Presidential Address 2008

Defining A National Response to HIV

Weerasinghe G[1]

Our Chief guest, Prof. Savithri Gunasekara, Guest of honour, Dr. Beng Goh, Past Presidents, Fellows of the College, members of the Council, members of the College and distinguished invitees.

In my address at this solemn inaugural ceremony of the 13th Annual Scientific Sessions of the Sri Lanka College of Venereologists, I hope to discuss briefly the situation of HIV/AIDS in Sri Lanka and the Sri Lanka response to the challenge posed by the epidemic of HIV/AIDS. My discussion here can be considered as a preamble to the 13th Annual Scientific Sessions and I will try to be fair by the entire spectrum of professionals present in the audience.

Since the detection of the first case of AIDS in USA in 1981, mankind has been living with the ever growing challenge posed by HIV/AIDS. What are the many challenges raised by HIV/AIDS?

It is a health challenge

It is an economic challenge

It is a social challenge

It is a political challenge

It challenges the mere existence of mankind on earth.

Am I exaggerating? I don't think so.

World situation

Le us see briefly the world situation regarding HIV/AIDS. In the year 2007, the estimated number of people living with HIV in the world was 33 million (30-36million) and the majority are in Sub- Saharan Africa.

Africa

Africa is the continent most affected by HIV /AIDS in the world. The prevalence of HIV in most of Sub-Saharan countries is between 5-30%. Some of these countries have experienced a decline in the life expectancy at birth by nearly 50% compared to what it was in the early 1980s. Economic growth rate has also fallen, for example, the per-capita Gross Domestic Production (GDP) in Zambia has come down from US$ 505 in 1980 to US$ 370 in 1999. The HIV epidemic has had a devastating effect in Africa.

Asia

The second worst affected region by HIV epidemic is Asia. Though the prevalence rates in Asia are low, the absolute numbers are very high. In 2007, an estimated 4.9 million people were living with HIV in Asia. Since it first appeared in the region, approximately 2.6 million men, 950,000 women and 330,000 children have died of AIDS related diseases.

Sri Lanka

Let us review the epidemiology of HIV infection in Sri Lanka very briefly. Since the 1st case was detected in 1986, the total number reported by the end of 3rd quarter of 2008 was 1029. As against the reported numbers of people living with HIV in Sri Lanka, the estimated number ranges between 3800 to 4000 and the adult prevalence is < 0.1%.

Among the reported cases, nearly 84% of persons have acquired HIV through heterosexual contact and 11% through homosexual /bisexual contacts, totaling to 95%, who have acquired HIV through sexual exposure. The majority (80%) of them are in the 15-49 year age group. What has been evident from the reported data is that more women are being detected with HIV infection throughout the years. This may either be a true increase in infections among women or be due to increased testing and reporting. Though the majority of HIV infections have been reported from the Western province, patients have been reported from all districts of the country and from all walks of life

Therefore, I would like to emphasize the fact that HIV is not a problem distant from us and is very much closer than commonly understood to everyone in the society.

[1]*Consultant Venereologist, Colombo South Teaching Hospital, Kalubowila.*

National response

The major question I am attempting to discuss here is the national response to the HIV epidemic in Sri Lanka. Sri Lanka has been classified as a low prevalence country (that is <1% in general population and <5% among high risk groups) or a country in the latent stage of the epidemic, according to the newer classification of the HIV epidemic in Asia.

Therefore, what should be the best possible response to the HIV epidemic in this country?

The best response should take into consideration certain criteria and understandings based on evidence. Firstly, I wish to emphasize here, that while we are in a low prevalence or latent stage of the epidemic, the generalized or mature epidemics have created devastation in other parts of the world, including in some Asian countries. What is important to understand is the **WINDOW of OPPORTUNITY** that we have been provided with to deal with the problem. How best can we use this window of opportunity?

It is evident that the response should be urgent. It is true that we have to have medium term and long term objectives and activities to achieve those objectives. But to turn back the tide of the HIV epidemic, we have to think of an urgent response which is best fitting to the above mentioned window of opportunity. For example, the promotional activities aimed at school children, general awareness programmes etc. are necessary and should be a part of the overall response. But I am certain that you will agree that we need to use the window of opportunity to address issues that will stop or slow down the epidemic **NOW** without depending only on programmes that may take 10-15 years to show results.

The response should be effective and evidence based. The available data do not suggest the possibility of expansion of HIV epidemic through injecting drug use in Sri Lanka, where 95% patients have acquired HIV through unprotected sex. This is important evidence - that HIV transmission takes place among Sri Lankans mainly through unprotected sex in heterosexual or homosexual contacts. Since HIV is transmitted mainly through unprotected sex, it is worth examining the available evidence about the sexual behaviours of Sri Lankans.

Sexual behaviours among Sri Lankans

Human sexuality is complex and people have varying views and value systems around sexual matters and morality throughout the world. Whenever human sexuality is being discussed, a question that arises frequently, is how frank are we and how far we are/ or can be open about such matters. We often like to or pretend to think that sexuality is something related to Western cultures and the people in the East are distant from sexuality.

In my view this is one major denial not only by the Sri Lankan society at large, but even to some extent by the medical profession as well. I would like to draw your attention to some historical facts which may be helpful to understand the extent of sexuality of people in the Eastern world. The 'Kama Sutra', an ancient Indian text on human sexual behavior written hundreds of years ago, in 'Maha Baratha', is a clear example. Kamasutram, generally known to the Western world as Kama Sutra, is widely considered to be the standard work on love in Sanskrit literature. The text was composed by Vatsyayana, who is believed to have lived sometime between the 1st to 6th centuries AD. The historical sculptures and paintings depicting human sexuality are seen at many places in India. The 'Isurumuniya lovers' and 'Sigiriya Frescos' are some historical evidence of artistic impressions of sexuality found in Sri Lanka. Therefore, sexuality is not alien to people in this part of the world. I now hope to present briefly some data which is relevant to understanding the sexual behaviours of different segments of our society.

STD clinic attendees

The first group that I wish to present is attendees to Sexually Transmitted Diseases clinics.

The average number of partners per attendee during last 12 months among those who attended the Central STD Clinic in Colombo and the STD Clinic Ragama

between 1st January and 30th March 2008, are given in Table 1.

Table 1 - Average number of partners/ male and female attendees of the Central STD Clinic and the Ragama STD clinic

	Per male attendee	Per female attendee
Central STD clinic	2.06	1.31
Ragama STD clinic	2.14	1.04

Female attendees below 16 years (age of consent), female sex workers and incomplete data were excluded.

Behavioural Surveillance Survey findings

Let us go through the results of the Behavioural Surveillance Survey, conducted in 2006 and 2007. Three wheel drivers, male drug users and Free Trade Zone (FTZ) male factory workers Average number of partners per subject of given category of sample during last 12 months are given in Table 2.

Table 2 - Average number of partners by type reported by three wheeler drivers, male drug users and Free Trade Zone male factory workers

	Three-wheel drivers N= 1444	Male drug users N=779	Male factory workers, N= 1325
Average number of regular female partners	0.8	0.5	0.5
Average number of non-regular female partners	0.5	0.7	0.13
Average number of commercial female partners	0.5	0.7	0.2

Among female factory workers (n= 1563), the average number of regular and non- regular partners during last 12 months was 0.3 and 0.01 respectively.

Beach Boys

The real size of the beachboy population is not known, though it is estimated to be about 30,000. By definition, they are sex workers. Traditional thinking is that they sell sex to foreign male tourists. Let us examine the BSS findings.

Table 3 shows the average number of partners per BeachBoy (n = 553) sampled in Gampaha , Colombo, Kalutara and Galle during last 12 months

Table 3 - Average number of partners per Beach Boy (n = 553) sampled in Gampaha , Colombo, Kalutara and Galle

	male partners	female partners
Percentage of beach boys who had sex with	45.4%	81%
Mean number, local partners	0.6	1.2
Mean number foreign partners	2.0	3.1
Mean number of regular	0.2	0.7
Mean number, non-regular	2.2	3.6

While average numbers of foreign male and female partners per beach boy were 2.0 and 3.1, the average number of non-regular male and female partners per beach boy were 2.2 and 3.6 respectively during the reporting period.

The average number of male partners with whom beach boys had insertive and receptive anal intercourse during last 12 months were 1.3 and 3.1 respectively.

This evidence challenges the traditional view that beach boys are homosexuals , as the data shows that in reality, Beach Boys are active bisexuals .

Men having Sex with Men (MSM)

Table 4 shows the finding of BSS on average number of partners reported by 302 men who reported having sex with men (MSMs).

Table 4 - Average number of partners per MSM (n= 302)

	Anal sex with male partners	Sex with female partners
Percentage of MSM had	92.4%	23%
Mean number of regular partners with whom MSM had,	0.9	0.2
Mean number, non-regular partners with whom MSM had,	8.8	0.3

While the average number of male partners with whom MSMs had insertive and receptive anal intercourse during last 12 months were 7.5 and 10.0 respectively, the average number of non-regular partnerswas 8.8 per MSM duringlast twelvemonths..

Female Sex Workers

Table 5 indicates the average number of paying male clients per FSW (n=1094) reported on the last day worked by female sex workers in different locations.

Table 5 - Average number of paying male clients per FSW (n=1094) reported on the last day worked by female sex workers by category

Category of Female Sex Workers	Average number of paying male clients on the last day worked
Brothel (N=303)	3.3
Street (N=498)	2.3
Massage parlour (N=179)	2.4
Karaoke bar (N=74)	1.6
Casino (N=40)	1.7

In addition to paying clients, all categories of FSWs hadsex withnon-payingand involuntary clients during the reporting period.

Clients of sex workers

Clients of sex workers are a category that has to be discussed here. There are some questions about them that we have to find answers to, such as:

1. Who are these clients?
2. Where are they coming from?
3. What are their absolute or estimated numbers ?
4. Do they engage in casual sex in addition to having sex with sex workers ?

It seems that men who buy sex from women, far outnumber the insignificant numbers of injectingdrug users in Sri Lanka, and MSMs, and beach boys even after considering them together.
Table 6 provides estimates for high risk populations

Table 6 - High and Low Estimates estimates for high risk populations* +

Category of High Risk Population	Population size estimate	
	Low	High
IDU	800	7260
MSM	41250	123750
FSW	4800	7200
Male clients of FSWs	96250	288750
Ex-clients of FSWs	154000	462000
Beach boys	-	30,000
Total of HRP	297100	918960

* Key : IDU – Intravenous drug user ; MSM – men who have sex with men ; FSW – Female sex worker;
+ Source - Estimation and Projections, NSACP/UNAIDS/ WHO/2007

Taken together, it is estimated that 300,000 to 1 million sexually active adults practice high risk sexual behaviours. Casual sex is not considered here.

The fundamental conclusion that can be arrived at from this evidence is that, though there are differences with western cultures, the sexual activities seem to be very high in different population groups in this country. It is reasonable to assume that nearly one million of sexually active adults may be included in those groups.

Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections are another dimension that reflect the level of high risk behaviours that exist in society.

The association between STIs and HIV is well documented and understood. STIs facilitate both acquisition as well as transmission of HIV infection. Therefore, the treatment, control and prevention of STIs are fundamentally important for the control and prevention of HIV infection. I would like to discuss briefly about the STIs situation in the country.

If we go through the distribution of major STIs by age groups from 2003 to 2007 as shown in Table 7 , it is clear that the most affected age groups is between 15 to 44 years. The data also indicate that viral STIs have over taken bacterial STIs (National STD/AIDS Control Programme data).

Table 7 - Major STIs 2003 -2007 by age

	0-14 yrs	15-24 yrs	25-34 yrs	35-44 yrs	45+ yrs	Total
Syphilis	28	1541	2054	542	213	4378
Gonorrhoea	80	4607	5638	1510	577	12412
Genital herpes	108	6302	7692	2052	790	16944
Genital warts	216	12604	15384	4104	1580	33888
Total	432	25054	30768	8208	3160	67622

The major bacterial STIs (syphilis and gonorrhoea) show a declining trend throughout the years under consideration. The major viral STIs, namely genital herpes and genital warts show an increasing trend.

STD clinics throughout the country have diagnosed 10153, 10268 and 9496 new episodes of STIs in years 2005, 2006 and 2007 respectively. We know that these data reflect only the tip of the ice-berg while the greater part of the ice-berg remains hidden. The annual estimates of new episodes of STIs are between 60,000 to 200,000.

While recognizing the important contribution of the well organized STD services in the country under an excellent team of professionals providing dedicated

leadership in keeping HIV at a low prevalence or in latent epidemic status, the prevalence of STIs indicates to us that Sri Lanka is vulnerable to an explosion of the HIV epidemic. I would like to emphasize only one fact here. The figures of STIs are clear evidence of the extent of risky behaviours that people practice, namely unprotected sex..

In Sri Lanka, HIV transmission is driven primarily through unprotected sex be it commercial or casual, heterosexual or homosexual. When one considers sex trade/sex activities whether by FSWs, male sex workers, MSM, or Beach Boys, the key factors that facilitate the HIV transmission are:

1. the proportion of men who visit female sex workers,
2. client/partner turnover and,
3. levels of condom use.

Once the virus is introduced into these different networks of people (sex industry of both female and male, MSM, BB), infection levels can rise rapidly among members and thereafter move to the general population. Higher the proportion of men who buy sex, and higher the client / partner turnover, higher are the chances of acquisition and transmission of HIV infection.

Condom use

The level of condom use is an important dimension that has to be looked into. It is worth going through the findings of BSS to understand this aspect.

Table 8 shows that Except for male factory workers and three wheel drivers with commercial partners, condom use among them with non-regular partners and male and female drug users with regular , non-regular and commercial partners is low.

Table 8 - Summary of conodom use for vaginal intercourse every time in the previous 12 months

	With regular partners (% frequency)	With non-regular partners (% frequency)	With commercial partners (% frequency)
Three wheel drivers	2.3	31.2	64.8
Drug users (male)	1.1	18.8	47.4
Drug users(female)	0.0	9.1	50.0
Factory workers(male)	4.4	28.3	81.8
Factory workers (female)	2.0	-	-

Table 8 shows that Except for male factory workers and three wheel drivers with commercial partners, condom use among them with non-regular partners and male and female drug users with regular , non-regular and commercial partners is low.

Table 9- Summary of condom use for vaginal intercourse every time in the previous 12 months - FSWs

	With paying clients (% frequency)	With non-paying partners(% frequency)
Brothel	62.9	9.8
Massage parlour	70.4	4.2
Street	81.9	11.7
Karaoke	62.5	2.4
casino	39.4	4.8

As seen in Table 9, while the condom use among sex workers in casinos with clients was not up to the needed level, it was extremely low among brothel, massage parlour, street, karaoke and casino based sex workers with their non-paying partners.

Table 10 shows that while the beach boys and MSMs have high numbers of partners, condom use among them was extremely low with both female and male partners.

Table 10 - every time condom use of Beach Boys and MSM - in the previous 12 months

	For vaginal sex		Male to male anal sex	
	With regular partners(% frequency)	With non - regular partners (% frequency)	With regular partners(% frequency)	With non-regular partners(% frequency)
Beach boys	4.8	47.2	21.6	45.9
MSM	18.2	36.1	25.9	46.5

In summary, while the so-called Most At Risk Populations (MARPs) such as different categories of female sex workers, male sex workers including beach boys and men having sex with men have high partner turn-over rates, condom use was low. According to estimates, the proportion of men who buy sex also seems to be considerable. Evidence indicated that migrant workers were also increasingly vulnerable in environments they were employed in other countries and especially those who were engaged in unskilled work in the Middle-Eastern countries.

Therefore, in order to use the window of opportunity that has been provided, to turn back the tide of HIV epidemic in Sri Lanka, what is needed urgently is the implementation of the single most effective intervention – which is the promotion of consistent use of condoms among groups mentioned above namely FSWs and their clients, MSMs, Beach Boys **(**and migrant workers**).**

While I have no intention of discussing the various aspects of implementation of condom promotion intervention I would like to draw your attention to one dimension of the proposed activity. And that is the importance of an enabling environment. While health care services and relevant stakeholders are trying to promote condoms, certain other arms of Government are doing exactly the opposite. Again let us see the findings of BSS.

About 33.2% of street based sex workers and 9% of brothels based sex workers have been harassed by police for carrying condoms.

I vividly remember what was said by a South African judge who came to Sri Lanka for the International Conference on Aids in Asia and Pacific (ICAAP) in August 2007. He said that the moment he touched Sri Lankan soil he became a criminal because sex between two consenting adult males is an un-natural and punishable offence according to legal provisions in Sri Lanka.

In my view, certain legal provisions drive some of this high risk groups into hiding, making them inaccessible to health care delivery systems though they are still accessible for their clients. Some groups have been marginalized by the law for no fault of theirs, but because of their sexual orientation which is a biological phenomenon beyond a person's control. Such groups do not like to be identified since their behaviours have been labeled as unnatural or otherwise. The sexual preferences and sexual orientations are person-specific and the scientific world does not see anything un-natural in having sexual relationship between two consenting adult males or females.

The commission on AIDS in Asia in it's report titled 'Redefining AIDS in Asia' recommends that, 'legal provisions should not hamper or disrupt efforts to control or treat HIV. Rather than trying to address HIV risk and transmission among groups at risk as a legal issue, health enhancing services should be made available or improved. Governments should remove legislative, policy and other barriers to strengthen their access to services. They may also issue legislative and/or administrative directives to police, correctional, and judicial services to facilitate the provision of HIV related services to people most at risk'.

I am happy today to have a brilliant legal professional, an Emeritus Professor of Law as our Chief guest. May I propose that the medical and legal professionals – the Sri Lanka College of Venereologists and the Bar Association of Sri Lanka together study all relevant legal provisions and make necessary recommendations for the consideration of Government of Sri Lanka.

Empirical evidence has shown that if interventions reach at least 80% of the target population, the programme induces behaviour change in at least 60% leading to exceeding the minimum level needed to reverse the HIV epidemic's upward trend. The effect of condom promotion on the HIV epidemic has been proven beyond any doubt in Asia and else where in the world. Thailand, Cambodia, some parts of china and India are examples closer to us.

It is well proven that in Thailand, by implementing the 100% condom programme, the number of STI cases came down significantly. The HIV annual incidence also decreased from 150,000 in 1990s to 15-18 000 new cases in 2005.

Promotion of condoms should be a part of a comprehensive package centered around that single most effective intervention. Other interventions without this essential component will be of little use in turning back the tide of HIV epidemic. We have to be guided only by scientific evidence and nothing else.

In summary

1. Though Sri Lanka is in a low prevalence or latent epidemic level of HIV infection, it has a significant potential for the expansion of epidemic.

2. That potential has originated from the sex industry which comprises sex workers and their clients, who are believed to be main driving force of the HIV epidemic in Asia as stated in the report of the Commission on AIDS in Asia. Further, MSM, Beach Boys and the vulnerability of migrant workers are added to the same potential. High client/partner turnover and low or no condom use, are other contributory factors to that potential.

3. While there could be and should be medium term and long term objectives and targeted interventions to achieve those objectives, the need of the hour is an urgent and an effective intervention/s to stop the upward trend of the HIV epidemic in Sri Lanka.

4. The single most effective intervention is the promotion of condom use to at least 60% among the above mentioned groups engaging in risky sexual behaviours. While there should be specific and targeted interventions to promote condoms among sex workers, MSMs, Beach Boys and migrant workers, the clients of sex workers have to be reached through a condom social marketing programme. The report of Commission on AIDS in Asia says that interventions should target clients of sex workers through powerful mass media campaigns, which can instill a virtual and lasting norm of condom use during paid sex.

If we don't use the opportunity that has been provided to us to stop HIV epidemic from moving to higher levels, history will never absolve us for not taking appropriate action to stop the HIV epidemic in this country.