is no evidence that this population has a higher HIV prevalence than those who remained.

In Batticaloa HIV was seen more as a problem or threat from "outside"; there was a strong belief that returning overseas workers are the single and most prominent source of HIV and STI in Sri Lanka. A culture of blame is developing that is stigmatizing overseas workers. While this view was not widely expressed in Trincomalee it emphasizes the need for improving knowledge and awareness of HIV prevention in a way that is not stigmatising and promoting rights-based approaches.

Related to this, a major obstacle to uptake of HIV-related services is the perception of no or low threat to the individual. In a low prevalence setting this is justifiable for many people, but

this attitude may be compounded in a conflict zone where the risks and consequences of acquiring HIV are small compared to the threat of violent injury or death. Furthermore, promoting behaviour change to reduce HIV risk and initiatives to strengthen community resilience are challenging in a population where many often feel they have lost control of their own lives. Even if these contextual dynamics change in the future these attitudes will likely persist for some time.

In some regards the conflict may have been protective against HIV. Those displaced from rural areas to towns reported better access to health care and education. Displacement had increased the availability of HIV-related information for those in camps in Batticaloa due to better access to Ministry of Health services and NGOs. Due to the security restrictions the population had less mobility, thus reducing opportunities for engaging in risk behaviours such as contact with sex workers. Similarly, there was a decrease in the numbers of transport workers who in many settings have been identified as an at-risk population facilitating the geographical spread of HIV.

To ensure that HIV is effectively addressed comprehensive HIV prevention activities in most-at-

risk populations are a priority. Of note is that in both districts there are no targeted activities for MARPs and the few activities that are being conducted amongst sex workers are not comprehensive. There is limited capacity amongst NGOs and MoH to reach MARPS but this should be prioritized. NGOs are better placed to reach more marginalized populations but to date there has been little effort at local level to engage NGOs in the response.

Finally, post-conflict the HIV vulnerabilities may change and, in some ways, increase. Increased mobility of, and access to, the affected population, opening up of transport networks and improved incomes are some of the factors that may influence HIV vulnerability in this phase. More effective interventions now will help to address heightened vulnerability in the post-conflict phase. Stakeholders need to be prepared for this changing context and be able to respond appropriately to new dimensions of HIV vulnerability and risk.



# 5. Conclusion and Recommendations

The assessment has contributed to increased understanding of the vulnerabilities and risks to HIV in the conflict-affected communities of eastern Sri Lanka. Although the north was not able to be accessed, and caution must be exercised in generalising the findings, many of the recommendations below would also be relevant in other conflict-affected areas of the country.

## 5.1 Recommendations

### 1. Policy and Strategy

- Ensure that the vulnerability of conflict-affected populations (including IDPs and returnees) is recognised and specific activities are taken to address this in the operationalisation of the National HIV Strategic Plan 2007-2011.
- Even in a low prevalence setting HIV needs to be integrated into the humanitarian response; the IASC Guidelines on HIV/AIDS Interventions in Emergency Settings provide

guidance on minimum interventions.

- Sector leads (cluster leads where applicable) should ensure that HIV considerations are incorporated into their sector's response to humanitarian emergencies involving IDPs.

### 2. Coordination

- A regional level STI/AIDS Committee needs to be established to mirror the national structure to oversee and develop strategies to address all aspects of HIV programming.
- The GoSL through the NASCP should ensure that senior level membership of the NAC is extended to the following sectors; uniformed services (including military and police); education; civil society (including youth groups and NGOs working in the North and Eastern provinces) to ensure there is a multi-sectoral and interagency approach to HIV.

### 3. Protection

- UNHCR, UNICEF and other protection actors should systematically monitor and address the needs of vulnerable women and children (access to relief, income generation, and protection from sexual exploitation and abuse).
- Refocus the prevention and response to SGBV so that the wishes of the survivor are respected and the principle of confidentiality is paramount; this will require a review of the national law that makes reporting of sexual violence in adults by health care providers mandatory.
- UN agencies need to ensure that the Code of Conduct against Sexual Abuse and Exploitation is known and understood by all staff including implementing partners and that conflict-affected communities are aware of their rights and the reporting mechanisms for violations.
- All NGOs should adopt and implement a code of conduct against sexual abuse and exploitation and ensure all staff members and sub-contractors are aware of it and their obligations.

### 4. Prevention

#### Most at risk Populations

- The NASCP should introduce and scale up HIV prevention activities in MARPs as a priority
- As civil society are much better placed to reach MARPs the technical and resource capacity of NGOs and CBOs (including access to donor funds) needs to be strengthened as a priority. This is particularly necessary in conflict-affected communities where security measures and high levels of stigma hamper access to these populations.

#### Migrants

- Integrate comprehensive HIV awareness including provision of IEC materials into a pre-departure orientation for male and females going overseas to work.
- The government should enact legal safeguards with recipient countries to protect migrants from exploitation and abuse.

#### Uniformed personnel

- HIV and STI prevention in uniformed personnel (military, police, special forces) needs

to be systematised and regular, including access to confidential, quality sexual health services, information and condoms.

#### General Population

- Re-orientate HIV awareness in the general population to focus on messages that aim at reducing stigma and discrimination and avoid blaming HIV on particular groups. Target community and religious leaders in recognition of their key role in determining attitudes and behaviours

#### General measures

- Ensure greater availability of condoms and ease of access to condoms at no or low cost especially for at risk populations.
- Introduce sexual health information from a broad range of sources including more diversified IEC material in Tamil that will also be accessible to those with low or no literacy through a variety of media, including radio, films and drama.
- Ensure strict standards of confidentiality within STI services and highly trained counsellors to provide VCT.

- Include the northeast in the national quality assurance scheme for laboratories providing HIV testing.
- Improve STI management, including using a syndromic approach (which can still be supported by laboratory diagnosis), prevention counselling, and partner tracing and treatment.
- Given the role of the private sector in treating males with STIs, consider the use of social marketing for management of sexually transmitted infections in males. Lessons could be learnt from successful use of this model in India.

#### Sexual violence

- The clinical response to sexual violence needs to be comprehensive and should include emergency contraception, hepatitis B immunization, STI prophylaxis and post-exposure prophylaxis to HIV. Relevant government and UNFPA representatives should be included in the regional Clinical Management of Rape Training organised by UNHCR and supported by UNFPA to be conducted in Thailand in June 2008.

## HIV in the Workplace

- Provide staff of humanitarian agencies with condoms and HIV prevention information. More comprehensive interventions can be implemented once the situation stabilises.

### **5. Care, treatment and support**

- Train a small core group of health care workers in each district, including those working in STI clinics and key reproductive health staff to be able to manage HIV infection and its consequences confidentially, in privacy and competently. This will foster confidence in local services and help to reduce stigma and possible discrimination amongst health care workers towards PLWHs.
- Decentralise some aspects of care and support of PLWH though ARVs could continue to be provided in Colombo. Consult with PLWH in conflict-affected areas through Lanka Plus to determine the most useful services and mode of provision that could be provided locally in an acceptable and accessible manner. Possibilities include identifying NGOs or CBOs at district level to provide

treatment adherence support, livelihoods initiatives, psychosocial support, positive prevention, link with services in Colombo and be an ongoing source of information about HIV for PLWH. These should not be HIV specific NGOs to avoid singling out people who access services. Local support networks of PLWH could be initiated once confidence in services is established.

### **6. Surveillance, monitoring + evaluation**

- Prioritise the collection and use of HIV-related programmatic data at local level. In particular data relating to access, uptake and quality of services such as STI management, and HIV counselling and testing needs significant strengthening.
- In terms of HIV surveillance, behavioural and biological data is urgently needed in MARPs. Once a mapping and population size estimation of MARPs has been conducted, consider respondent driven sampling as a means to collect these data in conflict-affected areas due to the particular challenges.

- Improve surveillance and reporting of STIs (i.e. by disaggregating according to syndrome).
- Establish a mechanism to monitor patterns of substance use as an early warning of a shift to injecting and a subsequent escalation in HIV risk amongst substance users.

## **7. Alcohol Misuse**

- Conduct a rapid assessment relating to alcohol use and other substances amongst conflict-affected populations to better determine the magnitude of the problem, its determinants and consequences and develop a response to address the harms associated with alcohol. The Rapid Assessment of Substance Use in Conflict-Affected and Displaced Populations tool jointly developed by UNHCR and WHO could be adapted and used. WHO could take the lead on this in Sri Lanka.

