Technical Guide On HIV/STI/Hepatitis Service Cascade For Community-Led HIV/STI Services

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Ministry of Health

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Technical Guide

On

HIV/STI/Hepatitis service Cascade For Community-Led HIV/STI Services

COLOFON

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment (or therapy)
ARV	Antiretroviral medicines
CD4	Cluster of deviation 4 (marker on white blood cells)
CSO	Community Service Organization
DNA	Deoxyribonucleic acid – a nucleic acid molecule
DPEP	doxy-PEP
FPA	Family Planning Association of Sri Lanka
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSV 1-2	Herpes simplex virus, types 1 and 2
MOH	Ministry of Health
MOP	Manual of Process
NGO	non-governmental organization (registered with the Government)
NSACP	National STD/AIDS Control Program
NSP	Needle & Syringe Program
PEP	post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
RNA	Ribonucleic acid
STD/STI	Sexually transmitted diseases / sexually transmitted infection(s)

Foreword by the Director of the National STD/AIDS Control Programme of Sri Lanka

The goal of ending AIDS as a public health threat by 2030, as outlined by the Joint United Nations Programme on HIV/AIDS, is ambitious but achievable. In Sri Lanka, we are committed to this target, recognizing that it demands concerted efforts, inclusive policies, and a deep understanding of the populations most affected by HIV and other sexually transmitted infections (STI). Our response must be guided by evidence, equity, and empathy.

To achieve the 'End of AIDS' target, it is essential to work closely with key populations who are at greater risk and face higher barriers to accessing health care services in general and HIV/STI prevention, treatment, and care services in particular. These groups, including men who have sex with men, transgender individuals, people engaged in sex work, people who use drugs, and beach boys, have unique vulnerabilities that require tailored approaches. Community Service Providers (CSP) play a critical role in reaching and supporting these populations, offering not only HIV/STI prevention, testing, and treatment services but also the compassion and confidentiality that are fundamental to effective prevention, testing, treatment, and care services.

This new Guidebook for HIV/STI/Hepatitis Community Service Providers is a vital tool in strengthening the capacity of CSPs across Sri Lanka. It provides clear, practical guidance that CSPs can use to navigate outreach challenges, connect individuals with essential health services, and contribute to national prevention efforts. By enhancing the skills and knowledge of CSP, this guidebook supports a key pillar of our strategy: ensuring that all people, regardless of their background, have access to the information and services they need to live healthy, empowered lives.

As we move forward, let us reaffirm our commitment to working in partnership with key population communities. Together, we can overcome stigma, break down barriers, and make significant strides toward our shared vision of a Sri Lanka free from stigma and discrimination of key populations and for a generation that HIV/STI no longer burdens.

Dr. Vindya Kumarapeli
Director, National AIDS/STI Control Program
Ministry of Health, Sri Lanka

Introduction: What is this Guide about?

What is this Guide, and what does it aim to do?

This Guide aims to help community service providers (CSP) improve their knowledge needed to prevent HIV/STI and Hepatitis and facilitate access to HIV/STI, Hepatitis testing, treatment, and care for key populations in Sri Lanka.

How is this guide structured?

The Guide is divided into four parts:

Part A: Community-Led HIV service cascade and the roles of community service providers (CSP) – Outreach Workers and Peer Educators

Part B: Information about HIV prevention and testing, sexually transmitted infections (STI), and sexual health issues as they relate to key populations

Part C: Focuses on supporting people living with HIV

Part D: Information to better understand the lives and situations in which key populations live and operate, aimed at making HIV service delivery more understanding.

How can community service providers use this Guide?

Community service providers can use the manual in several ways:

- To search for correct answers or check their answers to clients' questions. The manual is, therefore, written in Q&A format.
- To read and catch up on areas of knowledge where they feel they could improve.
- To seek inspiration for new discussions and questions, they may ask their clients to test their knowledge and/or awareness rather than repeating previous topics repeatedly.
- To prepare for HIV tests and examinations that are part of their job requirements.

How can NGO directors, outreach coordinators, and CSP supervisors use this guide?

NGO directors, outreach coordinators, and other managers/supervisors should aim to improve the quality, scope, and accuracy of information that CSP and other HIV service providers use in their work. The guide can be used as a training tool; for example, the manager/supervisor

may discuss one or more sections each week during team meetings for CSP to refresh their knowledge. The guide can be used as a study book, and there is an examination tool that managers/supervisors can use to check whether the level of knowledge of their staff is sufficient and where additional training or supervision is necessary.

Where does the information in this guide come from?

Information was collected from the NSACP, Global Fund, World Health Organization, and Family Health International (FHI360) documents.

What further reading is required?

As part of their knowledge, NGO directors, supervisors, managers, and outreach coordinators, CSPs interested in broadening their knowledge and understanding better how their work fits into broader national and international efforts to address the HIV/STI epidemics should also read the Process Manual. This will also be the resource material for the NVQ trainees in social and outreach work course for HIV services.

PART A

The HIV/STI Service Cascade & the Rationale for Key Population Organizations providing Community – Led HIV/STI services.

Chapter 1: The HIV/STI Situation and Response in Sri Lanka: an overview

What is the state of the HIV/AIDS epidemic among key populations in Sri Lanka?

Sri Lanka has continued to maintain a low-level HIV epidemic since the start of the global HIV/AIDS pandemic. The HIV/AIDS Epidemic Model estimated that 4,700 people were living with HIV by the end of the second quarter of 2024[1]. The estimated HIV prevalence is less than 0.1%. Almost three decades since the detection of the first HIV infection in Sri Lanka, as of June 2024, a cumulative total of 6,126 HIV infections have been reported to the National STD/AIDS Control Programme (NSACP). Of them, 1,579 have died. The availability of ART free of charge in all STD/HIV clinics has encouraged more people to come forward for HIV testing. In 2023, a total of 694 new HIV cases were reported; in the first half of 2024, a total of 421 newly diagnosed cases were reported to the NSACP[1], indicative of a growing trend in seeking health services.

The 2018 Integrated Biological and Behavioral Surveillance IBBS survey revealed that the highest HIV prevalence was found among men who have sex with men (MSM) (1.5%), followed by transgender women (1.4%). Prevalence was low among females engaged in sex work (0.1%), clients of sex workers (0.1%), and people who inject drugs (0%). These rates are higher than the reported data of previous years. In 2021.

While Sri Lanka has maintained a low HIV prevalence of less than 0.1% among Female Sex Workers between 2014 and 2018, there was a slight increase in syphilis prevalence among this population in Colombo, rising from 1.6% in 2014/15 to 2.2% in 2018. The 2018 (IBBS) survey, covering five districts, revealed low HIV and STI prevalence rates across key populations. However, the presence of risk behaviors, including inconsistent condom use and low HIV/STI testing uptake, coupled with limited coverage of HIV/ STI prevention programs, suggested a potential for future increases in HIV/STI prevalence.

Has the response to HIV/STI in Sri Lanka been successful so far?

The Sri Lankan response to HIV and STI is characterized by many successes, as shown by the maintenance of low HIV prevalence levels. However, new HIV diagnoses among some key populations have been rising in recent years. There has been a good collaboration between

[1] https://www.aidscontrol.gov.lk/images/pdfs/hiv_data/quarter_report/HIV-AIDS_Quarterly_Report_-_2nd__Quarter_2024_v2_1.pdf

NSACP and civil society organizations in the establishment of HIV prevention programs for key populations who are receiving a package of HIV/STI and Hepatitis prevention services via community service providers (CSP). The integrated provision of free HIV, STI and Hepatitis screening, diagnosis and treatment services through the island-wide network of STD clinics has been a defining strength of the national response. Sri Lanka's response to HIV recognizes the comparative advantages of the public health sector and civil society organizations, and the complementary nature of their contributions. There have been significant increases in recent years in the number of KPs seeking HIV and STI testing, although coverage remains too low[2]. An increased number of people living with HIV(PLHIV) have sought treatment in recent years, and more significant numbers of people living with HIV on treatment are being retained on ART and achieving viral suppression. However, further work is needed to improve this. Another strength of the national response has been collecting and disseminating strategic information to guide programming. A significant advance that considerably enhances data use in programming is the establishment of the Electronic Information Management System (EIMS).

Is the Government in favor of providing HIV/STI services to key populations?

Yes. According to the latest National HIV/STI Strategic Plan for Sri Lanka (2023-2027), the government aims to end HIV as a public health threat by 2030. The government recognizes that this is only possible if it closely collaborates with key population organizations.

What are Sri Lanka's national strategic plans for 2023-2027 priority areas?

The National Strategy covers eight priority areas:

1	Expansion of combination prevention of STI/HIV targeted interventions for key populations and vulnerable groups;
2	Scaling up HIV testing approaches with universal access to treatment, care, and support;
3	Enhanced STI/HIV surveillance (as the latest data is from 2018);
4	Improving the integration of HIV into other health and non-health service delivery packages to reach the general population and youth;

[2] Review of the Package of HIV Services for Key Populations in Sri Lanka, 2020. By David Lowe for Health Equity Matters, MOH and FPA.

5	Generating strategic information and conducting operational research for policy and programme planning, as well as monitoring and evaluation;
6	Public-private partnerships for improved prevention, treatment, and care for people living with HIV;
7	Creating an enabling environment by addressing human rights and gender equity;
8	A sustainable national response through a strengthened health system and a socially contracted community system is a priority.

What is the Clinic - Community-Cluster model?

The Clinic-Community-Cluster model is a dynamic healthcare framework that designates identified STI clinics as the central hubs of strategically formed clusters. These clusters, comprising the clinic and affiliated community groups (NGOs/CSOs), key population networks, and PLHIV Organisations, enhance healthcare accessibility, coordination, community engagement, and planning.

Quarterly coordination meetings serve as a platform for collaborative decision-making and information exchange. This model promotes a holistic approach to healthcare by addressing not only medical needs but also negative social determinants and community-specific factors, promoting gender equality, reducing stigma, and maximizing the intervention effects at the local level. Clinic Community Clusters allow for efficient resource allocation, ensuring optimal utilization of available resources, planning, and overcoming challenges[3].

Why is a focus on key populations needed for a successful HIV/HIV, STI program?

In Sri Lanka, as in many other Asian countries, key populations—including men who have sex with men (MSM), transgender people, Female sex workers, people who inject drugs (PWID), and beach boys—are disproportionately affected by HIV, STI and Hepatitis. This heightened vulnerability is largely due to structural factors and the increased likelihood of engaging in behaviors that carry a higher risk of HIV/STI transmission, such as condom less anal sex, condom less sex with multiple partners, and sharing of injecting equipment. These risks are

[3] Concept Notes (SIC) on New Prioritized Key Population Interventions in Sri Lanka 2025-2027.

further exacerbated by stigma, discrimination, poor Health care seeking behaviour, and punitive legal environments.

A supporting enabling environment is therefore essential to increase access of key populations to health services in general and to HIV/STI services in particular.

Why are key populations reluctant to access HIV/STI services?

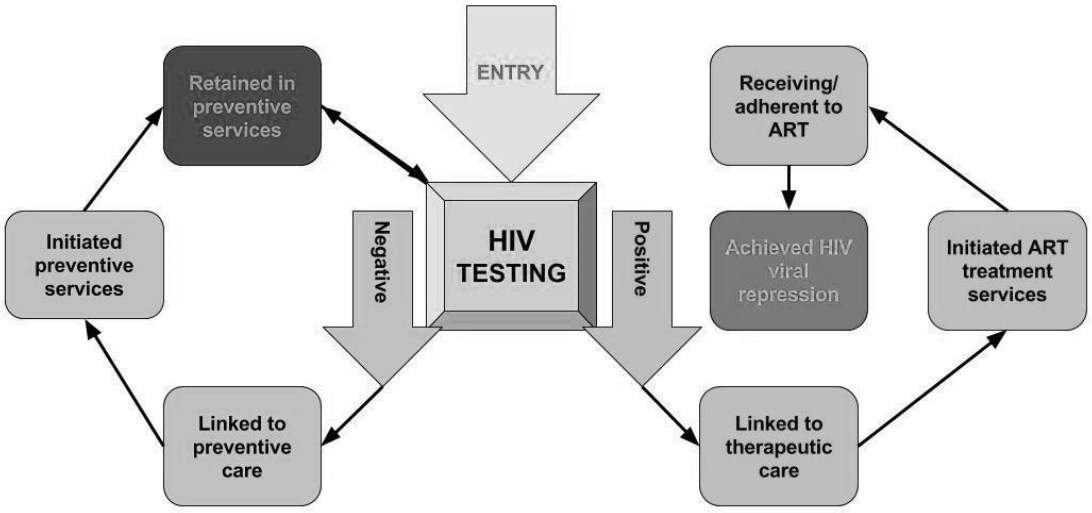
Even though comprehensive HIV treatment is available in Sri Lanka, including free testing and ART and STI treatment at government clinics and hospitals, many key population members still avoid HIV/STI services. They do so mainly because of negative attitudes, actual or perceived stigma by health care providers, locations where their privacy is not considered, inconvenient opening hours, or simply because they do not think they are at risk of STI or HIV infection. This typically means they are unaware of their HIV status. This means key population members may unknowingly be living with HIV already. Because they are not enrolled in antiretroviral treatment (ART), they may be spreading the virus to their sexual partners without realizing it, thus perpetuating the HIV epidemic.

What is the HIV/STI service cascade?

The HIV/STI service cascade refers to a continuum of HIV/STI prevention, testing, treatment, care, and support services. For key populations, this starts with HIV/STI outreach, which is often the entry point for them in the HIV/STI service cascade. Outreach focuses on HIV/STI prevention but is ultimately aimed at facilitating HIV/STI testing. After doing an HIV test, clients enter the 'prevention cascade' on the left if they are harmful or the 'treatment cascade' on the right if they are found HIV positive (see figure below).

Fig. 1[4]: Continuum of HIV prevention, testing, and treatment services: the two-sided service cascade

[4] Figure based on Van Griensven, F., Guadamuz, T. E., de Lind van Wijngaarden, J. W., Phanuphak, N., Solomon, S. S., & Lo, Y. R. (2017). Challenges and emerging opportunities for the HIV prevention, treatment and care cascade in men who have sex with men in Asia Pacific. Sex Transm Infect, 93(5), 356-362.



What is the Community Service provider's (CSP) role in the HIV/STI, Hepatitis service cascade?

Outreach workers and peer educators (CSP) play a key role in HIV/STI prevention and promoting HIV/STI testing. They provide awareness about HIV/STI and about the importance of HIV/STI testing among key populations. They also distribute HIV/STI prevention commodities (condoms and lubricants, sterile needles and syringes). KP Outreach workers and Peer Educators (KP Community service providers) can also refer clients to PrEP and PEP services. Some community service providers have been trained to conduct HIV STI screening tests and can provide these to their clients. In linking key population members who do not know their status to HIV testing services, they help identify previously undiagnosed HIV infections—this is called **"case detection."** Putting previously undiagnosed people on HIV treatment is the most promising HIV prevention and control strategy this is because people who are on ART treatment eventually (after 3-6 months, on average) become completely un-infectious as soon as their HIV viral load becomes undetectable, according to the latest science around U=U ("Un-detectable is Un-transmittable").

What is the role of healthcare providers at the STI Clinic in the HIV/STI service cascade?

Once a CSP refers or accompanies a client to a testing site (either an NGO or a STD clinic), the client is enrolled to the STD clinic there. The person responsible can be the consultant, nurse, PHI, HIV/STI counselor, or a clinic doctor. The HIV/STI counselor/doctor then conducts pre-test counseling, after which the client has an HIV/STI test. If the result is negative,

post-test counselling is conducted. Clients may be referred back to the community service provider for PrEP services if counselling discovers that they are at high risk for HIV.

If the client tests are reactive/positive, the STI Clinic will provide ARV and other required services and link with a PLHIV organization if the client needs such support and agrees to it[5].

What is the role of HIV case management in the HIV/STI service cascade?

HIV case management plays a vital role in treatment and support. It is a service provided to all newly diagnosed clients from key populations. It aims to support them and help them overcome barriers to accessing HIV treatment. Case management is discussed in detail in Chapter 8.

What does 'loss to follow-up' mean in the context of HIV services?

Even though there is a perfect referral system between community service providers and HIV testing services or between HIV testing sites and STD clinics, there are some cases that are disconnected due to various reasons. This loss to follow-up can be due to structural barriers such as stigma, discrimination, and healthcare seeking behaviour; key populations living with HIV often seek treatment later in the disease course when they already have multiple health problems. Loss to follow-up means that a client is no longer actively engaged in HIV treatment and services and needs to be re-connected with the consent of the client. This is an essential task of CSP.

If treatment is so effective, should we stop doing prevention activities?

No. Especially for MSM and transgender people, most new HIV infections appear to happen during the acute infection phase before they are diagnosed. This means that any onward infections could not have been prevented earlier by putting them on treatment. Prevention remains very important, also for people engaged in sex work and people who inject drugs.

What types of NGO services are available for key populations in Sri Lanka?

In the past, outreach-based prevention efforts used to be the main focus of NGO interventions for key populations in Sri Lanka; the focus was on condom and lubricant distribution and HIV/STI awareness raising via peer education. Since a successful pilot project in 2018-2019, outreach has become more focused on promoting testing services and on HIV case-finding in

[5] See for details about standard operating procedures at STI/HIV clinics: Standard Operating Procedures for HIV/STI Care and Prevention – Sexual Health Clinic Level, NSACP, MOH, 2021.

high-prevalence districts. But in other districts, the peer-led model is conducted, and clients are provided with the HIV treatment and prevention service package.

Refer to Annex 1 for a list of HIV/STI services in Sri Lanka

Chapter 2: Ethical principles when providing HIV/STI services

What is the mission behind the provision of HIV/STI services as CSP?

The mission of this program is to contribute to achieving the targets of the Ministry of Health (MOH), which include ensuring that by the year 2030, 95% of all people living with HIV are diagnosed (tested); 95% of all diagnosed people access ART treatment, and 95% of those accessing treatment achieve an undetectable viral load. (95% - 95% - 95%)

How does outreach contribute to this mission?

By reaching out to key populations at risk of HIV/STI and linking them to testing (the first '95' target). Community service providers also raise awareness of HIV/STI risk, promote HIV/STI prevention methods, and help key populations access community-friendly HIV/STI counseling and testing and treatment services. Community service providers also encourage and facilitate access to STI testing and treatment services and refer to harm reduction services for people with substance addiction.

How does case management contribute to this mission?

Case management assists people living with HIV to live well by supporting timely access to health services, first and foremost, ART treatment, STI and Hepatitis screening and treatment and TB screening and treatment services. People helping people living with HIV also facilitate referrals to other psychosocial support services, including those run by PLHIV Organisations. Ultimately, case management should empower clients to become independent and take charge of their healthcare needs.

Note: refer to Section 2 of the Process Manual for further reading.

Why are ethics important when providing HIV/STI services?

Because HIV is such a stigmatized disease and because HIV is often linked to other stigmatized identities and behaviors (sex work, homosexuality, transgender people, drug use). Therefore, when trying to reach key populations, maintaining ethical principles is probably much more critical than other health interventions.

What are the most important ethical principles and values when providing HIV/STI services to key populations?

The most important ethical principles are:

- Equality,
- Acceptance and being non-judgmental,
- Empathy,
- Duty of care,
- Informed Consent,
- Privacy and Confidentiality,
- Professionalism,
- Honesty and Integrity,
- Appropriateness,
- Responsibility
- Accountability

This chapter addresses each of these. Please refer to Section 3 in the Process Manual for a more in-depth explanation.

What is equality?

All clients should be **treated equally** based on the fundamental belief that **all human beings are equal and have equal rights to good healthcare,** regardless of age, gender, ethnicity, socio-economic status (class), family/cultural background, religion, personal beliefs, sexual orientation, gender identity or gender expression.

What is acceptance and being non-judgmental?

HIV/STI Service Providers must not let their beliefs affect how they treat their clients. They should always focus on public health principles and provide psycho-social support by accepting clients without passing judgment while always showing them dignity and respect, even if clients engage in actions or behaviors they may disapprove of.

What is empathy?

Empathy is like “walking a mile in the client’s shoes,” trying to understand the world from the client’s perspective. It is also about having compassion, being client-centered, and respecting clients' right to decide what is best for them.

What is Duty of Care?

A responsibility to ensure the safety or well-being of clients and others. Intervention may be needed if the client's safety or others may be compromised, such as linking the client to a professional expert. This may need to be done even if the client is resistant. Still, only when it is necessary, and there is no other way, for example, when a client is suicidal or threatening to harm themselves or others.

What is informed consent?

Clients should only use HIV/STI services (including the services provided by community service providers, as well as outreach/peer education) if they are willing to do so. Their consent **must** be sought before engaging clients in any service, which must be an informed decision. The "client consent form" (see Process Manual) ensures this. Clients are given the option to refuse any or all of the services provided at any time. The only exception would be in cases where there is a 'duty of care' issue (see above).

What is privacy and confidentiality?

The personal issues and private information of clients MUST ALWAYS remain a secret for people who do not need this information for professional or service-related reasons. Client files must be kept in safe/secure locked cabinet in a private room and can only be seen by the relevant community service provider and their manager/supervisor.

What is professionalism?

This is about being professional with clients at all times and not getting romantically or sexually involved with them, no flirting or dating! This is crucial to maintaining the reputation of the HIV/STI services, especially CSOs/NGOs, and to ensuring good working relationships with other organizations.

What is honesty and integrity?

Honesty is about being straightforward, frank, and open with clients, which is necessary to build rapport and maintain trust. Integrity is about being honorable and decent, especially not exposing clients to risks or dangers. Integrity also covers ensuring the just treatment of those who are unable to protect themselves, such as minors (persons below the age of 18) and also persons with disabilities (physically/mentally) to the point that they are unable to function fully. Note that minors (under 18) must have a letter of consent provided by the client's

guardian/parent; otherwise, the clients should be handed over to the relevant doctor or counselor in another clinic for further action.

What is appropriateness?

The information, support, and skills must be relevant to a client's situation and suitable for their needs. They must also be appropriate in content and tone for the client's comprehension. Avoid being repetitive, too complicated, or too simplistic. Never provide wrong or inaccurate information; it is OK to tell a client that you are unsure how to answer their question and that you will get back to them with an answer later.

What is responsibility and accountability?

Each Community Service Provider in the program must be fully responsible and accountable for all duties carried out under their job description/scope, including the resources entrusted or made available to them. Accountability is also related to measuring results and showing evidence for work done **in line with the program's** monitoring and evaluation (M&E) requirements.

Chapter 3: Role of Community Service Providers

What is outreach?

Outreach is an activity conducted by trained persons who work to help prevent HIV/STI, Hepatitis transmission among key populations and help people access HIV/STI testing services so that they can enter into HIV/STI treatment and care in case they have HIV or STI. The ultimate goal of outreach is to increase awareness about HIV/STI and ways to prevent it and to detect new cases of HIV/STI to ensure that undiagnosed people living with HIV are supported in accessing testing and thereafter antiretroviral treatment as well as psycho-social support services. In Sri Lanka, there are full-time outreach workers and 'peer educators'; there is also a distinction between field-based (offline) outreach and virtual (online) outreach.

How are community service providers recruited?

Community service providers (full-time outreach workers or part-time peer educators) are recruited from the KP community they will serve. The reason is that they will then have 'special knowledge' about the community that an outsider may not have. They may better understand the slang, jokes, or unique terminologies that members of that community use. Community service providers working together in a team mustn't be all recruited from the same group of friends or in the same age range, ethnicity, or class, as this will limit their ability to reach out to other networks needing services. If someone wants to be a CSP who is not active in the relevant community or Ex KP, they should not be enrolled as an outreach or peer educator.

What are the tasks of the community service provider?

Outreach workers and peer educators are tasked with:

- Actively looking for potential clients for HIV/STI services at the locations (online or offline) where these potential clients can be found.
- Providing accurate and appropriate information and education to raise knowledge and awareness about HIV, STI, and other related issues.
- Providing accurate and appropriate information and education on how HIV/STI risk can be reduced and can be prevented, providing multiple options tailored to the needs and situation of each client, including the use of condoms, PrEP, PEP.
- Distribute HIV/STI prevention commodities (condoms, lubricants)

- Convincing members of the key population that they serve that it is beneficial for them to access HIV/STI counselling and testing services**.**
- Providing HIV screening tests by themselves; the result of this test can be either reactive or non-reactive. Only reactive test results need to be referred for confirmation HIV testing at an HIV/STI testing site or to the STD Clinic.
- Refer or accompany clients of unknown HIV status to HIV testing services and pass them on to the STD clinic.
- If a client test reactive and is confirmed for HIV, they are linked with PL HIV networks by the STD Clinic (if required and with their consent), which can support newly diagnosed clients.
- Ensuring cooperation between the CSO/NGO and local STD/HIV clinics.
- Documenting their work, seeking feedback on satisfaction with HIV/STI services from the clients, and reporting progress regularly to the next level.

How can potential clients be reached?

There are numerous ways to do outreach, including face-to-face outreach in locations where key populations gather, virtual outreach via the Internet and social media platforms (see Chapter 6), and peer-driven recruitment models, in which clients help to recruit additional members of targeted audiences.

How has the approach to outreach changed over the years?

Outreach activities have traditionally focused on the provision of correct information about HIV/STI transmission, prevention and treatment, the promotion of condom use, and the provision of condoms and referral to STI and HIV counseling and testing services that are friendly to key populations. This approach was then strengthened with a stronger focus on building clients' motivation and skills for behavior change (safer sex, HIV/STI self-testing, etc.) and on providing specific information or assistance to access HIV/STI testing services. Community service providers will now offer alternative sexual risk-reduction strategies (including promoting the use of pre-exposure prophylaxis (PrEP) or promoting sexual behaviors that are less risky than anal sex). The services provided to each client should be **differentiated** according to the client's needs. For instance, a client who is already well informed and proactive in safer sex would not need any HIV/STI awareness information or

HIV/STI prevention commodities and may only need to be given a referral to testing at a clinic, which they can go for by themselves. CSP should be able to assess what the client needs and provide the latest information or advice accordingly.

CSP should always be sensitive to the specific needs of clients and thus not shy away from discussing more entrenched issues, such as managing **Chemise,** drug/alcohol addiction and related situations in which HIV risk behaviour occurs (see Chapter 26 and 27); dealing with sexual or gender identity issues (Chapter 21); handling stigma, discrimination (Chapter 28) that occurs as a result of a person 'gender identity, sexual orientation, HIV/STI status or involvement in sex work.

What does it take to get more people tested?

In Sri Lanka, community service providers must gradually become responsible for both referrals to testing services and for the actual delivery of high-quality HIV/STI counselling and HIV/STI screening test services that are friendly to key populations.

More people will want to get tested if HIV/STI testing services are friendly, private/confidential, free of charge, not too far away, and if they have convenient opening hours. However, before KP members access HIV/STI testing services, the role of the community service provider is pivotal. They need to have detailed knowledge about the HIV/STI testing process to take away fears and reservations that clients may have about testing. Accompanying clients to testing services rather than just referring them is a good way to increase testing uptake.

What about clients who test negative?

The HIV/STI service cascade has typically focused on service uptake and retention of people who have tested positive for HIV. Many clients who test HIV-negative are never seen again despite often being at considerable risk for infection. This is a big leak in the HIV/STI service cascade in many countries in the region—people at high risk of infection should take an HIV/STI test regularly so that if (or when) they become infected, they can start treatment as soon as possible. Regular HIV/STI testing is also a good way for clients to access new options for HIV prevention, such as PrEP and PEP. (See Chapter 14). Community service providers should follow up with their HIV-negative clients to encourage regular testing and to help them access (and adhere to) PrEP if this is a prevention option they want to use.

What happens if a client tests positive?

If a client's screening test results are reactive, the CSP has to refer or escort them to the nearest STD clinic for confirmation testing and enrolment in HIV treatment and Care, as per the national HIV/STI Treatment protocol. With the client's consent, they can be referred to people living with HIV networks for HIV case management support (see Chapter 8 for more on what case management is and Chapter 17 on supporting newly diagnosed clients).

Should CSP stop seeing clients after referring them to HIV/STI testing services?

In principle, the outreach worker/peer educator refers or hands over a client to the STD Clinic for treatment and care. This healthcare provider then ensures the client can access follow-up tests and ARV therapy if the client receives a positive test result. A positive test result should not be revealed to the community service provider (except by the client if the client chooses, but there is no obligation to do so).

Clients who test negative should be followed up by the CSP so that they can re-test in 3-6 months. Some HIV negative clients are referred to PrEP services if they so wish. This can be a challenge, as the client may not wish to reveal their test result to the community service provider and the community service provider should not ask about the client's results directly.

What are common tasks of Community Service Providers?

Client Registration and Re-engagement

- Register new clients for services, both in-person and virtually (see Client Registration Form, Annex 3).
- Re-engage clients for continued support and follow-up, ensuring they stay connected with HIV/STI services at least every 3-6 months.

Education and Awareness

- Provide information on HIV, STI, Hepatitis, PrEP, PEP, harm reduction, and safe sex practices.
- Conduct sessions on safe sex, correct condom use, proper use of lubricants, and the harm associated with IVdrug use.
- Distribute educational materials (leaflets, posters) and offer behavior change communication materials to support HIV/STI risk reduction.

Condom and Lubricant Promotion and Distribution

- Promote the use of and supply condoms and lubricants, ensuring continuous access and monitoring stock levels (see Condom and Lubricant Stock Management Form, Annex 7).
- Demonstrate correct condom use and promote the selection of condom-compatible lubricants (using a penis model).

HIV and STI Testing and Counseling

- Offer HIV and STI testing/Self Testing/Guided Self Testing in community settings, clinics, mobile units, and during outreach events, recording results in relevant forms (see Outreach Rapid HIV Test Result Form, Annex 6).
- Provide pre-test information and post-test counseling to support clients in making informed decisions.
- Facilitate HIV community-led testing, including rapid diagnostic tests and client self-testing options.

PrEP and PEP Services

- Identify and educate relevant clients about PrEP, assist with registration for PrEP services, and provide initiation and follow-up support.
- Offer information about Post-Exposure Prophylaxis (PEP) for clients who may have been exposed to HIV.

Drug Harm Reduction Education and Chemise

- Educate clients on the risks of drug use, including the dangers of unsafe injecting and needle sharing.
- Guide safe injecting practices and strategies to reduce the risk of HIV transmission, aligned with Sri Lanka's harm reduction Programme.
- Conduct outreach in chemsex venues, providing men who have MSM safety kits (party packs) with condoms, lubricants, HIV self-test kits, and PrEP/PEP information.

Linkages to Healthcare Services

- Refer or escort clients to STD clinics for HIV testing, STI diagnosis, and treatment (see Clinic Escort/Referral Form, Annex 4).
- Facilitate access to comprehensive HIV care, (ARV) treatment, and Hepatitis Treatment services.
- Refer client to the STD Clinic for mental health, Tuberculosis screening and treatment, Hepatitis screening and treatment and family planning services when necessary.

Chapter 4: Interpersonal Communication

What is interpersonal communication, and why is it important in HIV/STI outreach?

Interpersonal communication is exchanging information, ideas, and feelings between people. In HIV/STI outreach, effective interpersonal communication helps build trust, encourages open dialogue, and makes clients feel respected and understood. This can be crucial for community service providers in Sri Lanka, as clients may face stigma. A respectful, supportive approach helps clients feel comfortable discussing sensitive topics such as sex, sex work, and drug use, improving the likelihood that they will access and stay connected with necessary services.

How can community service providers create a supportive environment for clients?

Creating a supportive environment starts with showing empathy and understanding. Greet clients warmly, make eye contact, and show genuine interest in what they say. Use simple, respectful language, avoid pre-judgmental verbal or non-verbal expressions, and listen actively to demonstrate respect and openness. Building rapport and creating a safe space can help clients feel valued and accepted.

What is active listening, and how does it benefit clients?

Active listening involves fully concentrating on what the client is saying rather than just passively hearing the words. It includes using non-verbal cues like nodding, maintaining eye contact, and responding with brief affirmations like “I see” or “I understand.” By listening actively, community service providers show clients their concerns are taken seriously, encouraging them to share openly. In a context like Sri Lanka, where topics around HIV,

(homo)sexuality, and drug use are sensitive, active listening can help clients feel accepted and more willing to discuss their needs openly.

What is motivational interviewing, and how can it help in HIV/STI outreach?

Motivational interviewing (MI) is a communication technique that helps clients explore and resolve ambivalence about changing certain behaviors. Instead of telling clients what to do, MI encourages clients to articulate their own reasons for change, building their motivation from within. In HIV/STI outreach, MI can be used to help clients consider safer sexual practices, regular HIV/STI testing, adherence to treatment, or reducing alcohol and drug use. It is particularly useful in Sri Lanka, where individuals may feel reluctant or uncertain due to stigma; MI allows them to make decisions on their own terms.

How does motivational interviewing differ from giving advice?

Unlike direct advice, motivational interviewing focuses on asking open-ended questions that help clients reflect on their motivations and goals. For example, instead of saying, “You should consider using condoms to stay safe,” a provider might ask, “How do you feel about using condoms as a way to protect yourself?” This approach gives clients more control and ownership over their choices, which can lead to more sustainable behavior change. Community service providers can build a more respectful and effective relationship by respecting clients' autonomy. More importantly, it is likely that a client will adopt safer behavior more readily if the decision comes from themselves rather than an outsider.

What are some basic techniques used in motivational interviewing?

Motivational interviewing relies on several techniques, including:

- **Open-ended questions**: Encourage clients to share their thoughts and feelings rather than respond with simple "yes" or "no" answers. For example, "What are some of your goals regarding your health?"
- **Affirmations**: Recognize and encourage clients’ strengths and positive actions. Example: "It sounds like you have already made great efforts to stay healthy."
- **Reflective listening**: Rephrase the client's words to show understanding and prompt deeper reflection. Example: “So, it sounds like you are worried about your health but unsure about the next steps.”

- **Summarizing**: Recap what the client has shared to reinforce their statements and help them see the bigger picture. Example: “To sum up, you’re interested in staying safe but find it challenging to use condoms consistently due to social pressures.”

How can motivational interviewing address ambivalence in clients?

Clients often feel ambivalent about making changes, especially when facing social stigma, financial barriers, or personal doubts. Motivational interviewing helps clients explore multiple sides of their ambivalence. For instance, a provider might say, “On the one hand, you’re worried about the risks of unprotected sex, and on the other hand, you feel pressured not to use condoms with certain partners. How do you feel about that?” This approach validates clients' feelings and helps them weigh the benefits and risks non-judgmentally.

How can cultural sensitivity enhance communication in the Sri Lankan context?

In Sri Lanka, cultural norms around respect, modesty, and family expectations play a significant role in decision-making. Community service providers should approach sensitive topics with respect, use appropriate language, and avoid pushing clients too hard. It is essential to be mindful of cultural values and the pressures clients may face from their families or communities. For example, rather than directly discussing sexual behavior, a provider might initially frame discussions around “health and well-being” to make clients feel more comfortable.

What should community service providers avoid when using motivational interviewing?

Providers should avoid being confrontational, judgmental, or directive. Motivational interviewing is about guiding or coaching but not instructing. Avoid pressuring clients, making assumptions, or imposing personal values. Even well-meaning advice can sometimes come across as judgmental. Respecting each client’s perspective and letting them lead the conversation about their behavior and choices is essential.

How can providers build trust with clients who face stigma and discrimination?

Building trust requires patience, empathy, and consistency. Providers should create a non-judgmental atmosphere, use affirming language, and respect clients’ confidentiality. Trust is built over time, especially with clients who may have faced discrimination or stigma in the past due to their HIV status, sexual orientation, or drug use. Small actions, like remembering a client’s preferences on how they drink their tea, for example, or checking in about their well-

being, can make a big difference. Showing that the provider genuinely cares can help clients feel safe and supported.

How can providers use interpersonal communication to encourage clients to return for follow-up visits?

At the end of each visit, providers can affirm the client's progress and positively emphasize the importance of follow-up care. Saying, "You're taking important steps for your health and life, and we're here to support you every step," can motivate clients to return. Providers can also set reminders or offer to follow up via phone to reinforce the message that they are available to help. This approach helps build a reliable support system for clients feel comfortable returning to.

Chapter 5: Using social media and the internet for outreach

What is virtual outreach?

Many community service providers use the internet to find prospective high-risk clients, especially those not available in the physical hotspots or who do not want to come to the facility to access services. This is called "virtual or Online outreach". Online outreach is a way to explore online sites/hotspots where men who have sex with men, transgender people, and people who engage in sex work go for fun or to find friends, boyfriends, casual sex dates, or clients. Some of these sites can also be used to access networks of people who use substances. Such sites include Facebook ('secret groups') and Facebook Messenger, dating apps such as Grindr and HeeSay, and groups in WhatsApp, Signal, and Viber.

Potential clients on social media platforms and dating apps primarily use these platforms to date or find clients. Therefore, community service providers should be available as a resource and not intrude on their time and privacy unless asked. Thus, community service providers should first build rapport and gain trust.

Are there risks involved in virtual outreach?

Although a virtual outreach worker is not at direct risk of physical attack by others while online, the online and offline worlds are not entirely separate universes; one should take certain safety precautions when being online. This Chapter establishes some rules and advice on how to do so.

What are the benefits of virtual outreach over physical outreach?

Online and physical outreach should not be seen as separate; they must complement each other. Even before the COVID epidemic started, virtual outreach had become a necessity, given that key populations had started interacting increasingly online. They use Facebook, WeChat, Twitter, dating apps (HeeSay, Grindr, Hornet), and other online platforms such as WhatsApp to contact each other.

Another advantage is that there is virtually no chance of police harassment when conducting virtual outreach.

There is also no time limit: most virtual locations for dating can be accessed around the clock, in contrast with real-time venues, which often have specific hours of operation. During late

night hours, the use of a chat-box could be an option, as CSP cannot be expected to be active 24 hours a day.

Another advantage is the sheer number of potential clients who can be accessed online. For planning purposes, however, it is important to carefully assess when each of the online venues is typically busiest.

For people who are a bit shy or introverted, it can be easier to communicate about sensitive issues, such as sexual preferences, when online as compared to during a face-to-face discussion.

Online outreach also allows the community service provider to compile a prepared list of factually accurate topics or frequently asked questions (such as the questions presented in this guide) that can include links to additional online or offline resources.

Are virtual outreach & Physical outreach locations mutually exclusive?

No, online and physical outreach should be seen as complementary. Online outreach is often used as a way to establish initial contact with a potential client, which can be followed by a face-to-face meeting for the provision of follow-up services, such as assisted or unassisted HIV self-testing. Sometimes, it is the other way around: A client may be encountered at a physical venue, and after exchanging social media or other contact information, follow-up support may be provided online. The fact that online and offline settings are not mutually exclusive is also why virtual outreach should use some of the same safety precautions as offline outreach, especially regarding vulnerability to violence, breaches of confidentiality, or blackmail.

What are the limitations of virtual outreach versus outreach at physical venues?

There are several disadvantages. Wi-Fi or 5G/4G networks may be unreliable, leading to interruptions, especially in remote rural areas of Sri Lanka. Clients can suddenly cut off the conversation, run out of phone credit, and/or block the community service provider; clients can pretend to be somebody who they are not, or potential clients could become upset when finding out that the community service provider is not a potential sex date or drug use buddy, but a community service provider.

Another significant disadvantage is that the boundary between dating, flirting, romance, and professional outreach may be blurred, mainly if the community service provider uses the same online ID for their work as they do in their personal or sexual life. For this reason, it is

recommended that a community service provider uses a different ID or Facebook page for their personal and professional lives.

Finally, most outreach staff arre perceived by potential clients to be either HIV positive themselves or a part of the community and therefore pose a risk to be stigmatized and discriminated.

How can I find potential clients online?

Community service providers may already know where people from the community they serve tend to go when they are online, whether they are looking for friends, long-term partners, casual sex dates, or drug-use buddies. If this is unclear, the community service provider should ask their friends or clients they have met in real-world venues. As mentioned above, community service providers should ideally create a professional ID tag that reveals their purpose, for example: “HIVOutreach2021”, “GetTested2022,” or “Stay Safe.”

The organization providing outreach services must conduct a “space and time mapping/density mapping” to determine which applications or chat rooms are busy during which hours of the day/days of the week. Clients should also have an idea when community service providers are available for online chats. This can be done by including operating/chatting hours in user profiles.

How can I start a conversation with a stranger to make them my client?

If a community service provider has decided to engage in virtual outreach and has created a profile that reflects that they are interested in meeting people as a community service provider rather than meeting friends, boyfriends, or casual sex partners, they can approach people with a short statement about themselves. For example: “Hello! My name is XXX. I work for an organization that promotes sexual health. Would you mind having a chat with me?”

If the CSP uses a dating app, they need to be available as a resource and conduct passive outreach rather than actively reaching out to people. Doing so may lead to their being blocked by the client, as they are on the platform for dating and not really for health services.

Should I use my profile/account when doing virtual outreach?

Even though this is usually not in line with the service agreement that one has to sign when opening an account on most dating apps such as Grindr or HeeSay, from a safety and professional perspective, it is essential to use a different user ID or account name when doing

virtual outreach. It is better never to use the same account name or user ID that one uses in one's private life. This is important because the outreach coordinator/supervisor may request a community service provider's username and password to look at the chats they have conducted with (potential) clients to give feedback on improving their performance further. One would not want a supervisor to have access to one's chats!

Is it okay to flirt with potential clients as a way of making contact with them?

No. One should not deceive a client by making them think that one could be their next sex date or life partner. That is not ethical. The client must know who the community service provider is and what the community service provider is interested in, which is providing information, answering questions, and promoting HIV/STI testing and safer sex. Community service providers must establish and maintain clear and professional boundaries with users.

A prospective online client has suggested sex (or a relationship) with me. What should I do?

Because online dating platforms are primarily intended for people to meet each other, it will most likely be just a matter of time before community service providers are approached for a sex date or a relationship while doing virtual outreach. Community service providers should kindly decline and explain to their contacts that they are not online to date or find sex or friends, but to do a job, which is to help improve the sexual health and well-being of potential online clients.

What is online harassment?

Online harassment is when someone is bothering you online. It can be in sexual, verbal, and psychological forms (threats, blackmail, etc.).

What should I do when someone harasses me online?

First, one can try to remind the user who is harassing the community service provider about the code of conduct of the online platform or website that is being used, by issuing them a warning. In this code of conduct, harassment is explicitly mentioned as strictly forbidden. If the code of conduct is breached and if this is reported to the website or application management, that user may be banned from the platform. As a last resort, if all else fails, the community service provider may consider blocking that user and/or reporting the user to the admin of the platform.

Apart from possibly reporting online harassment to the platform admin, ongoing online harassment should always be reported to the outreach coordinator/ supervisor. Before doing so, all evidence and activities related to the harassment (for example, screen capture, data logs, etc.) should be recorded.

Chapter 6: About HIV/STI counselling and testing

What is HIV/STI counselling?

HIV/STI pre-test information and (post-test) counselling refers to the process of providing age- and key-population-appropriate information and education about HIV/STI and the process of accessing HIV/STI testing, HIV/STI prevention services (including PrEP) and HIV treatment and care services to a member of a key population who is potentially interested in getting tested. Only a trained person should conduct HIV/STI counselling.

How can a client be prepared for HIV testing, and why is it important?

Since 2024, WHO no longer recommends pre-test counseling for HIV at the individual level; Sri Lanka's 2023 guidelines have also dropped this requirement. Instead, WHO recommends providing concise pre-test information to people testing for HIV. This communication should provide general information, answer clients' questions and offer an opportunity to refuse testing. The reason for this change in recommendation is that lengthy and intensive pre-test information or counselling has been found to not change risk behaviours or increase HIV knowledge, and that it may even deter testing among some populations, particularly those that need frequent retesting.

What topics can be included when providing pre-test information?

When pre-test information is needed by clients (individually or in a group), concise messages may include the following benefits of HIV testing and implications of undiagnosed HIV;

- the meaning of an HIV-positive diagnosis and of an HIV-negative diagnosis;
- benefits and importance of considering treatment as prevention – that is, U=U;
- the services available to those who test HIV-positive, including where ART is provided (and, importantly, that it is free);
- the confidentiality of the test result and any information shared by the client;
- the client's right to refuse testing and that declining testing will not affect the client's access to HIV-related services or general medical care;
- potential risks of testing in settings where there are legal implications for those who test positive or whose sexual or other behaviour is stigmatized or criminalized;

- the opportunity to ask the provider questions;
- importantly, for people who are using self-tests independently, information about where to seek further testing and confirmation, treatment and prevention services, as they will not receive this information from a health care worker following receiving their self-test result;
- for people with a reactive test result, the importance of attending a testing site for further testing;
- For people with a non-reactive test result, information about prevention options is needed.

Why is consent essential for HIV testing?

Consent means giving verbal permission or agreement to test for HIV. Mandatory or coercive testing is never warranted. All individuals should be allowed to refuse testing, and policies should protect those who opt out of testing. According to WHO guidance, testing should not be a condition for obtaining other benefits, and refusing testing should not be a reason for withholding other benefits.

What happens in post-test counseling?

In post-test counseling, essential information is provided based on the test result:

- **Negative Result**: Clients are guided on ways to reduce future risk, as many may have sought HIV testing after potential exposure(s) to HIV/STI, and they are linked to prevention services such as PrEP, and for further HIV and STI prevention information.
- **Reactive Result**: Clients are connected to a community service provider for referral to confirmatory testing at a facility. The provider will help enroll HIV Reactive people in healthcare, encourage self-care, and promote treatment adherence.

Why is counseling essential?

Counseling can make a critical difference by helping clients engage in HIV care early for clients who test positive. Knowing one's status allows individuals to manage their health proactively. However, in Sri Lanka, due to reasons related to stigma (including internalized stigma among many key population members), discrimination, and poverty, some people still disconnect from the health service cascade after a reactive/positive test and reappear only when they experience advanced AIDS symptoms. Effective post-test counseling and related HIV

case management are key to preventing people from disengaging from life-saving treatment services.

For people who test negative for HIV, post-test counseling is also essential, especially for those who are at high risk for HIV. By educating them about condom use or informing them and referring them to PrEP services, CSP can help ensure their clients stay HIV-negative.

How is HIV diagnosed?

HIV infection is confirmed with tests that determine the presence of the antigen and whether antibodies (the proteins that the body creates to fight a disease) to HIV are present in blood or oral fluids. If the screening test is negative, no further confirmation is required, and the client is negative for HIV, at least, they were before the window period, which can be any time from 10-90 days, depending on which screening test is used[7]. If the screening test is reactive, two further tests need to be done to confirm whether a client is HIV positive. This can be done at any STD/HIV clinic in Sri Lanka.

What different types of HIV tests exist?

There are three types of HIV tests:

1. HIV Antibody Test (3rd Generation test) in self-testing
2. HIV Antibody and Antigen Test (4th Generation test)
3. HIV RNA test

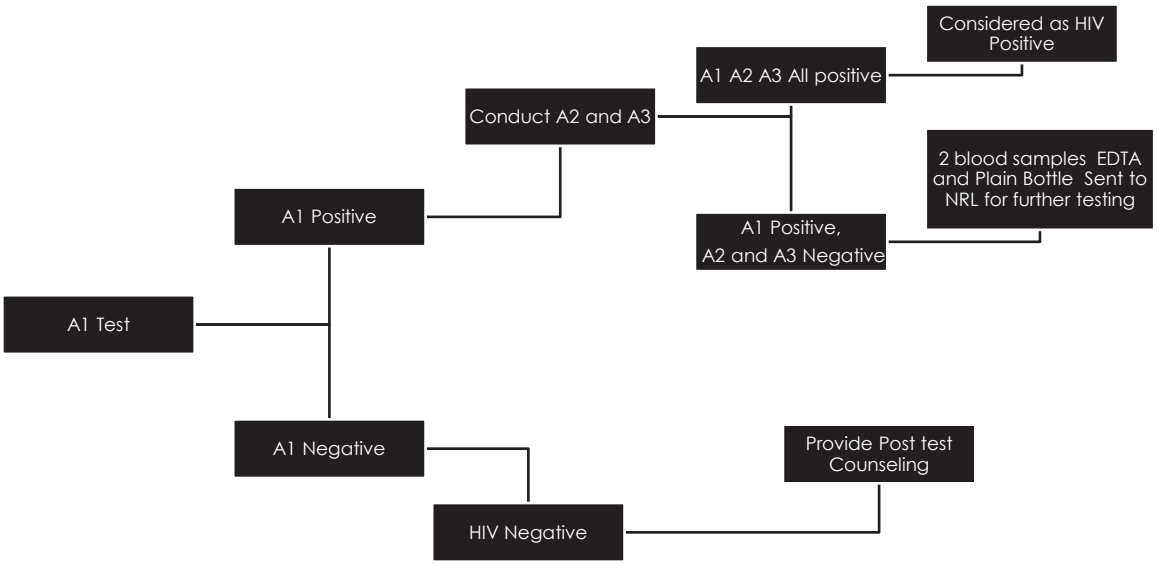
HIV Antibody Test (3rd Generation test) **Self Testing**	The most common HIV test (also called an immunoassay) tests for the antibodies that the body creates in response to its infection with HIV. This test can be taken from blood or oral fluid (not saliva). Blood tests tend to find HIV infections quicker than oral-fluid tests because the level of antibodies in the blood is higher. The **rapid test** is an immunoassay that produces a result within 30 minutes. It uses either blood or oral fluid to look for antibodies to HIV and is often used in non-clinic settings. All positive immunoassays need to be confirmed with a follow-up lab-based test.

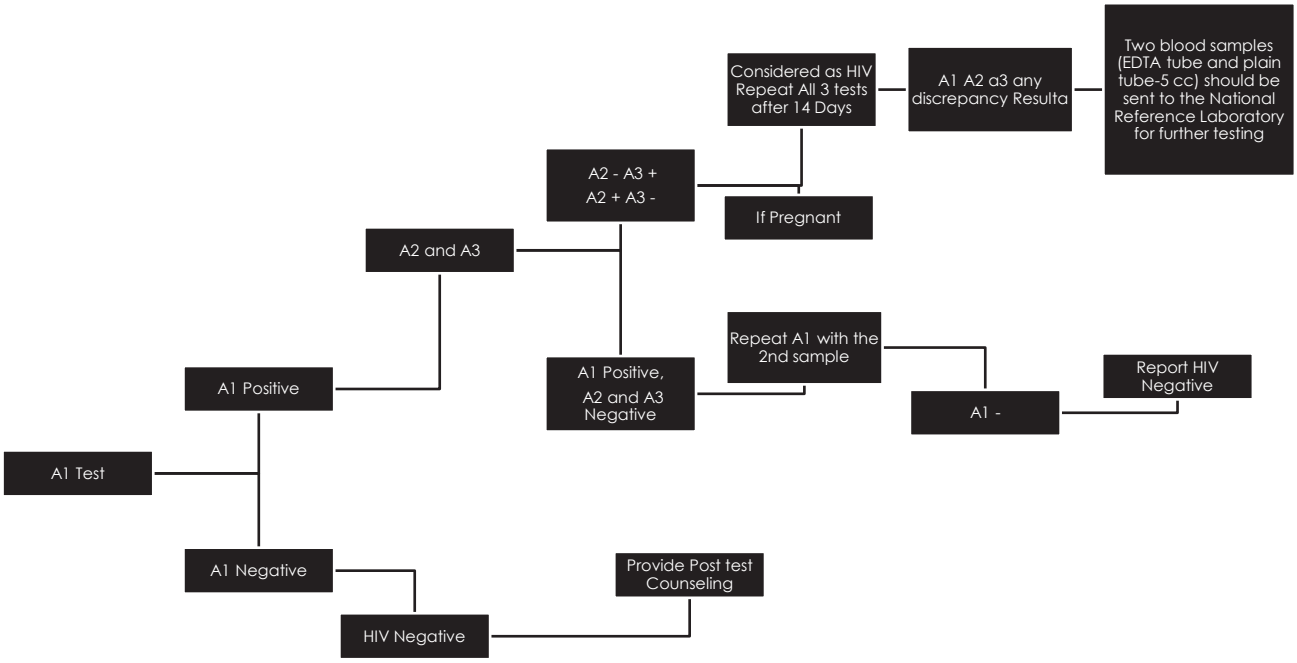
HIV Antibody and Antigen Test **(4th Generation test)**	By looking for both HIV antigens and antibodies to HIV, this test can diagnose HIV earlier than previous generations of HIV tests. Antigens are proteins on the surface of the HIV particle. The immune system produces antibodies in response to the HIV antigens. 4th generation tests are accurate 2-4 weeks after exposure, because this is when the p24 antigen becomes high enough to measure. A negative result at 28 days is good enough for most people (and situations), however, if this was a high-risk situation, getting a second test 8 weeks later is usually recommended to confirm the result.
HIV RNA test	RNA tests detect particles of the genetic make-up of the virus directly rather than the antibodies to HIV. Therefore, RNA tests can detect HIV much earlier, at about 10 days after infection or as soon as it appears in the bloodstream and long before the body develops antibodies or antigens become detectable. These tests cost much more than antibody-based tests, and are often introduced as part of PrEP programs to ensure people enrolling in PrEP are truly HIV negative.

What is the testing protocol (algorithm) in Sri Lanka?

Sri Lanka utilizes a three-test algorithm for HIV testing in individuals over 18 years of age. This algorithm involves a sequence of tests that are performed depending on the results of the previous test. The initial test (A1) is an HIV 1 & 2 Ag/Ab combo rapid test or an ELISA (Ag/Ab test). If the A1 test is positive, it is repeated along with two second-generation antibody rapid tests (A2 and A3) using a second blood sample for verification. If all three tests (A1, A2, A3) are positive, the individual is considered HIV positive, and linkage to HIV care and management is initiated. In cases where the A1 test is positive but A2 and A3 are negative, two blood samples (EDTA and plain tube) are sent to the National Reference Laboratory (NRL)at NSACP for further analysis[6].

[6] NSCAP/MOH, National HIV Testing Guideline 2023. Colombo. Available from: https://www.aidscontrol.gov.lk/images/publications/guidelines/National_testing_guideline__2023.pdf

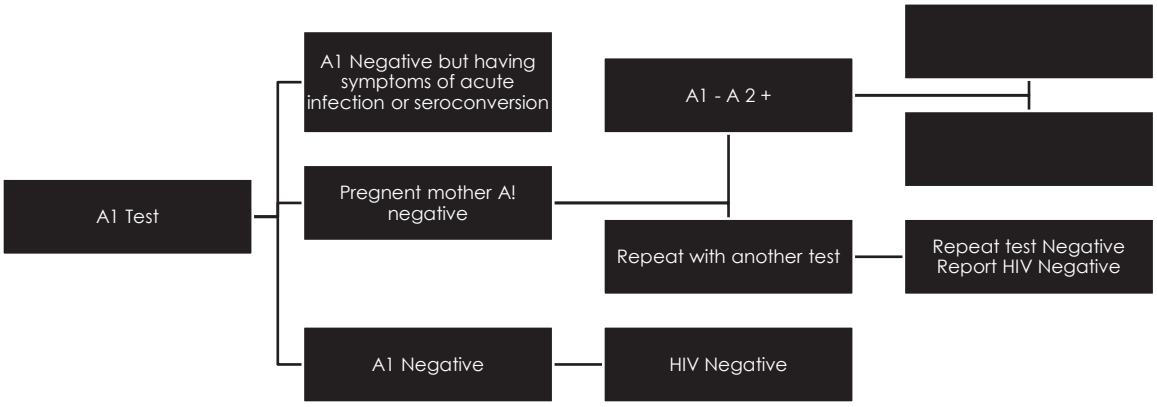




Three test algorithm (Scenario 2)

A1- HIV 1 & 2 Ag/Ab combo rapid /ELISA (Ag/Ab test)
A2- 2nd generation antibody rapid
A3- 2nd generation antibody rapid

* Consider retesting if the patient is in the window period or presence of symptoms of acute HIV infection or HIV Seroconversion



Test of triage

If the initial A1 test is negative, the individual is reported as HIV negative. However, retesting is considered if the individual is within the window period, exhibiting symptoms of acute HIV infection or HIV seroconversion. For pregnant women, if the A1 test is negative, it is repeated using a second blood sample. If the repeated A1 is also negative, the individual is reported as HIV negative. A separate "test of triage" algorithm is used in community-based testing, where different types of positive HIV test results are linked to the national testing algorithm for confirmation[6].

Who provides case management in Sri Lanka?

In Sri Lanka, case management is handled by the STD clinic consultant and trained medical personnel, including nurses, public health inspectors and doctors. This ensures that newly diagnosed clients receive consistent and professional follow-up and care.

☞ See Annex 1 for a list of HIV/STI services available in Sri Lanka.

Can a client also test for HIV/STI in the private sector?

Private clinics and labs offer HIV/STI screening services for a fee, catering to individuals who seek greater privacy and faster results than those typically available at government clinics.

While government STI clinics remain the primary testing sites, especially among HIV-positive respondents (96.8% of whom were last tested there, according to the 2018 IBBS survey), a notable number of individuals, particularly MSMs, prefer private facilities for the anonymity and convenience they provide. This trend highlights the demand for accessible, discreet testing options beyond public services.

Can a client also do a test alone, without any CSP or healthcare worker present?

Yes. **WHO has recommended HIV self-testing (HIV ST)** as an innovative strategy to reach the unreached and people who do not attend HIV testing services? The evidence shows that HIVST is safe, accurate, highly acceptable, increases access, and increases the uptake among those who are at high risk and who may not test otherwise.

The NSACP has introduced **OraQuick** oral fluid tests, which clients can use alone. The availability of HIV self-tests in Sri Lanka will help increase awareness of HIV infection. HIV ST has the potential of being a high-impact, low-cost intervention to reach high-risk individuals who are not seeking testing through other HIV testing delivery systems and to increase the number of people with undiagnosed HIV infection who are identified and linked to care services. HIV ST also presents an opportunity to provide linkages to HIV prevention services for those who are test negative[7].

What to do if a client wants to self-test for HIV?

The client can order a self-test kit for HIV from the Know4sure.lk website:
https://www.aidscontrol.gov.lk/index.php?option=com_content&view=article&id=98&Itemid=276&lang=en

A form needs to be filled out, which can be found here:
https://docs.google.com/forms/d/e/1FAIpQLScpyWQdSWKrtNjahm4PZTeLJLd5no65XtZYCkSrepzB8MbIKQ/viewform

For clients with limited literacy or computer skills, the CSP should assist in this process where possible. Outreach workers and Peer Educators are trained to provide HIV self testing and for assisted self testing. Concerns about privacy, especially among men who have sex with men, and logistical challenges have restricted CBT and HIVST primarily to **Drop-in Centers**

[7] NSACP, 2022. HIV self-testing. Standard Operating Procedures for the delivery of HIV Self-testing services in Sri Lanka. Available from:
https://www.aidscontrol.gov.lk/images/publications/guidelines/HIV_self-testing_SoP.pdf

(DICs) in Colombo. Scaling up CBT and HIVST in high-priority districts is seen as essential to reaching more individuals who may not engage with existing HIV testing at STI clinics.

☞ See Annex 1 for a list of clinics in the country.

Why are anonymity and confidentiality important when testing for HIV?

Anonymity and confidentiality are crucial; nobody will use an HIV/STI testing service if the result is not kept a secret. As discussed in Chapter 2 under ethics, this is one of the first principles for HIV/STI health care providers and Community Service Providers. Unfortunately, it is sometimes not respected. In many cases, HIV/STI testing is impossible to be done anonymously, with positive cases finding their way into government records.

Discussing intimate information with your clients also needs to be confidential. Always be professional and respect each person's right to anonymity and confidentiality. This will encourage your clients to trust you and give you more information about their feelings and behaviors, enabling you to help them progress toward engaging in safer behaviors.

What is the window period?

Some HIV tests check the blood for antibodies (proteins produced by the body and released into the bloodstream to fight infection) rather than for the presence of HIV particles in the blood. After infection with HIV, it takes a few weeks for the body to create these HIV antibodies. In other words, it is possible that during the time between when infection occurs and when antibody levels are high enough to be detected by the test, an HIV test result may show as unfavorable, even if the person was recently infected with HIV. This gap is called the "window period."

How long is the window period?

The length of the window period varies from person to person and also depends on the type of test used.

TYPE OF TEST	WINDOW PERIOD
HIV Antibody Test (3rd Generation test) Self Testing	4 to 6 weeks for most people (possibly up to 12 weeks or 3 months for some people)
HIV Antibody and Antigen Test (4th Generation test)	2 to 4 weeks
HIV RNA Test	10 to 14 days

Therefore, people should be tested regularly, if they can possibly every six months if they or their sexual partners have experienced risky behaviours.

Why is the window period important?

It is important, because it is a period of time during which a person has a negative test result but in fact is HIV-positive and highly infectious, as the viral load spikes and the body has not yet developed an immune response. Because of the window period, we can never be 100% sure that the person is really free of HIV when the test is negative, unless we had absolutely no risk behaviour in the period before we received the negative test result.

How can I best approach clients who resist HIV testing?

Many clients are fearful of accessing HIV counselling and testing services. Table 1 lists some common reasons that are used to rationalize the decision not to take an HIV test and possible responses to these arguments. It is important not to use any of these answers to stop the conversation or to provide a final answer. Rather, it is important to engage in discussion with your clients to find out what it is that stops them from having an HIV test. Between cities and villages, the reasons for not getting tested may be quite different. (Keep in mind, Table 1 is meant as an illustration or source of inspiration only, it is not a blueprint!)

If clients do not like the idea of testing with a CSP or at a facility, it is now possible to recommend them to do an HIV self-test kit. This way, a client can conduct an HIV screening test at the comfort and privacy of their own home.

Table 1: Common reasons for not having an HIV test and possible responses

Reason not to test	Possible response
"I have no money."	"HIV testing is free."
"I have no time."	"HIV testing does not take a long time. The whole process usually takes less than 90 minutes. There are different opening hours for clinics in the city, and there also are possibilities to test outside of office hours, for example via CBT and HIV self-testing."
"I don't know where to go."; "it is too far away!" Or "I have no transport!"	"I can take you to a safe and confidential location where you can get an HIV test, which is quick and free." OR "I

	can do the test for you or You can order an HIV self-test online and do the test at home!"
"People like me don't get HIV." **"I am only 'top', so I can't get HIV.'"** **"I choose my partners carefully, so I won't have HIV."**	"HIV does not choose people based on certain characteristics. It is transmitted via certain behaviours. If you have engaged in such behaviours, there is a chance you have HIV, regardless of the type of person you are or the type of person you had sex with."
"I don't think I need an HIV test."	"Have you ever had anal sex without a condom with someone whose HIV status you were not sure about? Have you had an STI? Have you had tuberculosis or hepatitis? Have you ever shared needles when injecting drugs? If you can answer YES to any of these questions, you should get tested."
"God (or fate) will decide if I live or die."	"That may be true, but God also has given you the capacity to think and decide about your own life and your health. Plus, if you have HIV and unwittingly spread it to others, God would probably not approve. It is better to know your status."
"Why should I know whether I have HIV or not? You have to die of something!"	"If you know you have HIV, it is not a death sentence. There is free treatment available, and if you take it as prescribed, you will likely die of old age, not of AIDS."
"I am afraid people will know it if I have HIV and will start gossiping. Better not to test."	This is an important and valid reason, especially in small towns / villages! Ensure that you take your client to a safe and confidential clinic. If you are not convinced of the standards of confidentiality in a clinic, it is better to recommend a self-test to the client (see above).
"I don't know what will happen if I test positive for HIV. I prefer not to know."	Here you have to discuss with your client why they prefer not to know; try to discuss the future with your client if they remain healthy versus when they get sick or even

	die. Discuss the impact this may have, also on their family.
"I cannot afford HIV treatment if I test positive for HIV, so I might as well not know it."	The Antiretroviral treatment for HIV is free.
"I am shy and I am worried that staff at the STD clinic will look down on me."	I can accompany you to support you and help you deal with this, if you wish. Alternatively, you can apply for an HIV self-test and do it yourself, in the privacy of your own home!
"I donate blood as a way to indirectly know my status"	Don't be so sure that the Blood Bank is able to contact you if they detect anything in your blood… Please get tested properly as you can also benefit from free HIV counselling and consultation.

What are effective ways to encourage HIV testing?

There are several reasons for why people particularly at risk should have an HIV test (and regularly if they are negative).

1. HIV testing is important because finding out whether people have HIV will enable them to access antiretroviral treatment. This will keep them alive and healthy. The earlier a person starts with this treatment, the better the long-term effects of the treatment and the fewer the long-term detrimental effects of HIV will be.

2. It is important to find out whether a person has HIV to avoid passing it on to others. People who are diagnosed with HIV are often extra careful and extra safe when having sex to ensure that their partners do not get exposed. Getting on antiretroviral treatment is in itself an effective way to avoid transmitting HIV to others once a person living with HIV is undetectable ("U=U", undetectable = untransmittable).

3. Testing is a good way to reduce anxiety about HIV or STI. Walking out of the testing centre with a negative result is a great feeling, and it can strengthen a person's resolve to remain free of HIV and be safe when having sex (including the possibility of taking PrEP).

4. Both HIV testing as well as antiretroviral treatment are free. You can stress to a client: "Why not make sure you access these services and stay in control of your health?"

5. “If it is not for yourself, you might consider getting tested to ensure you stay healthy for your family and friends or, if you have a partner, for your partner!”
6. “If you decide to settle down with somebody special, you may discuss together to start having sex without condoms. To do so, both of you should get tested to ensure that you are HIV negative.”

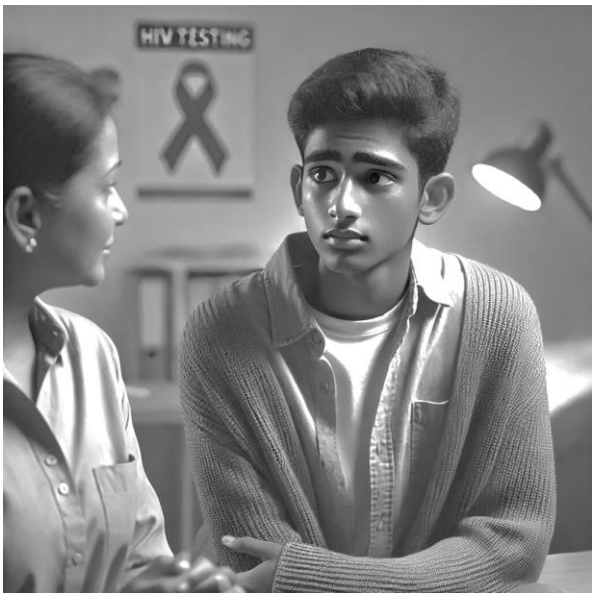
Are there clients that may face extra barriers to access HIV/STI testing?

Yes, there are certain groups of people who may have difficulty accessing HIV/STI counselling and testing. These groups include migrants or refugees who may not have citizenship in Sri Lanka and may have difficulty communicating with health care providers.

Another group that often faces difficulties accessing HIV/STI testing services are adolescents under the age of 18, who must, in principle, have written parental/guardian consent to access medical services (see important caveats below).

For these groups, they can discuss with the STD clinic staff to find a way to test or go for HIV self-testing (see above) could be an important and acceptable way to access HIV testing.

How about adolescent KP under the age of 18, can they get tested for HIV/STI if they want to?



According to the National HIV Testing Guideline 2023[6], for children under 18 years, HIV/STI testing requires consent from a parent or legal guardian. The healthcare provider should counsel the parent or guardian, explaining the reasons for testing and highlighting the potential benefits for the child’s health. If the parent or guardian initially refuses testing, the provider should engage in further counseling to address concerns and understand the reasons behind the refusal.

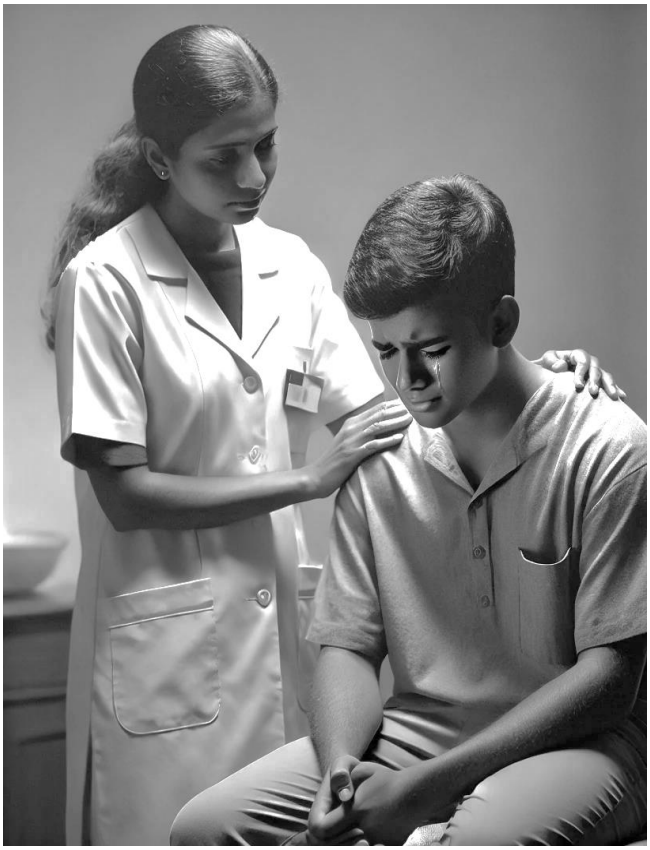
In cases where all efforts to obtain parental consent are unsuccessful, the healthcare provider holds an ethical responsibility to act in the child’s best interest. Since HIV treatment is life-

saving, the provider may proceed with testing and initiate treatment if needed, ensuring that the child's health and wellbeing are prioritized.

If an adolescent under 18 shows up for HIV/STI testing alone, the healthcare provider may proceed with the HIV/STI test if they are confident that the child understands the test and its implications. This approach acknowledges that, in certain situations, a child under 16 may have the maturity and understanding necessary to provide consent for testing independently of parental involvement.

Chapter 7: The Importance of HIV Case Management

What is HIV case management?



HIV case management is a service that aims to ensure people living with HIV can successfully enrol into HIV treatment and remain adherent to their treatment. It assists them to live well by supporting timely access to health services in general, and provides them with psycho-social support. The Venereologist, Doctors and STD Clinic staff (Case Managers) try to reduce other impacts of HIV on the life of people who are newly diagnosed, in particular the acute panic, stress and social isolation that can be associated with an HIV diagnosis. Case managers achieve these goals by listening to the client, working closely with the client and cooperating with local service providers to deliver appropriate health and social support services to people living with HIV. The ultimate goal of case management is to enable clients to become self-reliant and independent in their ARV treatment compliance and thus take control of their own life and healthcare.

Why is HIV case management important?

Before bringing clients in for testing, community service providers can give up-to-date and accurate information about the availability and benefits of HIV treatment, but once testing positive, clients are often in shock. It is at this stage that STD clinic case managers come in, ensuring that clients do not miss out on the benefits of HIV treatment services after they discover that they are HIV positive.

What do newly diagnosed people living with HIV need the most?

Initially, after diagnosis, all clients need support and counselling to ensure that they do not run away and miss out on life-saving HIV treatment due to their state of shock or panic. They need counselling so they understand the need and benefits of enrolling into antiretroviral treatment.

Chapter 8: Continuous Mapping and Sourcing of New Key Population Networks

What is Daily Record Form and Field Diary, and how are they used

Field diaries and daily record forms are tools used by outreach workers and Peer Educators to record observations and information gathered during fieldwork. They are essential for real-time mapping, which involves continuously identifying and assessing new locations where key populations gather. Outreach workers use field diaries and Daily Records by the Peer Educators to document various details about these new sites, including:

- Physical characteristics like roads, buildings, and landmarks.
- The presence and movement patterns of key populations.
- Contact information for individuals who can provide further insights or facilitate connections.

The information recorded in field diaries is then shared with the outreach team to inform decision-making about prioritizing sites for HIV prevention services.

What methods can outreach workers use to record information in their field diaries?

Four methods for recording information in field diaries:

- Maps: Outreach workers can draw maps of new sites, including details about the location and movement of key populations.
- Tables: Tables allow for structured recording of information about sites, including their name, date and time visited, specific observations, and actions to be taken.
- Dot points: This method offers a concise way to list key details about new sites and contacts.
- Diagrams: Simple diagrams can be used to visually represent the relationships between different sites and networks.

Outreach workers can choose the method that best suits their preferences and the type of information being gathered.

How does real-time mapping help prioritize sites for HIV outreach?

Real-time mapping utilizes a color-coded system, often referred to as a "traffic light" system, to categorize sites based on their HIV prevalence/number of HIV cases found and the need for intervention.

Prevalence	Discerption
High prevalence	Sites where two or more individuals tested positive for HIV during outreach activities are categorized as high priority. Outreach efforts are intensified at these locations, including increased HIV testing and distribution of prevention resources and information.
Medium prevalence	Sites where one individual test positive are classified as medium priority. Outreach work continues at these locations, with a focus on HIV prevention education and testing.
Low prevalence	Sites where no one tests positive are categorized as low priority. While HIV prevention resources and information are provided, the outreach team may shift its focus to other locations.

This dynamic approach ensures that resources are allocated effectively based on the evolving needs of different key population networks.

What is "random walking," and how does it complement real-time mapping?

Random walking is a technique inspired by Respondent-Driven Sampling (RDS) that aims to identify "outliers" within key populations—individuals with unique characteristics or who are not closely connected to established networks. These outliers may be at higher risk for HIV but are less likely to be reached through traditional outreach methods that focus on known hotspots.

While real-time mapping prioritizes locations, random walking prioritizes special/specific characteristics. By identifying a client with a unique characteristic, such as age, gender, or behavior patterns, outreach workers can leverage their knowledge and social connections to reach similar individuals. If a higher HIV prevalence is observed within this "random walk"

sample, it signals the need to adapt outreach strategies to better engage the newly-identified population.

Can technology be used to enhance real-time mapping and sourcing of key population networks?

Yes, technology can significantly improve the efficiency and reach of real-time mapping.

- Google My Maps: This free, web-based mapping service enables outreach teams to create, share, and update maps in real-time. Teams can add pins to mark locations, include detailed information about each site, and even track the movements of outreach workers.
- Messaging Apps and social media: Platforms like LINE, WhatsApp, Viber, and Facebook can facilitate communication and information sharing among outreach workers and key population members. These tools can be used to:
    - Disseminate HIV prevention messages.
    - Organize outreach events.
    - Maintain contact with clients.
    - Establish online support groups.
- Bulk SMS: Bulk SMS services allow organizations to send targeted messages to large groups of people, which can be useful for reminders about HIV testing or upcoming outreach activities.

The use of technology can streamline data collection, improve coordination among team members, and facilitate more targeted outreach efforts.

How can outreach teams effectively prioritize new sites or networks identified through mapping and random walking?

Prioritization requires a structured decision-making process. Teams should consider factors like:

- HIV cases identified: The number of individuals testing positive for HIV at a site or within a particular random walk is a crucial indicator of priority.

- Presence of other STI: High rates of syphilis or other sexually transmitted infections may indicate increased vulnerability to HIV and warrant further attention.
- Accessibility: The ease of reaching a particular location or population group is important to consider.
- Resource availability: Teams must assess whether they have the necessary personnel, funding, and materials to effectively serve a new site or network.

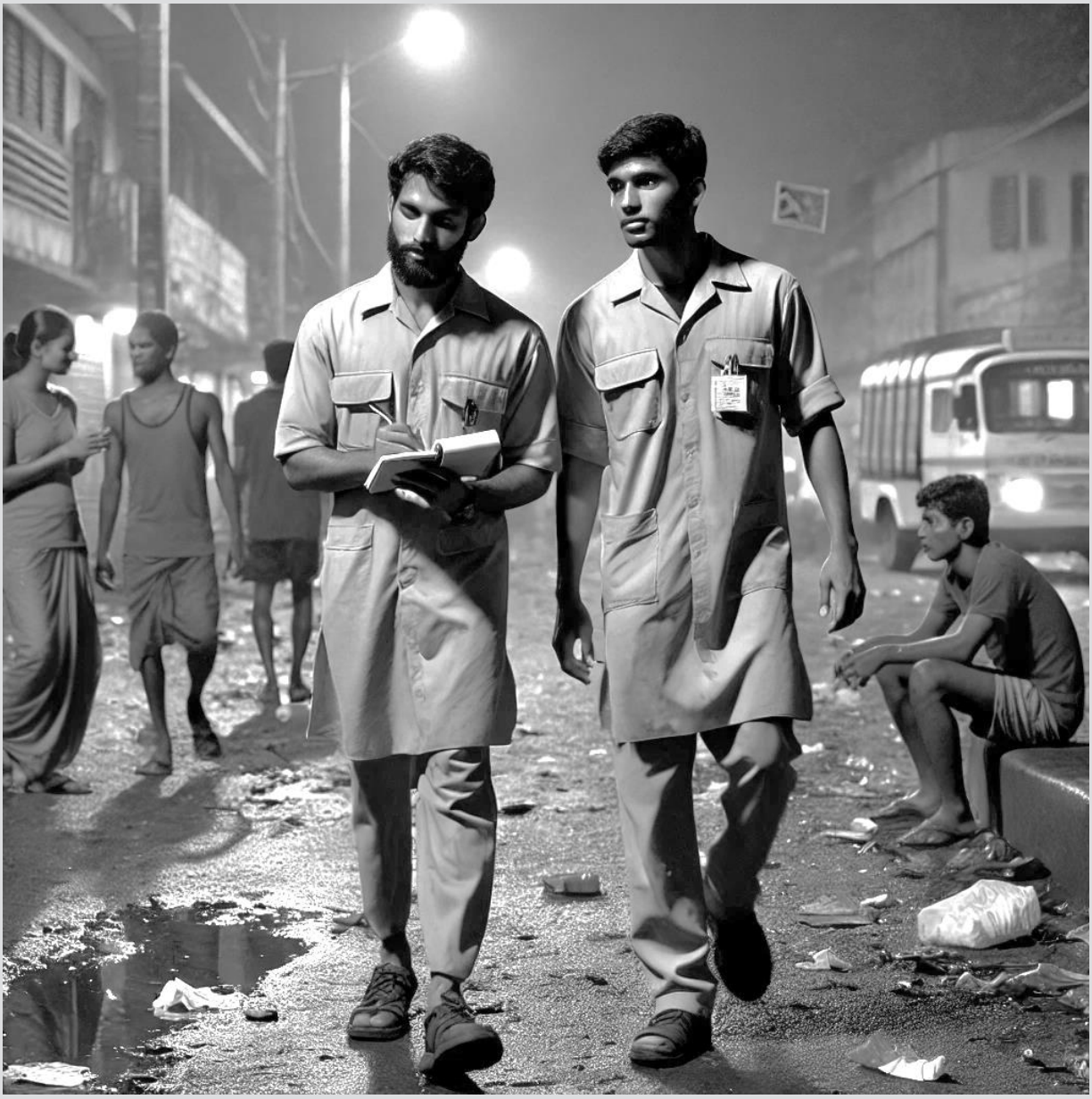
Regular team discussions are essential to review mapping and random walking data, weigh these factors, and make informed decisions about resource allocation.

What are the benefits of real-time mapping and sourcing for HIV prevention efforts?

Real-time mapping and sourcing offer several advantages:

- Enhanced HIV case finding: By continuously identifying new locations and underserved populations, these techniques increase the likelihood of finding undiagnosed individuals.
- Improved resource allocation: The traffic light system enables organizations to allocate resources strategically, focusing on areas with the highest need.
- Targeted outreach: Understanding the unique characteristics and needs of different key population groups allows for the development of tailored interventions.
- Adaptability: Real-time mapping and sourcing enable programs to respond quickly to changing trends and patterns of HIV transmission.

These approaches contribute to more effective and efficient HIV prevention programs, ultimately leading to improved health outcomes for key populations.



PART B: Understanding HIV/STI transmission and its prevention

Chapter 9: Basic information about HIV

What is a virus?

A virus is an organism so small that it is invisible to the human eye. There are many types of viruses, and not all of them affect us in the same way. For example, the flu is caused by the influenza virus; this virus can be transmitted through the air when we cough or sneeze.

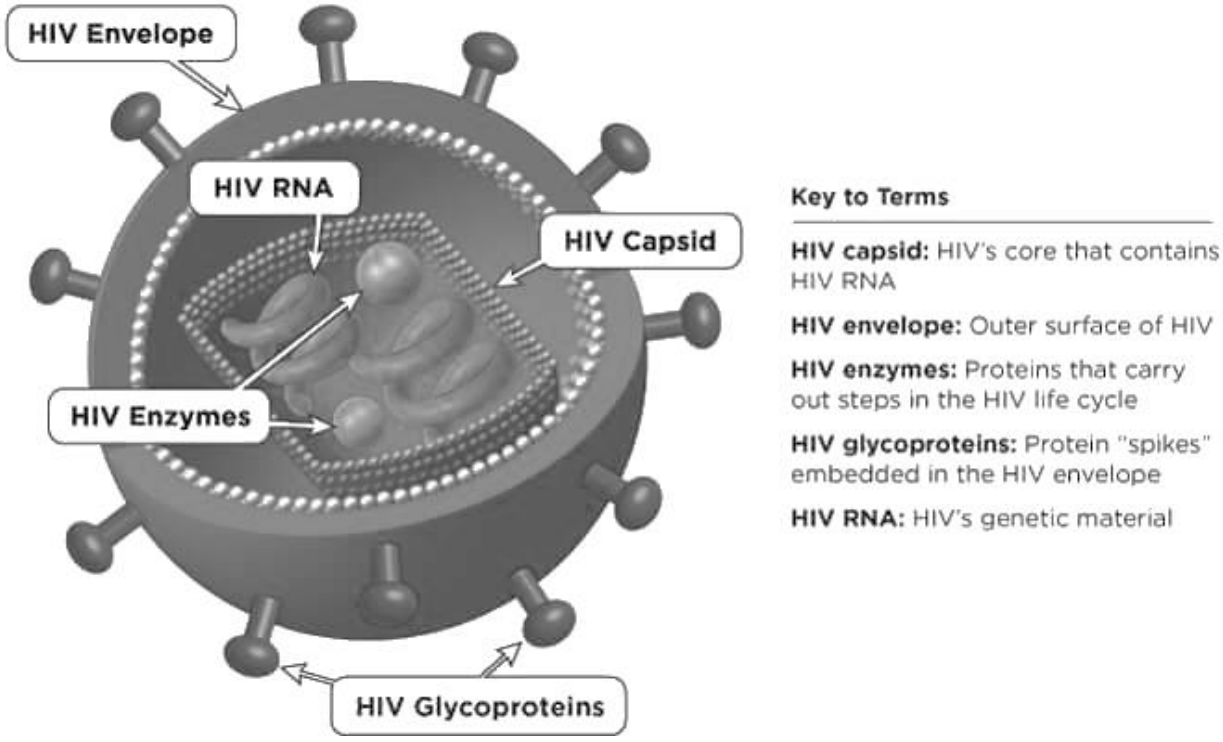
What is HIV?

The human immunodeficiency virus (HIV) can lead to the Acquired Immune Deficiency Syndrome (AIDS), which is, if left untreated, a serious set of diseases. HIV is transmitted via blood, semen and pre-cum, breast milk, vaginal fluids, and rectal fluids. If HIV is not treated, it usually leads to death. Fortunately, HIV is not as easy to transmit as the flu or COVID-19 virus, and its transmission can be prevented relatively easily.

What does HIV look like?

Look at Figure 2 below:

Fig. 2: Structure of an HIV



Source: https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/73/the-hiv-life-cycle

What are CD4 cells?

CD-4 cells are a type of white blood cell that play a role in the human immune system. These are the cells that HIV attacks. A person's CD4 count, i.e., the number of CD4 cells that remain in each mm^3 of blood, is a good indicator of the health of their immune system.

What is the HIV life cycle?

HIV attacks and destroys the CD4 cells of the immune system. HIV uses the machinery of the CD4 cells to multiply by making copies of HIV and spread throughout the body if untreated.

What are the body fluids that can transmit HIV?

Body fluids that contain and can transmit HIV include:

1. blood;
2. semen and pre-cum;
3. fluids that exist in the vagina;
4. fluids that are secreted in the rectum and
5. breast milk.

How does HIV affect the human body?

The body's ability to fight off any disease is called the immune response, which the immune system manages. It consists, among other things, of "defense cells" in our blood, which are known as the white blood cells, including CD4 cells (a subgroup of white blood cells). Usually, these CD4 cells help attack and destroy diseases and infections that enter the body.

HIV attacks the immune system by killing these cells and taking over their machinery for replication (see above). After some time, the immune system will wear down and become less effective. As a result, diseases and infections, some of which usually have little success in attacking the body, may find an open window through which they can damage. Without ART to stop HIV from multiplying, a person living with HIV may die after their immune system is destroyed. This stage in the disease progression is called 'AIDS.' Attacking the immune system can take many years, during which the infected person may not have any disease symptoms for long periods. Still, the person is infectious and can transmit the virus to others.

What is AIDS?

AIDS stands for 'Acquired Immuno-Deficiency Syndrome'. A syndrome is a set of symptoms of disease that often occur together. With AIDS, these symptoms are a result of severe damage to the immune system. When the immune system is seriously damaged by HIV it becomes unable to defend the body against certain "opportunistic" infections and tumours. These are

also known as HIV-related diseases. At this stage, the human body is highly vulnerable to a wide range of diseases, including tuberculosis, pneumonia and cancer. Unlike most other diseases, people with AIDS may experience with very different clinical problems, depending on which opportunistic infections they catch or develop. For this reason, AIDS cannot be diagnosed by a single symptom or sign; it depends on which virus, bacteria, or cancer, attacks the body first. A diagnosis of AIDS can only be confirmed by a doctor after examining and testing.

What is the difference between HIV and AIDS?

In short, HIV is a virus (human immunodeficiency virus), while AIDS is a disease (acquired immunodeficiency syndrome) leading to weakened immunity. AIDS may occur if a person with HIV is not taking ART medication and can lead to death if left untreated. When a person is initially infected with HIV, they may look well and feel as healthy as any other person. But without treatment and after continued attacks by HIV on the immune system, the person may gradually develop illnesses and symptoms and become weak. At this point, the HIV infection has progressed into the AIDS stage. This process can take between 3 and 10 years from the initial infection, depending on several factors.

A person with HIV may show no physical symptoms of any disease for a long time. This stage of infection is called **"asymptomatic**" (meaning no symptoms). As HIV continues to destroy the immune system gradually, a person may develop certain illnesses related to HIV infection. Having a number of these specific illnesses together means the HIV infection has become **"symptomatic"** and becomes visible as AIDS. If a person with symptomatic HIV or AIDS has no access to medicines, care, and support, they will most likely eventually die of illness.

A person can often lead an everyday life without knowing that they are infected with HIV. It is, therefore, easy to understand how someone may, without knowing it, transmit HIV to others. HIV also makes a person more vulnerable to other STIs and some other illnesses, such as Tuberculosis.

How long will it take before a person with HIV develops AIDS?

Depending on a person's physical and mental health as well as other factors, including the extent to which a person with HIV has support and a healthy lifestyle with plenty of rest, sports, proper nutrition, and peace of mind, it can take many years to develop AIDS, if at all. From

the point of initial infection, without ART, it can take between 3 and 10 years for most types of HIV; most often, it is between 7 and 10 years. However, scientists recently discovered a new subtype of HIV, called CRF19, which develops from HIV into AIDS three times faster, at around three years after infection (if a person does not take treatment). Fortunately, with the increased availability of HIV treatment, if a person with HIV is under medical supervision and promptly starts treatment with antiretroviral medicines (see Chapter 16, 17 and 18), they may never enter into the AIDS phase and will live a long and healthy life.

How long can a person with AIDS survive without treatment?

When a person who has entered the AIDS stage does not have access to appropriate antiretroviral medicines and medical care, he/she will usually die within 12 to 18 months. When a person has access to medical care and ART (see Chapter 17), most people with HIV will die of old age rather than of complications associated with HIV or AIDS.

With increasing access to ART, more people with AIDS are successful in bringing down their HIV Viral levels and recovering their immune system, returning to the asymptomatic stage of their HIV infection and living long and healthy lives.

Is it possible to see whether a person has HIV?

No one can assess whether a person has HIV just by looking at them because most people with HIV have no outside characteristics or symptoms. Many people have misconceptions about this. They think people with HIV are skinny or that their skin feels warm or looks different. These are misconceptions. The only way to know whether anyone is infected is with an HIV test (blood or saliva test).

☞ See Annex 1 for a list of clinics in your city/district.

Who gets HIV Infection?

Anyone exposed to the virus can become infected, though HIV is not easily transmitted (see Table 8). Some people do not get infected even after repeated unprotected exposures to it. Typically, HIV spreads through certain high-risk behaviors, like unprotected sex, sharing needles, or unsafe blood transfusions.

There's a misconception that only certain groups, like poor people, men who have sex with men, transgender people, people engaged in sex work, or drug users, get HIV, or that those

who look “healthy” or come from higher social classes are safe. This isn’t true. HIV doesn’t discriminate based on appearance, social class, age, or ethnicity. Anyone who engages in high-risk behaviors can be exposed to HIV.

The exception is for infants, who can get HIV from their HIV Positive mothers during pregnancy, birth, or breastfeeding without engaging in risky behavior.

What are some misconceptions about HIV?

Myths and misconceptions refer to wrong understandings or falsehoods about HIV. For instance, it is sometimes wrongly assumed that someone has gotten HIV due to a curse or demonic possession or that it can only affect people from homosexual or other sexual minorities. These people engage in sex work or other people often considered ‘sinful’ by religious conservatives. This is, of course, false, as HIV can affect anyone who is sexually active or shares needles and even from infected mother to child. Viruses do not adhere to any religion and have no idea about virtue or sin. A common misconception in Sri Lanka is an underestimation of one’s risk for HIV, and knowledge about HIV remains limited among many key population groups.

The facts in this guide should dispel myths and misconceptions. Chapter 10 covers misconceptions about transmission from daily activities or mosquito bites, while Chapter 17 covers misconceptions about treatment.

What is the difference between HIV 1 and HIV 2?

HIV-1 and HIV-2 are two different types of HIV. A 2008 study showed they are only about 55% genetically similar. HIV-1 is the most common type worldwide, causing about 95% of infections. Most HIV tests can detect both types. HIV-2 is rare and primarily found in West Africa, though cases have been seen elsewhere. It spreads less quickly, progresses more slowly, and leads to fewer deaths than HIV-1. Most antiretroviral drugs work against both HIV-1 and HIV-2, but some drugs, like NNRTIs (e.g., Nevirapine and Efavirenz), are not effective against HIV-2. The best treatment approach for HIV-2 is still less straightforward than for HIV-1.

What is viral load?

A person’s viral load refers to the amount of HIV in the bloodstream. See Chapter 17.

Chapter 10: HIV and its transmission and prevention

How can HIV be transmitted?

For the virus to be transmitted, one of five infectious body fluids of an HIV-infected person needs to enter the bloodstream of a person who is not infected with HIV. These five contagious body fluids are: blood, semen & pre-cum, vaginal fluid, rectal secretions, and breast milk. There must be a "point of entry" into the bloodstream for transmission. For example, a tear in a tiny blood vessel via which the virus can move from one person to the next. There also has to be a sufficient number of living viral HIV particles entering the uninfected person for transmission to occur. Even if an adequate number of alive HIV particles enter the bloodstream of an uninfected person, there remains only a relatively small chance that transmission happens—**fortunately, HIV transmission is never a 100% certainty** (see Table 8 in Chapter 15).

The most efficient route of transmission is when HIV-infected blood enters the bloodstream of a non-infected person directly, for example, by sharing injection needles and syringes with an HIV-infected person or by receiving a blood transfusion with HIV-infected blood.

HIV is most commonly transmitted through unprotected sexual activity. The easiest way for sexual HIV transmission to occur is through unprotected anal sex between an infected person and an uninfected partner. Unprotected vaginal sex also carries a risk for HIV transmission. Oral transmission is, in theory, possible if a person has problems with oral hygiene leading to bleeding gums or sores, but even then, the chance of infection is minimal. However, the risk of STI transmission through condomless oral sex is much higher.

Important to know: The risk for the receiving partner in anal, oral, or vaginal sex is higher than for the insertive partner (see Table 8 in Chapter 15).

HIV can also be transmitted from an HIV-infected woman to her child during pregnancy or childbirth or through breastfeeding; this can only happen if the mother is not being treated with ART medication during and after giving birth.

If an HIV positive person has condomless sex with an HIV negative person, will the negative person always become infected?

No. Although it is a common belief—even among some HIV service providers—that infection is guaranteed after unprotected sex with an HIV-positive person, HIV is actually not easy to

transmit. The risk per act varies depending on the type of sexual activity. For instance, the average estimated risk per each act of **receptive anal sex** is about **1.4%**, while for **insertive anal sex** it is around **0.11%**. For **receptive vaginal sex**, the risk is approximately **0.08% per sexual episode**, and for **insertive vaginal sex**, it is about **0.04% per each time someone has sex with an infected person**[8] (see Table 8 in Chapter 15).

Overestimating HIV's infectiousness, as many lay people tend to do, may lead to unnecessary stigma toward people living with HIV and can cause clients to feel overly anxious or fatalistic about their HIV status. Educating clients accurately on the actual transmission risks empowers them to make informed choices about their level of risk.

Is sex between men who have sex with men, transgender people, and people who engage in sex work always risky for HIV infection?

No. If two people have sex, there is only a risk for HIV transmission if one of the two partners is living with HIV and if they do not use condoms, PrEP, and/or if any partner who may be living with HIV is not on antiretroviral treatment. It also depends on the sexual behavior people engage in.

In short, it is relatively safe to have penetrative sex when condoms and water-based lubricants are used consistently. Even more compelling is the use of antiretroviral drugs, either for prevention (such as PrEP for people who are HIV-negative) or to prevent infecting others (antiretroviral treatment for people living with HIV), together with condom and lubricant use.

Which sexual behaviors are no risk, low risk, medium risk, and high risk?

A wide range of sexual behaviors is cited in Table 2. The possibility of HIV transmission is defined as:

- "no risk" for HIV transmission (safe sex)
- "low risk" (minimal chance for HIV transmission that may be ignored after informed decision-making)
- "medium risk" (a slight chance for HIV transmission)
- "high risk" (the highest chance for HIV transmission).

[8] See: https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html

As well as always promoting condom use to make penetrative sex safer, community service providers should also discuss the possibility of avoiding high-risk (especially anal) sex and trying out other less-risky sexual acts, such as oral sex or mutual masturbation. The table may help community service providers think of suggestions to make to their clients.

Table 2: Risk level of sexual behaviours

PRACTICE	RISK	NOTES
Abstinence	No risk	Abstinence from all forms of sex with others is not a realistic option for most people.
Masturbation	No risk	
Unshared sex toys	No risk	
Phone sex	No risk	
Cyber or webcam sex	No risk	
Hugging	No risk	
Massaging each other	No risk	
Telling each other sexual fantasies	No risk	
Watching pornographic movies	No risk	
Rubbing genitals together fully clothed	No risk	
Rubbing genitals together without penetration, unclothed	No risk	Provided there are no lesions on the genitals and no exchanges of infectious body fluids. Some STI (herpes and scabies, for instance) can be transmitted through contact with skin not covered by a barrier especially if there are lesions.
Mutual masturbation	No risk	There is no risk if there are no cuts or broken skin on the hands or other body parts used for masturbation and if there are no exchanges of any infectious body fluids
Sharing sex toys that have been cleaned or using sex toys with a new condom	No risk	Sex toys need to be cleaned with soap and water (or any suitable disinfectant) after each use. It is even better to use a condom on the sex toy and remove it after use.
Rubbing sweaty bodies together	No risk	No HIV transmission risk, although some STI (herpes and scabies, for instance) can be transmitted

		through contact with skin not covered by a barrier especially if there are lesions.
Biting as part of sexual play	No risk	It is no risk if there are no lesions or open sores or cuts in the mouth and provided that the biting does not cause the person to bleed.
Deep (tongue) kissing	No risk	There is no risk if there are no sores or cuts in the mouth or bleeding gums. Also, there is no risk due to saliva; saliva can contain antibodies to HIV but not the virus itself.
Oral sex on a man with a condom	No risk	Make sure to pick a condom that has a nice flavour! (Chapter 12)
Oral sex on a man without a condom	Low risk	STI can be transmitted through oral sex from the person receiving it to the person giving oral sex (the person who does the sucking). However, risk for HIV transmission in oral sex is extremely low and is much lower than that of anal or vaginal sex. It is even safer if no ejaculation in the mouth occurs.
Fingering or fisting	Low risk	Provided that basic hygiene is ensured and if there are no cuts or broken skin on the hands and no contact with semen or blood (fisting has a much greater chance of tearing rectal tissues), this practice can be safe.
Anal sex with a condom	Low risk	The risk of condom breakage is greater than for vaginal sex. It is safer if water-based lubricant is also used.
Rimming (Licking the anus)	Low risk	STI can be transmitted through oral sex, but the risk is lower than for anal or vaginal sex. The risk for the person licking is the same as in kissing or oral sex. However, parasites can be transmitted, too, which can be particularly unhealthy for people living with HIV. There is no risk when a dental dam is used (see Chapter 12).
Anal sex with multiple partners; condom use every time	Medium risk	Having multiple sex partners increases probable risk; however, correct and consistent condom use lowers risk. sex with multiple partners also increases probable STI risk.
Anal sex without a condom	High risk	Anal sex is one of the highest risk activities. The receptive partner is at greatest risk because the tissue lining of the rectum is more susceptible to tears or lesions during intercourse. Risk increases if a person has condomless sex with many partners.

Withdrawal of the penis before ejaculating while having anal sex without a condom	Medium risk to high risk	HIV can be present in pre-cum, meaning there is still a risk of transmission even if withdrawal occurs before ejaculation. Although withdrawal may slightly reduce the HIV transmission risk for the receptive partner, this reduction is minimal and not considered a reliable prevention method. The risk of transmitting other STI remains high, as these can also be present in pre-cum.
Anal/vaginal sex with a circumcised man without a condom	High risk	Circumcised men have a lower risk of acquiring HIV from an HIV-positive female partner compared to uncircumcised men. This is because the inner surface of the foreskin contains cells that HIV can easily infect, providing a pathway for the virus to access the bloodstream. When the foreskin is removed, this entry point is reduced, decreasing the opportunity for HIV to enter the man's body through the penis. The virus then has fewer access points, primarily limited to the small blood vessels at the tip of the penis. However, male circumcision does not provide full protection against HIV or other STI, nor does it reduce the likelihood of an HIV-positive circumcised man transmitting the virus to his sexual partners. Circumcision should be considered one part of a comprehensive HIV prevention strategy, alongside other methods like condom use and PrEP.
Anal or vaginal intercourse using oil-based lubricants and condoms	High risk	Oil-based lubricants can seriously damage condoms and increase the likelihood of condom breakage during intercourse. Try blowing up a condom like a balloon, and then put some Vaseline on it—it will explode!
Using the same condom twice	High risk	Condoms should not be re-used because it is not hygienic and increases the likelihood of breakage and slippage.
Using more than one condom at the same time	High risk	Using more than one condom increases the likelihood that the condoms will break or slip off during sex.
Source: Adapted from men who have sex with men outreach training manual. Hanoi, FHI Vietnam, 2008 and updated/checked with the latest scientific knowledge (2024).		

Can HIV be transmitted through anal sex?

Yes. The tissue inside the rectum is delicate; therefore, lesions and tears may occur during anal intercourse. This creates entry points for HIV and other STI to enter the bloodstream via the infected semen of the insertive partner. The chance of this occurring is significant when intercourse takes place without condoms, if an HIV-positive partner is not using antiretroviral treatment and/or if the HIV-negative person is not using PrEP (see Chapter 13). Please note that even when using PrEP or if an HIV-positive partner is on antiretroviral treatment, condom use is recommended to reduce the risk of transmission of other STI.

Transmission chances are zero if the infected "inserter" is on antiretroviral treatment and has an undetectable HIV viral load, even if he does not use a condom. An infected "bottom" person can infect a "top" person if no condoms are used and if the bottom is not on antiretroviral treatment with a suppressed viral load. In this case, infected blood caused by small ruptures in veins and blood vessels lining the rectum and other rectal secretions can enter the bloodstream of the penetrating partner via the penis. For STI and HIV infection, unprotected anal sex remains the most high-risk sexual activity.

Does it matter whether someone is a "top" or a "bottom" person when it comes to HIV risk?

Yes, it does, very much so! On average, when an HIV-infected top penetrates an HIV-negative receptive person (bottom), the average probability that the bottom becomes infected is 1.38% per each time they have penetrative sex. When an HIV-negative insertive person (top) penetrates an HIV-infected person (bottom), the chance of infection is 0.11% per sexual act. From an HIV-negative person's perspective, **having condomless receptive anal sex is, therefore, about 12.5 times riskier than having condomless insertive anal sex**.[9]

It is important to emphasize here **that these percentages can be much higher if one or both partners have an STI or if the partner living with HIV is in the stage of acute HIV infection or in the symptomatic phase when the HIV viral load is high and infectiousness increases**. The percentages provided here are population-based estimated averages, which can vary widely per individual and situation.

[9][10] See http://www.cdc.gov/hiv/policies/law/risk.html.

For someone who is HIV-negative who is having unprotected sex with someone whose HIV status they are not sure about or who is HIV-positive, it is a sensible prevention strategy to be **only the inserter in anal intercourse** and not to let the person with HIV or of unknown status anally penetrate! This could reduce the chance of HIV transmission by a factor of 12.5 because they engage in behavior with a 0.11% probability for transmission if their partner happens to be infected, whereas that would be 1.38% if they took the receptive role in anal sex.

Can HIV be transmitted through vaginal sex?

Yes. The chance of transmission is much smaller than in anal sex. The opportunity for transmission of an infected man to an uninfected female is two times greater than the reverse because the area in the vagina through which HIV can penetrate the body is larger than the area in the tip of the penis where HIV can penetrate the man's body. The probability of infection from an HIV-positive man to an HIV-negative woman is 0.08% per sex act, while the other way around, it is 0.04%.

Remember, **these percentages can be much higher if one or both partners have an STI or if the partner with HIV is in the stage of acute HIV infection or in the symptomatic phase**, when the viral load is higher and infectiousness increases. These percentages are population-based estimated averages, which can vary widely depending on the stage of infection, the presence of STI as well as other factors.

Can HIV be transmitted through oral sex?

The short answer is: under normal circumstances not—mainly because there is no entry point for HIV into the bloodstream of the partners engaging in oral sex. Some people assume that HIV can be transmitted through oral sex but that the probability of transmission is extremely small. Transmission is assumed possible if a person has bleeding gums or cuts in the mouth and that the risk is therefore bigger for the one who sucks/licks than for the one who is being sucked/licked. However other STI, including chlamydia, gonorrhoea, herpes and syphilis (see Chapter 11) can be quite easily transmitted through oral sex. The virus that causes genital warts (human papillomavirus, or HPV) is also transmitted orally, as are intestinal parasites (Amoebiasis) and the viruses that cause Hepatitis A or B infection (see Chapter 11 and Annex 2).

Why is it nearly impossible to transmit HIV orally?

HIV needs to enter the bloodstream of an uninfected individual for infection to take place. This can happen via one of the five body fluids mentioned (blood, semen /pre-cum, vaginal fluids, rectal secretions or breast milk). During oral sex, it is difficult for HIV to enter another person's body because the virus is likely to be in the mouth for only a short time; it has no entry point into the bloodstream of the person whose mouth it is visiting. After the person swallows the semen and the virus, it will be killed by the acids in the stomach.

Just to be safe, it is advised not to let semen of a man come into the mouth.[10] Additionally try to avoid 'giving' oral sex when there is a wound/bleeding/ulcer in the mouth or throat or when having a sore throat. Don't forget other STI's are transmitted orally quite easily, as mentioned above.

What do I answer when someone asks, "If someone ejaculates in my mouth, should I swallow or spit it out?"

You can advise that they either swallow quickly or spit it out. If there is any virus in the semen, the stomach acids will quickly kill it. Theoretically, it is not sensible to have infected cum in contact with mucous membranes (inside the mouth and throat) for very long. Minimizing this contact decreases the very small risk that HIV will be absorbed. So, spit when possible, or swallow quickly.

Does circumcision protect against HIV?

Because there is still a risk for HIV transmission via the small blood vessels in the tip of the penis, circumcised men who are insertive (top) are advised to continue to use condoms. Logically, there is no beneficial protective effect of circumcision for the bottom partner.

Three studies in African countries have proven that among men having vaginal sex, circumcised men had a 51-60% lower risk of getting HIV from an infected woman, compared with men who are uncircumcised[11]. This is because in uncircumcised men, the inner surface of

[1011] See the latest updates on oral sex transmission risk at: https://www.cdc.gov/sti/about/about-sti-risk-and-oral-sex.html and

[11] Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS medicine. 2005 Nov;2(11):e298; Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, Williams CF, Campbell RT, Ndinya-Achola JO. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The lancet. 2007 Feb 24;369(9562):643-56 and Gray RH, Kigozi G,

the foreskin of the penis provides an opportunity for HIV to access the bloodstream via a type of cell that is present there, called 'Langerhans Cells'. If the foreskin has been removed, this entry point is no longer there. It means less opportunity for the HIV virus to access the body of a man through the penis (it can then only enter via the small blood vessels located at the tip of the penis).

For men practising anal sex, there is some evidence that circumcision has some protective effect. This effect would be there only when the man is the top (insertive) and never, ever the bottom in unprotected anal sex! Because many men have experienced being bottom as well as top during their lifetime, circumcision is not generally a recommended prevention strategy for men who have sex with men.

Is group sex riskier than sex with only one partner?

The issue here is whether unprotected sex occurs and whether people with undiagnosed or untreated HIV are present in the group! In principle, the more partners someone has unprotected sex with, the more risk for HIV infection there is, especially if HIV testing is not commonly practiced. Basically, **having safe sex in groups with condom is safer than having condomless sex with only one or two partners of unknown or positive HIV status**.

When having sex with two or more partners at the same time, it is important to remember that the inserting partner can transfer HIV-infected body fluids from the rectum of one partner to the rectum of another partner if he uses the same condom with both or multiple partners. Reusing, or not changing a condom when switching from one to another partner during group sex, makes the likelihood of the condom breaking higher; STI also can be transmitted in this way.

The golden rule is that no matter the number of partners present, all should always take basic precautions for safe sex, no matter the context: always use a new condom with each partner when engaging in anal or vaginal sex, and also use sufficient amounts of lubricants.

Serwadda D, Makumbi F, Watya S, Nalugoda F, Kiwanuka N, Moulton LH, Chaudhary MA, Chen MZ, Sewankambo NK. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. The lancet. 2007 Feb 24;369(9562):657-66.

Can HIV be transmitted by rimming (licking the anus)?

The chance of HIV transmission when the anus is stimulated and licked by a human tongue is extremely small and can be considered negligible (see explanation about oral sex above; there is no entry/exit point for HIV). “Rimming”, or anilingus, therefore is a relatively safe sex act in terms of HIV transmission, but under unhygienic circumstances, the person performing it can get hepatitis A or B virus or other disease-causing bacteria or parasites from the person being pleasured.

Can HIV be transmitted by kissing or hugging?

No. Because kissing and hugging do not lead to HIV-infected blood, semen/sperm, rectal or vaginal fluids or breast milk entering the bloodstream of a non-infected person.

Can HIV be transmitted by mosquitoes?

No. First of all, HIV cannot survive for long outside the human body. Second, mosquitoes do not inject blood into another human being; they suck and “eat” it. The “H” in HIV stands for “human”; the virus can live only in the human body.

Can HIV be transmitted by having a bath in the bathroom of someone with HIV?

No. The reason is that there are no infected body fluids of the infected person entering the body of an uninfected person in a bathroom, and if HIV particles exit the body of a person with HIV in the bathroom (for example, if the person masturbates and ejaculates in the bathroom), the virus will not survive for long outside the human body. More importantly, unless the person taking a shower next has deep bleeding cuts in his feet, there is no entry-point for HIV into that person’s body. Since people with heavily bleeding feet are unlikely to feel like taking a shower, this possibility should be dismissed as impossible.

Can HIV be transmitted by sharing toothbrushes with an infected person?

While it may theoretically be possible, the risk is extremely low and nearly negligible. HIV transmission in a household setting (without sexual contact or needle sharing) is almost impossible. HIV does not survive long outside the human body and quickly becomes inactive when exposed to the environment. For transmission to occur through a shared toothbrush, there would need to be blood present on the brush and a direct entry point (like an open wound) in the mouth of the uninfected person. Practically speaking, the conditions needed for HIV

transmission in this way are highly unlikely. However, to minimize any risk of other infections, it is generally recommended not to share personal items like toothbrushes.

Can HIV be transmitted by sharing razors or other sharp utensils?

In theory, it is possible for HIV to be transmitted if fresh blood remains on a sharp object like a razor, and that object is immediately used by an uninfected person who also cuts themselves with it. However, in practice, HIV transmission this way is extremely unlikely. The virus does not survive long outside the body, and it is rare for a shared razor to be used immediately without cleaning. To minimize any risk, it is advisable for people living with HIV to avoid sharing razors or other sharp items.

What are other daily activities with NO risk of HIV transmission?

HIV cannot be spread by most (if not all) regular daily activities like eating together, sharing clothes/towels, living in the same house, working in the same office, playing sports together, etc.

What do I say when a client asks, "How can I prevent myself from getting HIV?"

The most certain way to prevent HIV is to avoid sexual activity (including oral and anal sex) and to never use or share needles or syringes. For most people, however, abstaining from sex completely is not realistic. Fortunately, there are effective ways to reduce HIV transmission risk, such as using condoms, taking PrEP (for HIV-negative people), and ensuring that HIV-positive partners are on ART to maintain an undetectable viral load.

What are options for preventing HIV while still enjoying a sex life?

The most common option is to use condoms and water-based lubricants correctly and consistently every time when one has anal or vaginal sex (see Chapter 12). The CDC estimates that condoms are approximately 80% effective at preventing HIV transmission when used in vaginal sex in real-world conditions; a 2013 study found the effectiveness in anal sex to be on average 70% (see Chapter 12). This lower-than-expected figure reflects challenges like incorrect use, improper fit, and occasional breakage or slippage. However, when used consistently and correctly, condoms can be highly effective at reducing the risk of HIV and other sexually transmitted infections. You should advise clients that when they find a well-

fitting condom and learn the skill of using it correctly, the protective effect of condoms can be a lot closer to 100% (see Chapter 12).

A second option to prevent HIV transmission is to use Pre-exposure Prophylaxis (PrEP) consistently, which can reduce the risk of HIV infection by up to 99% when taken daily as prescribed[12] (see Chapter 13) however PrEP only will not prevent STIs. When both condoms and PrEP are used together, the combined protection is estimated to reduce the risk of transmission of both HIV and STI even more. For people who have sex with more than one person, strategies to reduce their risk can be to reduce the number of partners and also reduce the frequency of sexual encounters they have. They can do this, for example, by masturbating more, which is a safe (and fun) way of reducing their urges and desires for sex (see Chapter 14).

If they choose to not reduce the number of sex partners or encounters, they can try to move from receptive to insertive anal sex, or move from anal or vaginal sex to oral sex, which is much safer by comparison. By having more oral sex and reducing other penetrative sex acts, sexually active people can dramatically reduce their risk for getting (or transmitting) HIV. Instead of anal/vaginal sex, they can also engage in mutual masturbation, thigh sex, rubbing or hugging. Virtual sex options such as webcam sex, phone sex or video call sex are another mode of risk-free sexual activity in terms of HIV (and STI) transmission, but one needs to take cyber security precautions (see Chapter 14).

Can people reduce their risk of HIV without bothering with condoms or PrEP?

A study in Sydney, Australia found that even when men do not use condoms or PrEP or even when none of their partners takes antiretroviral treatment, they still can employ certain strategies to reduce their risk for HIV infection (or for transmitting HIV to their partners, if they are already HIV-positive).[13] Three of these alternative strategies were found to significantly reduce the chance of getting HIV, when compared with men who did not use any strategy (and no condoms/PrEP). These alternative strategies are **much less effective and much less safe than always using condoms or PrEP**, but nevertheless, they offer some limited protection against HIV infection.

[12] Centers for Disease Control and Prevention. Pre-Exposure Prophylaxis (PrEP). HIV Basics. Available from: https://www.cdc.gov/hiv/basics/prep.html

[13] See http://europepmc.org/articles/pmc2768371.

The alternative strategies to reduce risk without using condoms are:

1. **Strategic positioning**. This means that if a person living with HIV has sex without condoms with a male partner who is HIV-negative or who is not sure about his status, then the person living with HIV is only the receptive partner (bottom) in anal intercourse. This is because, as discussed previously, an insertive partner (top) is up to 12.5 times less likely to get HIV from an infected receptive partner (bottom) than the other way around.

2. **Negotiated safety.** This means that two HIV-negative men date each other in a steady relationship in which they practise condomless sex with each other, but they promise each other that when having sex with others, they will always be safe. If an "accident" occurs, meaning that one of the partners breaks their promise and has condomless sex with someone outside the relationship, they must promise to always tell their steady partner. If two men enter into this type of arrangement, they should, of course, get tested first to ensure that they are both negative. And if they have sexual activity outside their steady relationship, they must keep testing for HIV regularly. They also need to be able to openly discuss their sex lives with other partners with their partner, if necessary—something which may be difficult in the context of Sri Lankan sexual cultures.

As mentioned above, in the Sydney study, while these two strategies significantly reduced HIV infection risk, they were not as effective/safe as consistent condom use.

3. **Serosorting**. This means that HIV-negative men only have (condomless) sex with other HIV-negative men, and people living with HIV have sex only with other people living with HIV. This led to an intermediate risk of HIV infection among HIV-negative men—a higher risk compared to consistently using condoms or when employing one of the other two strategies, but lower than having unprotected sex indiscriminately without exchanging information about presumed serostatus. Serosorting is usually not recommended because some HIV-negative men may be positive, but the virus may have entered their body so recently that it has not shown up in an HIV test yet, during the "window period". It is also possible that a presumably HIV-negative person had his last test quite a while (and quite a few partners) ago. He may have become infected but still relies on his previous (negative) test result. Even so, serosorting reduced the chance of transmission in the study; it was simply better than having unprotected sex with

partners of whom the serostatus was not known or discussed but not as good as the other two strategies or consistent condom use or use of PrEP.

4. **Avoiding anal sex.** Many clients do not know that there is a difference in HIV transmission risk between oral, anal and vaginal sex. Distinguishing clearly between anal sex, oral sex, mutual masturbation and other forms of sex, and promoting that a client switches from anal sex to oral sex and other safer sexual behaviours is an important, but very under-utilized risk reduction strategy.

5. **"Treatment as prevention."** Given that it has now been proven that people with an undetectable HIV viral load cannot transmit HIV to others anymore (i.e., the "undetectable=untransmittable" principle), it is much safer to have unprotected sex with a people living with HIV who has been on treatment for more than 12 months than with someone who is not, or someone who has only recently gone on treatment. This is assuming they are adherent and virally suppressed. Recent studies proving this fact used a cut off VL of 200 as being considered undetectable;

Please note that these alternative strategies help reduce some infection risk but only for people who get tested regularly, which is not the case for most Sri Lankan men who have sex with men

These alternative strategies are definitely not as safe as using condoms, lubricants and PrEP consistently.

The study also found that men who practised these alternative strategies had higher levels of STI other than HIV. Because to protect both STI and HIV someone should use condoms consistently,

Is withdrawal from the rectum before ejaculating effective to prevent HIV infection while having anal sex without condoms?

No, withdrawal is not an effective method for preventing HIV infection during unprotected anal sex. This is because HIV can be presented in pre-ejaculate (pre-cum) of the insertive partner, which can carry the virus even without ejaculation. Additionally, an HIV-positive receptive partner (bottom) can transmit the virus to an HIV-negative insertive partner (top) through blood or rectal secretions, independent of ejaculation.

While withdrawal before ejaculation may slightly reduce the risk for the receptive partner compared to ejaculating inside the rectum, it does not eliminate the risk of HIV transmission.

What does HIV treatment have to do with HIV prevention?

The answer is: everything! The HIV viral load of people living with HIV can become undetectable if they are fully adherent to their antiretroviral treatment for at least 1-6 months. "Fully adherent" means that they never (or almost never) forget to take their daily pill(s). The latest scientific studies have confirmed that people with an undetectable HIV viral load cannot transmit the virus to others. In other words, "undetectable means untransmittable" (U=U)! This should be an important motivation for people living with HIV to access and adhere to their medication, and for people who are unsure about their HIV status to get tested. Recent research, including the PARTNER 2 study and the Opposites Attract study, has shown zero cases of HIV transmission among sero-discordant couples when the HIV-positive partner has an undetectable viral load[14].

Why are people living with HIV who are undetectable unable to transmit HIV?

If a person living with HIV is taking ART, after a while (1-6 months, depending on several factors) this person's HIV viral load will drop to a level that is not detectable in laboratory tests. If this person has unprotected sex there is not enough HIV in their blood, semen/pre cum or vaginal or anal fluids to cause HIV infection in their uninfected partner.

Does U=U also work for injecting drug users?

As of May 2021, there is not enough evidence to confirm that people who inject drugs and are living with HIV can safely share needles or syringes without risk of HIV transmission, even if they have a suppressed viral load[15]. Therefore, harm reduction strategies, such as using clean needles and syringes, remain essential for people who inject drugs to protect their HIV-negative

[14] Rodger AJ, Cambiano V, Bruun T, Vernazza P, Collins S, Degen O, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. Lancet. 2019;393(10189):2428-2438. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30418-0/fulltext and Bavinton BR, Pinto AN, Phanuphak N, Grinsztejn B, Prestage GP, Zablotska-Manos IB, et al. Viral suppression and HIV transmission in serodiscordant male couples: an international, prospective, observational, cohort study. Lancet HIV. 2018;5(8). Available from: https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(18)30132-2/fulltext

[15] Centers for Disease Control and Prevention. Evidence of HIV Treatment and Viral Suppression in Preventing HIV Transmission. CDC Fact Sheet. 2020. Available from: https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf

peers. However, for sexual encounters, the protective "U=U" effect of ART (antiretroviral therapy) in reducing HIV infectiousness is the same for people who use drugs as for those who do not.

Can I rely on monogamy to prevent becoming infected with HIV?

Monogamy between two uninfected partners is, in principle, a good prevention strategy—but only if the partners fulfil two conditions:

> First, they must agree that if they have sex with others, be it 'by accident' (while high or drunk, for example) or otherwise, they must be 100% safe. If not, they may put their steady partner at risk.
>
> The second condition is that the partners need to be able to fully and honestly communicate with each other about their sex life. For example, if one of the partners has been unfaithful and did not use protection, they should be able to tell their partner so that they can protect each other temporarily, until the 'straying' partner has been tested negative for HIV.

It is often difficult for partners to openly and honestly admit to their partner that they had sex with someone else. Many men and women in presumably monogamous relationships become infected with HIV because a straying partner may be too afraid to tell their partner that they had unprotected sex with somebody else[16]. Therefore, monogamy can be a recommended strategy, but ONLY if both partners are 100% certain that there can be open and honest communication between the partners if one of them strays.

Should I use condoms with people who engage in sex work to prevent HIV?

One should use condoms (and/or PrEP, see Chapter 13) with any sexual partner of whom one does not know their HIV status. People who engage in sex work are not different from other people in this regard, although people in sex work may have more casual/commercial sexual context and therefore be at heightened risk for both HIV and STI.

[16] de Lind van Wijngaarden JW, Ching AD, Settle E, van Griensven F, Cruz RC, Newman PA. "I am not promiscuous enough!": Exploring the low uptake of HIV testing by gay men and other men who have sex with men in Metro Manila, Philippines. PLoS One. 2018 Jul 6;13(7):e0200256. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0200256

Chapter 11: Sexually transmitted infections and their transmission

What is a sexually transmitted infection?

A sexually transmitted infection (STI), previously called sexually transmitted disease (STD) is an infection transferred between humans by means of sexual contact (vaginal, oral or anal sex). Some STI can also be transmitted from mother to baby and through the sharing of injecting-drug equipment. STI overlap with a broader group of infections known as "reproductive tract infections". Some skin infections (such as scabies, herpes and rashes) can also be transmitted via sexual contact.

☞ for more details, see Table 4 and Annex 2.

What are the symptoms of STI?

Symptoms may differ from one STI to another. STI may lead to symptoms in the reproductive organs as well as in the skin around the vagina, penis or anus. Some STI also cause systemic symptoms that cause problems in other parts of the body. Some STI (such as chlamydia, gonorrhoea, Genital Warts, hepatitis B and genital herpes) sometimes cause no symptoms at all. Thus, although the person has an infection, they may have no symptoms and may not realize that they are infected. Despite being asymptomatic, they may still be infectious (see Annex 2). It is therefore important for clients who are sexually active to frequently test for STI, even if they have no (clear) symptoms.

Symptoms of STI can include:

1. Having to go to the toilet very often to pee and burning sensation while passing urine. This can also be a symptom of bladder infection.
2. An ulcer, wart or sore on the penis, vagina or anus.
3. Itching around the groin or between the buttocks.
4. A rash or redness around the groin or between the buttocks.
5. Pus/discharge coming from the penis/vagina/anus and/or pain during urination.
6. Other (see the STI listed in Annex 2 for details).

Why should someone bother about STI that are asymptomatic?

STI without symptoms can be transmitted to others and can cause serious complications, especially if they are not treated.

Why are STIs relevant to HIV prevention?

STIs, especially those causing ulcers or inflammation like syphilis, herpes, and gonorrhea, can make it easier for HIV to enter the body. Therefore, people with untreated STIs are more likely to become infected with HIV and are also more likely to transmit HIV to others. If a client has an STI, it is also an indication that they have had condomless sex, and therefore, diagnosis of an STI is a sign the client should also be tested for HIV.

Why are people with STIs more likely to get or transmit HIV?

STIs often result in open sores, lesions, or abrasions on the anus, vagina, or penis (or mouth/throat), which provide convenient entry points for HIV infection. STI can also cause inflammation in the genitals, producing a discharge. In people who also have HIV infection, the large number of HIV-infected cells in the discharge makes it easier to transmit HIV.

What are the most common sexually transmitted infections?

In Table 4 below, the most common STIs are briefly discussed:

Table 4: Overview of sexually transmitted infections

DISEASE	TRANSMISSION	CAUSE	MAIN SYMPTOMS	TREATMENT
Chlamydia	Vaginal, anal and oral sex; hand to eye; mother to baby	Bacteria	Sometimes none; however, it can include discharge from the penis or anus, burning urination and swollen, painful testicles	Curable with antibiotics

Gonorrhoea	Vaginal, anal, and oral sex; hand to eye; mother to baby	Bacteria	Sometimes none; however, it can include dripping penis or rectal discharge, painful urination, throat infection and swollen, painful testicles	Curable with antibiotics—but there are resistant strains
Syphilis	Sexual contact with sore; mother to baby	Bacteria	Painless sore near genitals, body rash with severe symptoms later	Curable with antibiotics
Herpes	Sex; skin to skin; mother to baby	Virus	Sometimes none; however, can include flu-like symptoms or painful blisters around genital area or mouth	No cure, but infection and symptoms are treatable
Human Papilloma Virus (HPV)	Sex; skin to skin; mother to baby	Virus	Sometimes none, but infectious; however, can include genital warts or ano-genital cancer	No cure for infection, but warts can be removed—also preventable by vaccine
Hepatitis B	Sex; sharing needles; blood related products/processes; mother to baby	Virus	Several (not specific), including flu-like symptoms, dark urine and light stools and jaundice	No cure for infection but preventable by vaccine
Hepatitis C	Sex; sharing needles; blood	Virus	Several (not specific), including	Curable with DAA No vaccine

	related products/processes; mother to baby		flu-like symptoms, dark urine and light stools and jaundice	
Scabies	Skin to skin	Parasite	Itching, rash	Curable, with insecticide
Lice	Skin to skin	Parasite	Itching	Curable, with insecticide

☞All these diseases are discussed in more detail in Annex 2.

Can an STI be cured?

All bacterial STI (Gonorrhoea, Chlamydia, Syphilis) can be cured with medicines—usually antibiotics, which should only be taken under medical supervision. Some viral STI, like Hepatitis C (Hep C), also have a cure now through antiviral treatments. Vaccines are available to prevent Hepatitis B (Hep B) and Human Papillomavirus (HPV). While a vaccine for Hepatitis C is under development, there is currently no vaccine available.

Can STI be cured at home by buying drugs from a pharmacy?

This is not recommended. It is impossible for an untrained person to know the diagnosis (which STI a person has) and what the latest recommended treatment for that STI is. Therefore, a client must always seek treatment from a doctor, or a consultant. This will also allow for proper testing for possible other STI (including HIV) that may not be showing any symptoms.

Can STI be prevented?

The chance of becoming infected with an STI can be reduced by avoiding risky sexual behaviors, similar to the prevention of HIV discussed in an earlier chapter. To reduce the risk, clients should be advised to:

- Use condoms during oral, anal, and vaginal sex.
- Use water-based lubricants with condoms, especially during anal sex.
- Limit the frequency of sexual activity and number of sex partners (if possible).

- If they have recently been treated or are being treated for an STI, they must make sure their sex partners are notified to practice prevention or receive testing and the treatment necessary.
- Don't share sex toys, if clients want to share, they should wash them and use a new condom every time they are used with a different partner.
- Maintain good genital hygiene (see the discussion further on).

Some STI can be transferred via skin-to-skin contact, see Annex 2. These can be prevented by maintaining good hygiene and checking the skin for itchy or painful rashes, and if these are present, by avoiding skin-to-skin contact.

How can someone know if they have an STI?

STI can be symptomatic or asymptomatic. Some STI have no specific symptoms. The only way that a person can find out whether they are infected (and by which STI) is by testing at an STI clinic.

☞ See Annex 1 for an overview of STI testing and treatment services in your city/district.

What should I do when I think my client may have an STI?

Community service providers must make sure that they are updated about services for diagnosis and treatment of STI in the sites where they work. It is important that STI services are friendly to key populations. This allows for the client to be open and honest towards health care staff at such services.

What should I do when a client is confirmed to have an STI?

Ensure they are aware of the precautions they should take to prevent transmission to their sexual partners. They should also be aware of the treatment procedures and encouraged to adhere to the treatment. Clients should understand that not following and completing treatment may lead to having to restart the whole treatment process and may also put their sexual partners at risk of infection.

What to do if my client has a bad experience while accessing an STI clinic?

After the client has been at the service, ensure that the client is given an opportunity to report how the experience was. If STD Clinic staff treat clients in an inappropriate or insensitive manner, it is important that this is reported to the outreach manager for further action; in some sites, Community-Led Monitoring activities are happening via which such incidents can be reported[17].

What are the differences between HIV and STI?

HIV is often sexually transmitted but can be transferred in other ways (through the sharing of needles or injecting equipment, through a blood transfusion with HIV-infected blood or from an HIV-infected mother to her baby). Therefore, HIV is different from most STI, which are generally transmitted only through sex.

How to self-check for STI?

Regularly examining the genitals and anal area for signs of STI can be done in less than one minute. This examination is also useful for detecting other uncomfortable problems, like skin rashes and in-grown hairs. Here's how this can be done:

1. Grab a small mirror. Find a private place and get naked.
2. Examine your body, especially areas of sexual contact. Do you see any sores, blisters, rashes, itchy areas, redness, swollen bits or fluid discharge or smell an unusual odour on or around your vagina or penis & balls (testicles) as well as around the anus?
    - Check your vagina or penis. Men should also lift the scrotum and look under the balls; if uncircumcised, pull back the foreskin and look at the skin under the foreskin. Women can use a mirror to see more clearly the inner parts of the vagina.
    - Look at the perineum area too (area between anus and balls or vagina).

[17] A community-led monitoring (CLM) pilot project has been introduced in 5 STI clinics in Sri Lanka as a method to receive feedback on HIV services from the users of those services. The input received from this feedback is expected to improve the services offered to high-risk, key populations in Sri Lanka.There are plans to expand it throughout the island by 2025.

- Check your pubic hair closely for small eggs, lumps or lice (or crabs), especially if you have felt itchy recently.
- Gently squeeze the penis along the shaft to check for any unusual discharge that is smelly or creamy in colour (remember, it is common for men to find some fluid when doing this; this does not necessarily mean you have an STI).

3. If you detect signs of an STI, it is time to go to an STI clinic for treatment!

The above are just simple self-examination steps which can only identify STI that show symptoms. Since most STI do not produce symptoms, if a client wants to be 100% sure they should get tested for STI at a clinic.

SOME NOTES ON GENITAL HYGIENE

Keeping the genitals clean and healthy is very important, particularly for uncircumcised men and transgender women with a neo-vagina.

Genitals should be washed every day with water, using mild soap if needed. Daily washing with water alone is often sufficient, especially for those with sensitive skin. Using mild soap occasionally, rather than every day, can help avoid irritation, especially in sensitive areas.

Avoid harsh or perfumed soaps, as they can irritate the penis, vagina, neo-vagina, and anus.

After washing, it is important to dry the area gently. Leaving the genital area moist creates an environment where bacteria and fungi can thrive.

For those with a penis, urinating before and after sex can help reduce the risk of infections by flushing out bacteria that could enter the urethra.

Perform regular self-examinations as described earlier to detect any unusual changes.

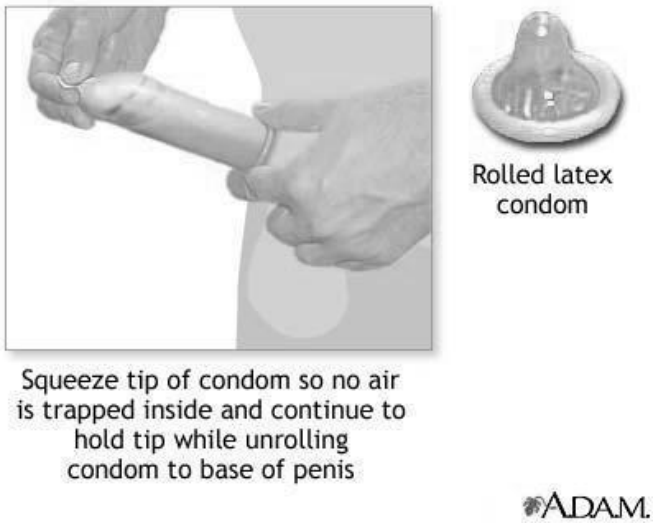
If condoms cause friction problems, try a small amount of lubricant inside the condom. Use just a bit, as too much can cause the condom to slip off.

Chapter 12: Condoms and lubricants

What is a male condom?

A condom is like a tight-fitting penis-shaped bag, usually made of latex or, more recently, polyurethane, that is used during sexual intercourse. It is put on a man's erected penis and physically blocks and captures ejaculated semen, preventing it from entering the body of a sexual partner. Condoms are used to prevent unintended pregnancy and transmission of HIV and STI (such as gonorrhoea, chlamydia, syphilis, hepatitis B and C), see Chapter 11 and Annex 2).

Latex condoms are the most common condoms in Sri Lanka.



Source: http://www.nlm.nih.gov/medlineplus/ency/imagepages/17082.htm.

For what types of sex are condoms used?

Condoms can be used for anal, vaginal or oral sex. From an HIV-prevention perspective, using condoms for anal and vaginal sex is more crucial than using them during oral sex. However, for prevention of other STI, condoms are just as important even during oral sex.

What is lubricant?

Lubricant (often referred to as “lube”) is a slippery gel or paste made of water and some other substances. The main function of lube in relation to safer sex is to reduce the risk of latex condoms tearing or breaking. Lubricant serves to reduce friction with the vagina, the anus or other body parts when using it in penetrative sex, especially when applied to a condom. This

enhances sexual pleasure, enables penetration of the rectum (which can be tight) or vagina (which can be dry) thus reducing the risk of bleeding, tears and wounds. Many condoms are packed already lubricated. But for anal sex, the amount of lubricant inside a condom package is not enough. Additional lubricant should be applied. Lubricant is sold in tubes or in plastic containers (see picture) and sometimes in handy pocket-sized sachets. It can easily be ordered online, especially handy for people who may be shy to buy it at a pharmacy![18]

What types of lubricants are there?

Lubricants are usually divided into two types: water-based and oil-based lubricants. Only water-based lubricants (including Durex and KLY Jelly) are safe to use with latex condoms. Oil-based lubricants (this can be Vaseline or any type of hand-cream or body lotion, including Nivea or sun lotion) are not safe to use with latex condoms—they can only be safely used with female condoms, which are only occasionally available in Sri Lanka[19], or with polyurethane condoms (which are not available in Sri Lanka).

There are several subtypes of water-based lubricants—some include fragrances and flavours; some are edible and some give a special effect (such as tingling or a cooling or warming sensation when applied).

[18] For example: https://medstore.lk/product/k-l-y-lubricating-gel-42-g/

[19] Condom Education and Demonstration Guideline Book, NSACP and UNFPA, 2016. Available from: https://www.aidscontrol.gov.lk/images/publications/guidelines/guideline_for_ale_condoms.pdf

For what types of sex should water-based lubricants be used?

Water-based lubricants can be used for any anal or vaginal sex.

How effective are (latex) condoms in preventing HIV and STIs?

Condoms are widely recommended for the prevention of pregnancy and STIs, including HIV. They are effective in reducing infection rates in both men and women. While not perfect, the condom is effective at reducing the transmission of HIV, genital herpes, Viral warts, genital warts, syphilis, chlamydia, gonorrhea, and other diseases.

Although a condom is effective in limiting exposure, some disease transmission may occur even with a condom. Areas of the genitals exposed to or hosting an infection may not be covered by a condom, and, as a result, some diseases, such as herpes and scabies, can be transmitted by direct skin-to-skin contact. The primary reason why people who use condoms regularly still get an STI is that they do not use them correctly and consistently.

The US Centers for Disease Control and Prevention estimates the average protective effect of consistent condom use to be 80% in vaginal sex[20]. A 2013 study found the protective effect of anal sex to be around 70%[21]. As mentioned in Chapter 9, this is less than you might have thought: the reason is that condoms are often not used correctly or not available in the right size, causing breakage or slippage. You should advise clients that when they find a well-fitting condom and learn the skill of using it correctly, the protective effect of condoms can be higher. Proper condom use decreases the risk of transmission for HPV by approximately 70%[22]. Another study found that consistent condom use reduced the transmission of herpes simplex virus-2 (HSV-2) in both men and women, with a more pronounced protective effect for women

[20] Centers for Disease Control and Prevention. Condom Effectiveness - How Effective Are Latex Condoms in Preventing HIV? CDC [Internet]. Available from: https://archive.cdc.gov/www_cdc_gov/condomeffectiveness/latex.html

[21] AIDSmap. Consistent condom use in anal sex stops 70% of HIV infections, study finds. [Internet]. 2013. Available from: https://www.aidsmap.com/news/mar-2013/consistent-condom-use-anal-sex-stops-70-hiv-infections-study-finds

[22] J. Lam et al., "Condom use in prevention of human papillomavirus infections and cervical neoplasia: systematic review of longitudinal studies", in *Journal of medical screening,* 21(1), 2014, pp. 38–50.

(reduction of risk of about 30% for men and 96% for women in discordant couples (where one partner is infected and the other is not))[23].

How do I deal with negative attitudes towards condom use?

Many men (and also women) feel that condoms reduce the pleasure they get from having sex, and therefore do not like to use condoms. When advising people on condom use, it is necessary and advisable to be open and honest about condoms.

Do not tell friends or clients that condom use does not make any difference in terms of sexual pleasure, because that is simply not true. However, using a condom that fits well and using plenty of lubricant (including a drop of lubricant on the tip of the penis before wearing the condom) can greatly enhance pleasure while having sex. Ask men who refuse to use condoms because of reasons of pleasure whether those 10 minutes of heightened pleasure are worth the chance of getting a serious disease, along with the anguish and fear that possible exposure to HIV or the symptoms of STI can bring.

If negative attitudes have to do with a perceived lack of intimacy, love and trust, you should try to explain how mechanisms of love and trust are contributing to the spread of HIV among men who have sex with men and among transgender people. True love has nothing to do with condom use! You could also turn the argument, those condoms are not used in love relationships, around by saying that if you truly love someone, your primary concern should be to protect that person from disease and thus you should use condoms.

Negative attitudes towards condoms can only be countered with arguments of reason. In an environment in which a significant number of sex partners have asymptomatic HIV or STI, it is the only way to go.

[23] Wald A, Langenberg AG, Link K, et al. "Effect of Condoms on Reducing the Transmission of Herpes Simplex Virus Type 2 From Men to Women." JAMA. 2001;285(24):3100-3106.

Table 5: 23 excuses not to use condoms and how to counter these!

EXCUSE	ANSWER
"Don't you trust me?"	Trust isn't the point; people can have infections without realizing it.
"It does not feel as good with a condom."	I'll feel more relaxed. If I'm more relaxed, I can make it feel better for you.
"I don't stay hard when I put on a condom."	I'll help you put it on; that will help you keep it hard.
"I'm afraid to ask him to use a condom. He'll think I don't trust him."	If you can't ask him, you probably don't trust him.
"I don't have a condom with me."	I do.
"It is up to him... it is his decision."	It is your health. It should be your decision too!
"I'm using the pill; you don't need a condom."	I'd like to use it anyway. It will help to protect us from infections we may not be aware we have.
"It just isn't as sensual; I can't feel a thing."	Maybe that way you will last even longer and that will make up for it.
"Putting it on interrupts everything."	Not if I help put it on.
"I guess you don't really love me."	I do, but I'm not risking my future to prove it.
"I will pull out in time."	Women can get pregnant, and anyone can get STI or HIV from pre-ejaculate (pre-cum).
"But I love you."	Then you'll help us protect ourselves.
"Just this once."	Once is sometimes all it takes!
"Condoms are unnatural. We should stay pure."	Protecting ourselves is a way to respect each other's health. Using a condom shows that we value each other's safety and future.
"Only people who are promiscuous use condoms."	Condoms are for anyone who wants to protect their health, regardless of their background or experiences.

"People in serious relationships don't need condoms."	Even in committed relationships, protecting each other is important. Using a condom means we care about each other's health.
"It is embarrassing to talk about condoms."	Talking about protection shows maturity and respect. If we can't talk about it, how can we be responsible together?
"Using condoms is against my beliefs/traditions."	Many traditional values supports protecting loved ones. Using protection shows we're taking care of each other's future.
"I'm clean, and I trust you're clean too."	People can have infections without knowing it. Using a condom is the only way to be sure we're both safe.
"Condoms are only for casual hookups."	Condoms are for anyone who cares about staying healthy. Protecting ourselves has nothing to do with how serious we are.
"I don't know where to buy condoms."	They're available at pharmacies and shops, and I can help you find them.
"We'll lose the moment if we stop to put it on."	We can make it part of the fun. I can help you, and it will keep us both relaxed.
"Condoms don't work—they break."	When used correctly, condoms are very effective. We just need to use a new one each time and follow the instructions.

How can condom use be made fun?

Community service providers can remind clients that they need to ensure that they can reach condoms and lubricant easily during sex, so that as little interruption as possible occurs when putting on the condom. You can suggest to your clients or friends to practise putting a condom on their partner with their mouth or to make it into an erotic foreplay; this could include manual and oral stimulation of the penis or putting a bit of lubricant on the tip of the penis before putting the condom on. If clients use condoms in boxes wrapped in plastic, it might be better to take the condom out of the box before having sex so opening the plastic wrapping and the box will not unduly delay the sexual encounter.

What about men who say they cannot maintain an erection when using condoms?

Some men do not like to use condoms because they have the idea—or an actual experience—that it diminishes or totally ends their erection. For these men, besides making condom use part of foreplay as mentioned above, you can advise them to practise putting on condoms while in the privacy of their home so that they can gain confidence maintaining an erection while free from performance pressure. With a bit of practice, this "condom-phobia" has been shown to be quite easy to self-treat![24]

For clients who absolutely refuse to use condoms, you can suggest to use PrEP as an alternative. Make sure they are aware that PrEP only protects against HIV, so they need to check regularly for STI. (See Chapter 13 for more info on PrEP).

Why do condoms sometimes slip or break?

Condoms may slip off the penis after or before ejaculation, break due to faulty method of application or physical damage (such as tears caused when opening the package), or break or slip due to latex degradation (typically from being used with oil-based lubrication, being past the expiration date or being stored improperly).

It is important to advise people to store condoms properly and always check the expiration date before using them. Also, avoid carrying condoms together with sharp objects (keys, coins, pins, etc.) because they may pierce the package of the condom or the condom itself.

If condoms slip or break, do they still protect against HIV or STIs?

Different types of condom failure result in varying levels of exposure to semen (and potentially HIV or STI). Failures that occur during application generally pose little risk to the user. One study found that semen exposure from a broken condom was about half that of unprotected intercourse; semen exposure from a slipped condom was about one-fifth that of unprotected intercourse. This means that even if a condom slips or breaks, it still provides some level of protection[27].

[24] Sanders SA, Graham CA, Yarber WL, Crosby RA. "Condom use errors and problems: a global view." *Sex Health*. 2008;5(4):255-62 and Crosby RA, Yarber WL, Graham CA, Sanders SA. "Condom use as a function of frequency of sex, relationship status, and condom use intentions among college men and women." *Sex Health*. 2010;7(3):287-91.

What to do if a condom has broken or slipped inside during anal sex?

For the insertive partner, try to urinate and then pull the foreskin back gently (if uncircumcised) and wash with mild soapy water only.

For the receptive partner (male or female), **do not** kneel and try to go to the toilet. Do not douche. Wash the outside of the anus only with mild soapy water. If the condom does not appear, do not panic – it will usually come out when you pass stool next time.! If you feel uncomfortable with the situation, visit a nurse or a doctor who will be able to take it out.

What to do if a condom has broken or slipped inside during vaginal sex?

For the insertive partner, try to urinate and then pull the foreskin back gently (if uncircumcised) and wash with mild soapy water only.

For the receptive partner, it will usually come out if you urinate, but if it does not appear, don't wait for your urine stream to shake it out in due course: the best is to search for it with a (clean) finger and take it out. Try removing the condom while sitting in a warm bath or seated over the toilet, and lubricate your finger before putting it inside, then use a hook-like motion to try to take out the condom. Standing and bearing down might help push it out, but it may also be more comfortable to lie on your back and feel around. Tell the person experiencing this not to worry too much: it cannot get stuck there forever and will eventually come out.

If you feel awkward and cannot get it out yourself, it is best to find a nurse or doctor who will be able to solve this problem in less than a minute.

What to do if a condom has broken or slipped during oral sex?

This information is only for people who have had somebody ejaculate into their mouth: Don’t be too concerned because the risk for HIV transmission, if there is any, is extremely small. If someone is concerned, they should rinse their mouth with water—but do not use Listerine or other harsh chemicals.[25] **Do not** brush your teeth, and do not floss for at least two hours because of the chance that your gums may bleed, providing a potential entry point for HIV.”

[25] From Dr Kathleen Casey, FHI360, personal communication.

Do condoms exist in different sizes?

Yes. In Asia, most condoms provided by health authorities have a diameter of 49-52 mm; the condom provided by the Sri Lankan health authorities has a 52 mm diameter. In Sri Lanka, the condoms available are the same size.

Does breakage and slippage of condoms decrease with increased experience?

Yes. Experienced condom users are significantly less likely to have a condom slip or break than less frequent users[27]. However, users who experience one slippage or breakage are at increased risk of a second such failure, mainly if the cause lies with the use of an inappropriately sized or inferior-quality condom.

What other things can people do to prevent condom breakage or slippage?

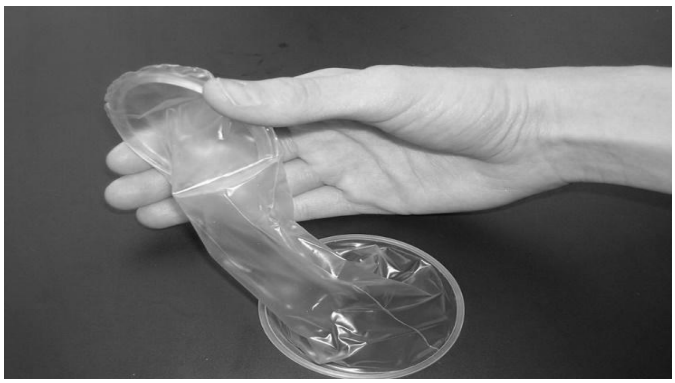
You can advise friends and clients to consider several things:

1. "Experiment with condoms of different sizes, shapes, and styles, and practice putting them on before intercourse."
2. "Practice talking with your partner about your desire and intention to use condoms."
3. "When using a condom, choose one that fits. Male condoms come in different sizes, shapes, and styles, but most condoms will fit most men."
4. "Open and handle condoms carefully. Never use a condom that is in a damaged package or is past its expiration date. Condoms should be stored loosely in a cool, dry place (not in your wallet or the glove compartment of your car) and kept where you can easily reach them if you decide to have sex."
5. "To reduce friction that can cause breakage, use plenty of water-based lubricant on the outside of the male latex condom and a small amount on the inside, at the tip. Some condoms come with lubricant, but often there is not enough, especially for anal sex; additional lubricant is recommended. Water-based lubricants include KLY Jelly, Durex lubricants, etc. and can be found next to the condoms in most pharmacies and in convenience stores."

6. “Never use oil-based lubricants like Vaseline, Nivea, antibiotic cream or any other oil-based cream with latex condoms. Oil-based lubricants can rapidly break down latex and allow the infection to pass through.”

What is a female condom and can men who have sex with men or transgender people use it?

Female condoms are larger and wider than male condoms but equivalent in length. They have a flexible ring-shaped opening and are designed to be inserted into the vagina. They also



contain an inner ring that helps insertion of the condom and helps keep the condom from sliding out of the vagina during sex. Recently in some countries, men who have sex with men and transgender people started using the female condom for anal sex. In this case, the ring that is inserted in the vagina is not used (it is taken out before use).

Chapter 13: Pre-exposure and post-exposure prophylaxis (PrEP and PEP)

What is pre-exposure prophylaxis? What is PrEP?

PrEP stands for pre-exposure prophylaxis. The word "prophylaxis" means to prevent infection or disease (to 'protect' against an infection). PrEP involves the use of antiretroviral drugs (ARV) by HIV-negative people to reduce the risk of acquisition of HIV. The drug can be taken as a pill (oral PrEP), as a long-lasting injectable, or (for females) in the form of a vaginal ring. PrEP is recommended by WHO as an additional choice for people at substantial risk of HIV infection as part of combination prevention approaches. The PrEP products currently recommended by WHO do not protect against other STIs or pregnancy.

It is important to remember when making recommendations for or against using PrEP: it is important to test for HIV on a regular basis when taking PrEP to ensure one is HIV negative; if a PrEP user tests HIV positive, then they need to be referred to the STD clinic for ART.

Is PrEP available in Sri Lanka?

Following a successful pilot project conducted from 2020 to 2023 in Colombo and some other sites, PrEP, in the form of orally-prescribed pills, (Fun Pill) is now available at a most of the STD clinics in Sri Lanka. Currently, access to PrEP is concentrated in certain areas, particularly urban centers, with limited availability outside of these regions.

How effective is PrEP?

Recent studies have indicated that PrEP, if taken consistently, can prevent 99% of HIV infections.[26]

Is PrEP a vaccine against HIV?

It seems a bit like that, but since PrEP does not work the same way as a vaccine in terms of helping the body create immunity against the virus, the answer is no. A vaccine teaches the body to fight off infection for several years. PrEP is taken in pill form and must be maintained on a daily basis for the protective effect to continue, or it can be event-based (see below).

[26] See https://www.cdc.gov/hiv/prevention/prep.html?CDC_AAref_Val=https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html

Can I also take PrEP now and then rather than every day?

Studies have shown that PrEP can be effective when taken "on demand" or intermittently, which is known as “event-driven PrEP” (ED-PrEP) rather than "intermittent PrEP" (iPrEP). A 2015 study called the IPERGAY trial in France and Canada tested this regimen among gay and bisexual men. Participants were instructed to take a double dose of Truvada (two pills) 2 to 24 hours before anticipated sex, one pill 24 hours after, and another pill 48 hours after. This method reduced the incidence of HIV by 86% among those who adhered to it[27].

While daily PrEP is generally preferred for consistent protection, this event-driven approach offers a viable alternative for those with less frequent exposure, providing strong protection when used as directed. In Sri Lanka, both ‘daily’ and ‘intermittent’ PrEP regimens were used during the pilot project and in the new NSACP PrEP guidelines[28].

How about injectable, long-acting PrEP?

Injectable, long-acting PrEP is now available in some countries as a long-acting option to prevent HIV. Unlike daily pills, this form of PrEP involves an injection of **Cabotegravir (CAB-LA)** given every two months, making it an excellent alternative for people who find it challenging to stick to a daily pill regimen. Studies, including the landmark HPTN 083 and HPTN 084 trials, showed that injectable PrEP was even more effective than daily oral PrEP at reducing HIV risk. In these studies, people who received injections every eight weeks had lower rates of HIV infection compared to those taking daily pills, with similar safety and tolerance.

This long-acting injectable PrEP may be particularly appealing to those with unpredictable sexual exposure, busy lifestyles, or difficulty remembering to take a daily pill. However, like

[27] Molina JM, Capitant C, Spire B, Pialoux G, Cotte L, Charreau I, et al. *On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection.* N Engl J Med. 2015 Dec 3;373(23):2237-2246. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa1506273 and Molina JM, Charreau I, Spire B, Cotte L, Chas J, Capitant C, et al. *Efficacy of On-Demand Preexposure Prophylaxis With Tenofovir Disoproxil Fumarate and Emtricitabine in the IPERGAY Trial.* Clin Infect Dis. 2018 Jan 1;66(2):236-243. Available from: https://academic.oup.com/cid/article/66/2/236/4098139

[28] Pre-Exposure Prophylaxis for the prevention of HIV infection in Sri Lanka. A clinical practical guideline. NSACP/MOH, Colo,bo, Sri Lanka 2023 Available at: https://www.aidscontrol.gov.lk/images/publications/guidelines/PrEP_Guideline_SL_1942023.pdf

all medications, it is essential to get regular follow-ups with a healthcare provider to monitor for side effects and ensure proper adherence to the injection schedule[29].

Who should take PrEP?

Anybody who is at substantial risk for HIV from sexual exposure should take PrEP. WHO recommends[30] that anybody who asks for PrEP should be prescribed it, even if they do not report any risky behavior, research has shown that people may not always want to 'confess' too risky behaviors or situations? Therefore, if they tell a healthcare provider that they need PrEP, the healthcare provider should believe them.

If I start taking PrEP, must I take it for the rest of my life?

No. Most people go in and out of periods in which they are at high risk for HIV infection; not everybody is equally at risk or equally sexually active all the time. Community service providers or HIV counselors can advise friends or clients that if their risk declines or even disappears, they can stop taking PrEP; for example, if they get a boyfriend and enter into a monogamous relationship. However, if after a few years, the relationship ends and they enter into a "party mode" once again, they can quickly go back on PrEP.

How soon after starting PrEP does the protective effect begin?

WHO recommends that two pills of PrEP should be taken at least 2 hours, but not more than 24 hours before condomless sex occurs; a user should continue taking one dose per day for as long as oral PrEP protection is desired AND for at least two days after the last potential sexual exposure[34]. Hence, it can be derived that the protective effect is in place two hours after taking the first two pills. For daily PrEP, it should be 1 daily for 1 week.

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[29] Landovitz, R. J., Donnell, D., Clement, M. E., et al. (2021). "Cabotegravir for HIV Prevention in Cisgender Men and Transgender Women." *The New England Journal of Medicine*, 385(7), 595-608 and Delany-Moretlwe, S., Hughes, J., Bock, P., et al. (2022). "Long-acting injectable cabotegravir for HIV prevention in cisgender women in sub-Saharan Africa (HPTN 084): a randomised, double-blind, placebo-controlled, phase 3 trial." *The Lancet*, 399(10337), 1779-1789.

[30] WHO PrEP implementation guidelines, 2024. Available from: https://iris.who.int/bitstream/handle/10665/378164/9789240097230-eng.pdf?sequence=1

Do PrEP medicines have side effects?

For the first few weeks of starting PrEP medication, a minority of users complained about nausea, vomiting, fatigue, and dizziness. For most people, these symptoms eventually disappear once the body gets used to it. One potential danger when using the drug is developing kidney problems. Another study found that some people taking **Truvada** had a minor decrease in bone mineral density within the first month of taking it. Once Truvada was stopped, the bone density appeared to return to normal measures.[31] These are two reasons why it is recommended to be under medical supervision, with quarterly check-ups to ensure the kidneys and bones remain healthy.

Does PrEP medication change the way the body or face looks?

No, there is no scientific or even anecdotal evidence for this.

If someone starts using PrEP, can they stop using condoms?

Like condoms, PrEP is highly effective at preventing HIV when used consistently and correctly. PrEP, however, only protects against HIV and not other STIs. Thus, regular medical consultation with relevant STI testing is crucial. Some people will keep using condoms while on PrEP, and others will decide to stop using them. If someone is already using condoms consistently and if doing so makes them feel comfortable and protected, community service providers should promote condoms even though they are on PrEP. Many people struggle with using condoms consistently, which is one reason why PrEP was developed. But people must decide for themselves what level of protection feels right and gives them the peace of mind to lead a sexually fulfilling life.[32]

How can my client get access to PrEP? What is the process involved?

Based on the NSACP PrEP Guideline document (2023)[33], a client can access PrEP in Sri Lanka by following these steps:

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[31] See http://www.aidsmap.com/iTruvadai-PrEP-causes-only-mild-loss-of-bone-mineral-density/page/2967903/.

[32] Excerpted from http://men.prepfacts.org/the-questions/.

[33] Pre-Exposure Prophylaxis for the prevention of HIV infection in Sri Lanka. A clinical practical guideline. NSACP/MOH, Colo,bo, Sri Lanka 2023 Available at: https://www.aidscontrol.gov.lk/images/publications/guidelines/PrEP_Guideline_SL_1942023.pdf

Initial Contact and Risk Assessment: The client may learn about PrEP through a community outreach worker or healthcare provider. An initial assessment is conducted to determine the client's HIV risk factors and their suitability for PrEP.

Referral to an STI Clinic: Clients meeting the eligibility criteria are referred to the nearest STD clinic for initiation and follow-up of PrEP.

Baseline Assessment and Testing: At the STD clinic, a comprehensive assessment is performed, including an HIV test (mandatory), STI screening, and renal function tests (serum Creatinine). Based on individual risk factors, additional tests like Hepatitis B and C screening and a lipid profile might be recommended.

Counseling and Education: Extensive counseling is provided to discuss PrEP effectiveness, dosage (daily or on-demand for men who have sex with men), potential side effects, adherence strategies, and the importance of regular follow-up visits.

PrEP Prescription and Dispensing: After a negative HIV test and completion of necessary assessments and counseling, the doctor prescribes the appropriate PrEP regimen. The client receives a supply of PrEP medication, typically a one-month supply for daily PrEP.

Follow-Up Visits: Regular follow-up visits are scheduled, typically at one to three-month intervals. These visits allow healthcare providers to monitor adherence, assess for side effects, provide ongoing counseling, and screen for STIs.

☞ See Annex 1 for a list of PrEP clinics in your state/district.

What is post-exposure prophylaxis? What is PEP?

Post-exposure prophylaxis, or PEP, is an antiretroviral medicine that is taken as soon as possible after someone has (or may have) been exposed to HIV to reduce the chance of becoming infected. PEP should start not later than 72 hours after the exposure, but preferably much sooner, and must continue for 28 days.

Who should take PEP?

In Sri Lanka, Post-Exposure Prophylaxis (PEP) is available for both occupational and non-occupational exposures, including potential exposure during sex. PEP for sexual exposure, also known as PEPSE, is accessible through the country’s STD clinics. After a potential sexual exposure, individuals can visit these clinics, where a case-by-case risk assessment will

determine if PEP is appropriate based on factors like the HIV status of the source and the type of exposure[34].

Although PEP is available, it is not widely promoted, and awareness among key populations may be low. Community service providers should inform clients about PEP as an emergency HIV prevention option and integrate this information with counseling on other prevention strategies, such as PrEP and safer sex practices. The 2022 PEP guideline

s emphasizes the value of offering PEP for non-occupational exposures to reduce the risk of HIV transmission.

Where does someone get PEP?

PEP is provided for free to healthcare providers who experience needle prick injury during procedures involving blood with people living with HIV clients or at any clinical procedure and also in cases of officially reported sexual assault of women. For other cases, PEP will have to be bought.

How soon after possibly having been exposed to HIV should someone take PEP?

The sooner, the better, but it should be within 72 hours after possible exposure to the incident. After that, the virus may have replicated itself too much for PEP to have an effect.

Does the availability of PEP encourage risky behaviors?

Some people fear that having PEP as a backup safety net may lead to people deliberately "forgetting" to use condoms. Counselors or community service providers should inform their clients that taking PEP is not fun or a game! First, it can be a hassle to get PEP via particular channels in some locations; some healthcare providers may frown on using PEP for this purpose. Apart from that, side effects while taking it can make the client quite sick.

What is DoxyPEP, and how is it being implemented in Sri Lanka?

DoxyPEP refers to the use of doxycycline as post-exposure prophylaxis (PEP) to prevent bacterial sexually transmitted infections (STI). In Sri Lanka, DoxyPEP is being introduced primarily through a community-based approach to people at high risk for HIV and other STIs.

[34] Protocol for HIV Post-Exposure Prophylaxis, NSACP and MOH, 2022 Edition. Available from: https://www.aidscontrol.gov.lk/images/publications/guidelines/Final_PEP_protocol_2022-5-10.pdf

Recent NASCP guidance outlines the procedures for providing a starter pack, see for more information and details the footnote[35]. The recommended DoxyPEP dosage is a single 200 mg dose (two capsules of 100 mg each), ideally taken within 24 hours, though it may still be effective up to 72 hours after exposure. By including DoxyPEP in community-based PEP packs, outreach teams can offer timely prevention immediately after potential exposure.

☞ See Annex 1 for a list of clinics in Sri Lanka.

How is DoxyPEP distributed in the community, and what follow-up care is involved?

DoxyPEP is distributed as part of a community PEP starter pack that includes HIV PEP(It is not available in all districts and STD clinics), making it accessible to high-risk individuals shortly after potential exposure. This approach allows community service providers to provide immediate prophylaxis, aiming to prevent both HIV and bacterial STIs in high-risk groups. The program emphasizes the importance of connecting clients who receive community-based PEP to STD clinics for comprehensive follow-up care. At these clinics, clients can receive further STI testing, treatment, and continued monitoring. This linkage ensures that individuals benefit from a full spectrum of care beyond the initial PEP intervention, supporting their overall sexual health[39].

Are there specific criteria for who can receive DoxyPEP?

The *Community PEP SOP* does not provide detailed inclusion criteria for DoxyPEP recipients, leaving specific eligibility guidelines unclear. Basically, clients who worry about potentially having had unprotected sex with someone who may have had an STI are eligible.

☞ See Annex 1 for a list of clinics in Sri Lanka.

[35] Standard Operating Procedures for Community PEP delivery for HIV and STI after sexual exposure. NASCP, MOH, July 2024.

Chapter 14: Behaviour change to reduce risk of HIV transmission

What is sexual risk?

Sexual risk is the chance of getting HIV or STI after having sex. Some sexual acts are riskier than others. Kissing and hugging, for example, constitute no sexual risk at all, whereas unprotected receptive anal sex has the highest sexual risk for HIV infection.

☞ See Table 2 in Chapter 8 for a list of sexual behaviors and their risks and Table 8 in Chapter 15 for a table on HIV transmission probabilities.

Why do people take sexual risks?

People take sexual risks for various reasons:

- **Thrill and Passion**: Some see risk as an added thrill or find that sexual desire and passion overshadow thoughts of potential danger.
- **Lack of Awareness**: Many don't realize their actions are risky or underestimate the effectiveness of condoms.
- **Influence of Substances**: Alcohol and drugs can lead to lowered inhibitions and a higher likelihood of riskier behaviors.
- **Trust and Love**: Love and trust often lead people to stop using condoms in relationships. This is common even in short-term, secure relationships.
- **Youth and Experimentation**: Young people may feel invincible, view sex as inevitable, or not consider long-term consequences.
- **Self-Esteem and Access**: Low self-esteem can make people care less about protecting themselves. This may also affect their willingness to seek information or HIV testing.
- **Life Pressures**: For some, daily struggles, such as poverty, violence, or other health issues, overshadow concerns about HIV risk, especially if they're offered money to skip condoms.
- **Social Pressures and Stigma**: Many fear the stigma around certain sexual behaviors, such as same-sex relationships, and avoid seeking help to protect their privacy.

- **Desire for Intimacy**: Many find condoms reduce pleasure or intimacy, while others believe only certain “types” of people are at risk, assuming they’re safe.
- **Testing Decisions**: Regular partners may stop using condoms after testing negative together, or if they are serodiscordant, they may rely on PrEP or antiretroviral treatment to stay safe.
- **Unplanned sexual events:** Sometimes couples have unplanned or sudden meetups for sexual activities where condoms are not available.

What is bare-backing?

Bare-backing (BB) is a term from gay slang that means choosing to have unprotected anal sex. It is not an accidental condom break or a drunk decision—it is a deliberate choice some people make. You will see barebacking mostly among certain men who have sex with men and transgender people. While some young men who have sex with men and transgender individuals skip condoms in their early encounters because they are not used to them, that is not quite barebacking; barebacking implies a conscious decision to go without protection.

Why do some men bareback?

There are many reasons:

"He does not look sick!" Many barebackers may think, “He looks fine; he cannot have HIV.” But looks can deceive. HIV does not have a “look”—people with it can be any shape, size, or social class.

“HIV? Whatever, it is 2024!” With medications extending life expectancy, some men feel HIV is not such a big deal anymore. They have lost the fear, seeing the virus as inevitable or manageable.

“I am on PrEP; no need for condoms!” Some men on PrEP skip the condom, trusting the proven strong protection of PrEP against HIV.

"Just get it over with." Known as “bug chasers,” a few men have such anxiety about contracting HIV that they would rather catch it than keep worrying about it. They feel it is inevitable, so why fight it?

"We are both positive." Some HIV-positive men figure, "Why bother?" with condoms when they are with other HIV-positive partners. But unless both have undetectable viral loads, there is still a risk of transmitting different HIV strains.

Self-confidence struggles: Men with low self-esteem may not feel able to insist on condoms or may not care enough about their health.

Party mode: Drugs and alcohol make users desire intimacy and may lower protective fear levels, especially drugs like ecstasy or crystal meth (Ice); under the influence, barebacking can seem more tempting and less risky.

This mix of reasons shows why barebacking happens. When talking to clients, remember that understanding their "why" is key to helping them make informed, safer choices.

Can people who are on ART or PrEP stop using condoms?

ART (for people who are living with HIV) and PrEP (for people who are HIV-negative) are highly effective in preventing HIV transmission, at least when the people taking it use the medication consistently and correctly. Can they, therefore, stop using condoms? This depends on the person. Each individual has to decide for themselves what level of protection feels right to lead a sexually fulfilling life, both for their partners and their safety and peace of mind.[36] If taken correctly, PrEP can reduce the risk of HIV infection by 99%. Combining PrEP with condom use increases that protection to 99.2%.

What is behavior change?

"Behaviour change" is a process through which people change behaviors damaging to others or themselves. In the case of HIV, these behaviors put them at risk of STI or HIV. Behavior change is usually a gradual process, with progress made and progress lost (steps backward or relapses). The ease or success of behavior change can differ from person to person. This may depend on their knowledge, attitude, perceptions, skills, supportive environment and psycho-social factors, etc.

[36] See also http://men.prepfacts.org/the-questions/.

Why is behavior change usually a gradual process?

It is unrealistic to expect immediate success when someone is trying to change a behavior, especially sexual habits. Behavior change is often gradual and may involve setbacks, with individuals moving back and forth along a continuum of decreasing risk. For the continuum of risk, see Table 2 in Chapter 8, which lists sexual activities from "no risk" to "high risk." Individuals from key populations may be at different stages in this process (see Figure 4) and can benefit from setting realistic, achievable goals for behavior change.

What is possible behavior change objectives?

When you are discussing with your friends or clients about changing their risky behaviors, you can suggest they pick one or some of the following objectives to help guide their commitment:

1. Start to become aware of HIV as a serious problem that could affect them.
2. If HIV-negative, continue to have regular HIV tests (see Chapter 5).
3. Have regular STI check-ups.
4. Start to realize the need to change their behaviour.
5. Try safer behaviors:
    a. Use condoms and lubricants during every sex act.
    b. Reduce the number of sex partners, if possible (not a suitable goal to set for someone who engages in sex work for a living!).
    c. Reduce anal sex in favor of oral or non-penetrative sex
    d. Reduce the frequency of sexual activity if possible
    e. Avoid sharing needles.
    f. Avoid having sex when drunk or high; avoid chemsex.
    g. Reduce the consumption of alcohol or drugs.

How fast can people change their behavior?

A behavior change typically occurs gradually, from being uninterested, unaware, or unwilling to change (pre-contemplation) to considering a change (contemplation) to deciding and

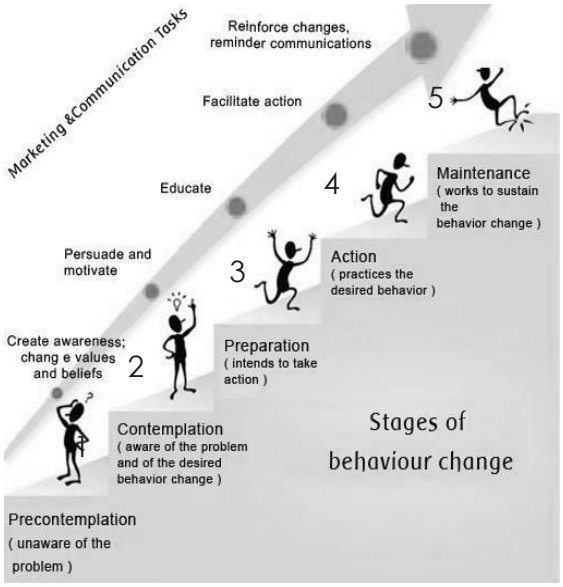
preparing to make a change. Genuine, determined action is then taken, and, over time, attempts to maintain the new behaviour occur.

Relapses are almost inevitable and become part of working towards lifelong change. Relapses can occur at every stage of behavior change. Newer graphic depictions of the behavior change process allow for a “loop” back towards condomless behaviors, thus presenting behavior change not as a linear but as a cyclical process.

What are the main stages of behaviour change?

There are five stages of behaviour change. People can move between different behaviour change stages—it is usually not a linear process.

No	Stage	Explanation
1	Unaware or pre-contemplation	The client does not yet acknowledge that there is a problem behaviour that needs to be changed
2	Aware or Contemplation	The client acknowledges that there is a problem but is not yet ready to make the change or feels not yet certain if the behaviour should change
3	Preparation or determination	The client is getting interested and ready to change behaviour (intention)
4	Action or willpower	The client is taking action and is starting to change the behaviour
5	Maintenance	The client is maintaining the behaviour change; the challenge is to prevent occasional relapse*
*** Relapse can happen between each and any of the stages**		



NOTE

The large arrow shows the way to help a person move up to the next stage

Source: http://www.slideshare.net/abpascual/2013-behavior-change"

Fig. 4: Stages of behaviour change

How can I tell which stage of behavior change someone is at?

When you talk to a friend or client, adapt your message to where they are on the change journey. Are they unconcerned about HIV or STIs? They may be in the "pre-contemplation" stage, not yet seeing a need to change. If they are aware and worried, they are in "contemplation." When they start exploring safer options, like thinking about using condoms, they are preparing. If they are trying out these behaviors, they are in action. Finally, if they consistently stick with safer choices, they are in the "maintenance" stage. (See Table 7 for more tips.)

What should be discussed at each stage?

Check out Table 7 to help you tailor your discussions to each stage. The key? Avoid one-size-fits-all advice. Each person's story is different, so find out what matters to them and work from there.

What is a relapse?

A "relapse" happens when someone slips back to riskier behaviors after making some progress. Most people are expected to face a few setbacks before new habits stick.

How can someone prevent relapse?

Help them spot the "warning signs" of risky situations. Maybe they forgot to bring condoms, drank too much, or assumed their partner had protection. Discussing these triggers helps them prepare for next time. You can also encourage them to share safe sex tips with friends, which strengthens their commitment and spreads the message in their circle.

Table 7: Stages of behaviour change and guidance for targeted advice[37]

Stage	Thoughts and level of awareness or resolve	What to say or advise a person in this stage
Unaware Stage (Pre-contemplation)	Clients do not know about HIV or do not see it as relevant to them.	Focus on raising awareness. Talk about how HIV and STI spread, the risks of transmission, and how prevention matters to them personally. Emphasize the importance of HIV testing as a first step.
Aware Stage (Contemplation)	Clients are uncertain about changing. They may feel conflicted, as giving up unprotected sex might feel like a loss, even though it could mean better health and safety. They consider barriers (time, cost, fear) but may not fully relate the risk to themselves.	Help them see that the long-term benefits of change outweigh the short-term drawbacks. If they are hesitant about HIV testing, reassure them about the peace of mind that comes with knowing their status. Share relatable examples (while keeping confidentiality) to make the issue feel closer and more personal.
Preparation Stage	Clients are ready to make specific changes and may start experimenting with safer behaviors, such as using condoms in certain situations.	Encourage their progress by highlighting the benefits of their new actions. Offer practical tips, like different condom options (sizes, shapes) and strategies for discussing condom use with partners. Support their confidence by acknowledging their early successes with safer sex.

[37] See G. Zimmermann et al., "A 'stages of change' approach to helping patients change behavior', in American Family Physician, 61(5), 2000, pp. 1409–1416, http://www.aafp.org/afp/20000301/1409.html.

Action Stage	Clients adopt safer behaviors they have been planning for.	Reinforce their positive steps by celebrating the changes they are making. Please share examples of benefits and personal experiences to keep them motivated. If they experience a relapse (like a lapse into unprotected sex), reassure them that setbacks are normal and part of the change process. Please encourage them to keep going.
Maintenance stage	Incorporating the new behavior over the long term. Discouragement over occasional slips may halt the change process and result in the client giving up.	Congratulate the client and encourage to continue. Provide advice on how to make the changes stick; warn the client about relapse by giving strategic advice to avoid situations in which relapse can occur, for example, warn against becoming drunk or using drugs, which is known to cause relapse in individuals who would under normal circumstances have only safe sex.

Chapter 15: Dealing with accidental exposure to HIV

What do I say when someone asks, “Help! I had unprotected sex last night! Do I have HIV now?”

This is a question community service provider may encounter in their work. Sometimes people may put themselves at risk: they may be drunk or high (under the influence of drugs), they may be offered money to have sex without a condom, or they may just have been too “hot” (lustful, horny) while having sex. Sometimes, people are unable to negotiate safe sex with a more powerful person; sometimes, rape occurs. Make sure you understand why the condom was not used or why it broke to help prevent it from happening again by giving appropriate information. Did the client use the wrong type of lubricant? Did he use a condom that was too old—past its expiration date? Was the condom too small or too big?

The community service provider should sit down with the client and explain that having unprotected sex means giving HIV a chance to enter their body. It is a relatively small **chance**, not a **certainty**. Below are some points that might be raised to make the client less worried:

1. Of course, whether transmission occurred or not depends on whether the sex partner had HIV. This is almost always impossible to confirm unless the sex partner openly told the client. Considering the low prevalence of HIV in Sri Lanka, the chance is not very big that any random sex partner has HIV.

2. Assuming the sex partner had HIV, the chance of transmission partly depends on how high their viral load was, which depends on how long they had been infected already and whether they were on ARV treatment or not (see Chapter 8 and Chapter 17). If a client was in the acute phase of HIV transmission and the client was the receptive partner in anal intercourse, the chance of transmission could be between 14-36% per sexual act and 0.8-2.6% in vaginal receptive intercourse.

3. If the partner had HIV and was on ART and had an undetectable HIV viral load, the chance of transmission is zero, according to the latest science. Remember: U=U (Undetectable is Untransmittable).

4. If it was the client who has HIV and worries that he may have infected someone else, the client should be informed that it depends on whether his sex partner was taking PrEP or not. Also, if the client is already on ARV and has achieved undetectable viral load, the chance of transmission is zero.

5. Whether transmission of HIV occurred or not also depends on whether one or both of the partners had another STI, which makes HIV transmission up to 7 times more likely[38].

6. It will further depend on the sexual behavior the client had last night—for example, whether they had anal or only oral sex, whether your client was receptive or insertive when having anal sex, and whether ejaculation took place inside the rectum.

7. It will depend on whether sufficient lubricant was used, which decreases the chance of bleeding or tears.

8. Whether transmission of HIV occurred or not may also depend on physical features of the sex organs, such as the size of the penis or the width or flexibility of the rectum

[38] Ward H, Rönn M. Contribution of sexually transmitted infections to the sexual transmission of HIV. Curr Opin HIV AIDS. 2010;5(4):305–10.

(which partly depends on experience and sexual skills); however, there is no scientific information about these factors.

Taking all these factors into consideration, reliable sources estimate that if 10,000 HIV-negative people have unprotected receptive anal sex with an HIV-infected man, 138 of them will become infected with HIV (a transmission efficiency of 1.38% per sex act).

This means that being unsafe with a person with HIV does not necessarily mean that everybody will become immediately infected. It means there is a **chance (probability)** that the person has been infected. For clients who do not understand the concept of probability or chance, one can compare this with buying lottery tickets. Some people win the lottery (get HIV) whereas a large majority do not.

See Table 8 for transmission probabilities—for each situation, there is an assumption that 10,000 uninfected people have the behavior with an infected source, and the number in the right column estimates the number that, on average, will become infected. Be aware that despite these perhaps surprisingly small chances, people tend to engage in a good deal of sexual activity, and these small changes have resulted in HIV prevalence of 5%–42% in some Asian cities. For example, winning the lottery is a slight chance, but hundreds of people win it weekly!

In addition, it should be noted that during the acute infection phase of HIV (2-6 weeks after infection), the viral load of a newly infected person spikes, and HIV transmission risk for someone engaging in unprotected anal receptive intercourse can be 14-36% per sexual act, much higher than during the chronic phase of HIV infection that follows it (1.4%). This is what makes HIV prevention so tricky because 2-6 weeks after infection, most people who are newly infected will not yet have tested for HIV and, hence, are unaware that they have it, unknowingly spreading it further.

Table 8: Estimated risk for infection of HIV per act, by exposure route – SEE WARNING below!

Exposure route	Estimated infections per 10,000 exposures to an infected source during the chronic phase of HIV infection
Blood transfusion	9,250 (92.5% chance per time)
Needle-sharing injection drug use	63 (0.63% chance per time)
Receptive anal intercourse*	138 (1.38% chance per time)
Needle stick	23 (0.23% chance per time)
Receptive vaginal intercourse*	8 (0.08% chance per time)
Insertive anal intercourse*	11 (0.11% chance per time)
Insertive vaginal intercourse*	4 (0.04% chance per time)
Receptive oral intercourse*	Extremely low/negligible
Insertive oral intercourse*	Extremely low/negligible
Note: *=assuming no condom or PrEP or ART use. Source: http://www.cdc.gov/hiv/policies/law/risk.html	

WARNING

The information in Table 8 is considered to be very sensitive. Public health professionals usually do not provide it to the public because there is a fear that people may start "gambling" with risks. They may think: "Oh, only 0.11% chance? I will just take that risk." Please use this information *only* to help people who had unsafe sex put their risk into perspective do not use this knowledge as a prevention strategy for yourself or your partners!

Also note that these are chances *per each sex act*. If someone has sex several times per week or month, these chances really add up!

It should be emphasized that if a person has an STI, the chances for HIV infection per sex act become up to 7 times greater. Also, if a person is in the acute phase or late phase of HIV infection, when viral load is high, the chance of infection further increases to 14-36% per contact for the receptive partner in anal intercourse NOTEREF _Ref182380843 \h 41.

What do I say when someone asks, "Help! The condom broke! What do I do now?"

If a client contacts the community service provider or HIV counsellor with this question, they can advise the client first of all to stay calm. As discussed previously, possible exposure to HIV does not always lead to transmission. The following points can be made to the client:

- "If you were the insertive partner, wash your penis; pull back the foreskin (if you have one) and rinse thoroughly. Try to urinate as well"
- "If you were the receptive partner and semen entered your rectum, sit on the toilet and try to let it drip out. Do not use a showerhead or douche to clean yourself inside: this has been associated with increased infection risk."
- "If you had oral sex, (as mentioned in Chapter 12) there is almost no chance of HIV transmission. You can either quickly spit out or swallow the semen that has entered your mouth. You can rinse your mouth with water but do not use strong chemical mouthwash solution (betadine, Listerine etc.); do not brush your teeth, and do not floss for at least two hours because of the chance that your gums may bleed, providing a potential entry point for HIV."

If there is a big chance that the client was exposed to HIV (if they know that the sex partner is HIV-positive), Post-Exposure Prophylaxis (PEP) treatment is recommended, if available (see Chapter 13). Stress to the client that the treatment requires the anti-HIV drugs be taken at full strength for one month. Only a doctor can prescribe this medicine, which is available at all STD clinics in Sri Lanka. If the client believes they have been exposed to HIV, this treatment must be started as soon as possible (within 72 hours, but preferably earlier) and continued until it is completed.

Is a person with HIV who does not use condoms or is not on ART always equally likely to transmit HIV to others?

No. The per-contact risk of HIV transmission during the acute phase of HIV infection (2-6 weeks after infection) can be multiple times higher than during the chronic phase due to the extremely high viral load present shortly after the infection[42]. This has been documented across various types of sexual contact, with higher risks especially noted in unprotected anal and vaginal intercourse. After this acute infection period, viral load (and thus, infectiousness) decreases sharply,

What should be done after accidental exposure to HIV?

After accidental exposure to HIV, it is essential to keep in touch with your clients and advise them to undergo an HIV test. The client can either wait for the window period before testing or do a test immediately and repeat it once it is over. RNA tests can be a solution, as they have much shorter window period (a few days) than antibody/antigen tests. (See chapter 5).

Part C: Supporting ART, Treatment for opportunistic infections & Care of Key Population Members Living with HIV

Chapter 16: Supporting Newly Diagnosed Clients with HIV

How do you address a client who is in distress?

Often, clients may come into a state of panic after hearing of their HIV diagnosis. It is no use to give them too many facts about HIV at this early stage when people often cannot take information in. Listening and being there for them is the best thing you can do. You should immediately give them one message: "I am here for you; I will be with you and support you to the best of my ability. You are not alone; there are many like you."

Wait until they calm down so you can use the talking points to help clients regain a sense of control over their lives and destiny (see below).

What should I tell someone who has just been diagnosed with HIV?

It is essential to determine how the client feels and their main concerns. Write down their main concerns so you can remember them, and then you can try to address those concerns systematically.

Once they have calmed down sufficiently, clients should, first and foremost, be made aware that they live in a time where excellent medical treatment is available and that it is free. They should understand that by ARV treatment, they will be able to live a long, healthy, and happy life until the death of old age—they are unlikely to die of AIDS-related complications.

Then, the community service provider or counselor should explain to the client how they can help them go through the procedures and follow-up processes necessary to enter treatment. With the introduction of an integrated electronic registration and billing system in the STD clinic, the personal information of all STI/HIV clients is captured in a central database (EIMS). While people who test for HIV can be provided with anonymous testing and counseling, they need to be registered as soon as the diagnosis is confirmed and medical treatment is needed.

After the registration, a community service provider (perhaps a volunteer from a people living with HIV network or an outreach coordinator) can support the client in the follow-up process; this includes confirmation tests, TB screening, other screening tests, consultation with the doctor, etc. Eventually, the client can also be assisted to access support groups such as a people living with HIV organization or other non-HIV related services, but this will come in due course.

It is normal that the client will feel lot of different emotions in coming to accept the idea of living with HIV. However desperate or illogical their feelings may be, it is really important to not dismiss them. Tell the client that it is a good idea to let these feelings out—be angry, be sad, be confident, be desperate, be calm, be afraid, be numb. Suppose the client becomes overwhelmed by negative feelings. In that case, the community service provider or counsellor should be sensitive to whether the client could be prone to self-harm or potentially harm anyone else. Always be ready with the necessary referrals in case you may need help from mental health professionals through the STD clinic.

How do you advise a newly diagnosed client about disclosure issues?

If the client is ready to do so, one of the most effective ways to make a newly diagnosed person feel better is to seek support from friends, family, or especially from other people living with HIV. This will involve disclosing their HIV status to others, and this is not a small matter considering the climate of stigma and fear that surrounds HIV in Sri Lanka. For clients who are from a key population, disclosure of HIV status may be a "double disclosure" as they may also have to explain they are gay/bi, transgender, or have been involved in sex work. Three well-known registered PLHIV networks in Sri Lanka are Positive Hopes Alliance, Lanka Plus, and Positive Women Network[39].

Clients should be made aware that **only they can decide whether or not to disclose** their HIV status. However, the HIV caregiver or community service provider can advise them about the issues to consider. Clients should carefully weigh all factors when deciding whether or not to disclose:

- Why: Tell someone to obtain help and support from this person, which can help the client face challenges related to life as a person living with HIV.
- Who: Only people who can be a source of help and support should be told (very much related to Why)?
- How: Usually, a face-to-face meeting to disclose one's status is better than a call or message. The meeting should be one-on-one, but sometimes, the client may need to be

[39] See: https://lankaplus.org.lk/ and https://www.facebook.com/p/Positive-Hopes-Alliance-100064427726309/

escorted by a community service provider. Clients need to be prepared with relevant facts and answers (anticipate FAQ).

- When: Disclosure should be done at a time that is not busy, with ample time to spare for discussion.
- Where: The location should be a confidential and private environment (calm and quiet).

If after considering all of the above disclosure does not seem like a good idea, perhaps the client is not ready to disclose.

What do I say when someone asks, "I almost feel sorry, I did the test and found out, I was positive? Is that normal?"

The client might find themselves wishing they had never found out about their HIV status. This is hard to hear at first. However, the fact that a client has been diagnosed means they can take steps to care for themselves. The community service provider can tell their client:

> "By knowing your status, you can take control over your health. You can live a long and healthy life by monitoring your health regularly and taking ARV treatment. The alternative would have been that you would only find out your HIV status in a few years."

Can HIV be treated? How?

Yes. HIV is treated with two groups of medicines. One group of medicines is used to slow or reduce the spread of the virus within the body. These are called antiretroviral Treatment (ART). The other group of medicines fights illnesses caused by a weakened immune system. These are called medicines to cure or prevent opportunistic infections (see Chapter 17).[40] People who begin HIV treatment on time will most likely never need to use the second group of medicines because their immune systems are and will remain strong enough to fight off possible opportunistic infections before they take hold.

[40] Much of the information in this section was taken from https://www.thebody.com/

Can HIV be cured?

The medicines mentioned previously cannot cure either HIV or AIDS but suppress it and keep it down. The medications help people live a healthy and, therefore, a higher-quality life. If the ART is taken regularly and faithfully, people living with HIV will die of old age rather than of AIDS-related causes. Many misconceptions exist about herbal and other superstitious "cures"; please refer to Chapter 17.

Is treatment for people with HIV available in Sri Lanka? Is it free?

Yes, HIV treatment at STD clinics and government hospitals is free.

What happens if people with HIV do not get treated?

If people who need treatment do not receive it, they will gradually get sicker and sicker, and eventually, they may die of illnesses related to AIDS. On the other hand, people who are on treatment and under medical supervision can live long and healthy lives.

I am worried my client may commit suicide or harm himself; what should I do?

Sometimes, it happens that clients enter into a state of mental crisis. This is beyond the ability of community service providers to deal with, and they should not even try. It is better to refer to a mental professional instead. If there is no such person around, the community service provider should discuss with the doctor or counselor of the STD Clinic where the client was diagnosed and ask for advice. It is very well possible that clients can be prescribed medication to deal with their acute anxiety and despair, and in doing so, the community service provider may help save their lives.

See also Chapter 28 on mental health.

If someone breaches my client's confidentiality when it comes to their HIV status, is there any legal action that can be taken?

Yes. Legally, in Sri Lanka, the confidentiality of a person's HIV status is protected by the Privacy Law. Clients could be referred to a lawyer or HIV support group to obtain support to take legal action against anyone who breaches this law.

What else can I do to make my newly diagnosed client feel better?

Community service providers should be there for them; initially, there is sometimes not much that one can say to make a client feel better. The community service provider should act as a close friend or family member. The community service provider can send them regular messages or call regularly to check on how the client is doing until they are ready to go through the following steps towards initiating their ART. (See next Chapter 17).

Chapter 17: Supporting the health and wellbeing of people living with HIV (PLHIV)

What are ARV and ART?

ART stands for antiretroviral treatment (or therapy), which covers the provision of medicines and professional medical care. ARV stands for antiretroviral medicines, which work against retroviruses (HIV is a retrovirus).

What types of antiretroviral treatment exist?

Different classes of antiretroviral drugs act at various stages of the HIV life cycle. Antiretroviral drugs are broadly classified by the phase of the retrovirus life cycle (see Figure 3 in Chapter 9) that the drug attacks. There are six types (no need to remember these exactly, but just in case a client asks about this):

1. **Entry inhibitors** interfere with the virus's ability to bind to receptors on the outer surface of the cell it tries to enter. When binding with the cell receptor fails, HIV cannot infect the cell.
2. **Fusion inhibitors** interfere with the virus's ability to fuse with a cellular membrane, preventing HIV from entering a cell.
3. **Reverse transcriptase inhibitors** prevent the HIV enzyme reverse transcriptase (RT) from converting single-stranded HIV RNA into double-stranded HIV DNA. The process is called "reverse transcription".
4. **Integrase inhibitors** block the HIV enzyme integrase, which the virus uses to integrate its genetic material into the DNA of the infected cell.
5. **Protease inhibitors interfere** with the protease enzyme, which cuts typically long chains of HIV proteins into smaller individual proteins. When protease does not work correctly, new virus particles cannot be assembled.
6. **Multi-class combination products** combine HIV drugs from two or more classes or types into a single product.

To prevent strains of HIV from becoming resistant to a type of antiretroviral drug, healthcare providers recommend that people living with HIV take a combination of antiretroviral drugs in an approach called "highly active antiretroviral therapy" (HAART).[41]

What are common misconceptions about HIV treatment?

There are some people who claim HIV can be cured with alternative treatments. This is not true. Apart from treatment with antiretroviral medications (ART), no other treatments have been proven to work against HIV. HIV cannot yet be cured, just treated and managed and kept under control.

The following unproven (one could call them 'fake'!) treatments or activities are common in Sri Lanka and other parts of South Asia:

- **So-called "alternative remedies"**: These include herbal or 'natural' treatments that salespersons claim can cure HIV or AIDS. This category also includes traditional medicines like Chinese and Ayurvedic remedies. While Chinese and Ayurvedic medicines may help alleviate specific symptoms of opportunistic Infections, they definitely **cannot** eliminate the virus from the body.
- **Religious rituals or practices by spiritual healers**: Spiritual healers, such as Shamans, may claim that they can cleanse the body of HIV through rituals or prayer. However, HIV is biological and cannot be removed through religious practices, no matter how elaborate or sincere. Religion can be a source of comfort and support for many people, helping them cope with HIV, but it should not replace medical treatment.
- **Homeopathy**: Some claim that homeopathic remedies can cure or control HIV. However, homeopathy lacks scientific evidence for effectiveness against any viral infection, including HIV. Homeopathic remedies cannot stop the virus from replicating or prevent the immune system from deteriorating.
- **Diet-Based Cures**: There is a misconception that specific diets—such as vegan, detox, or raw food diets, can rid the body of HIV. While good nutrition supports general health, diet alone cannot control HIV or serve as a substitute for ART.

[41] See https://www.niaid.nih.gov/diseases-conditions/starting-antiretroviral-treatment

- **Supplements and "Immune Boosters"**: Herbal, vitamin, mineral, or hormone supplements are often marketed to "boost CD4 counts" or strengthen the immune system against HIV. Some also claim that substances like methamphetamine (meth) can make ART more effective by "flushing" HIV from hiding places in the body. None of these approaches are effective, and some (like meth) are harmful and can worsen a person's health.

Clients should be advised that only ART is proven to treat (though not cure) HIV. Research on a cure is ongoing, but at present, there is no alternative to ART for managing HIV effectively.

How can a person living with HIV monitor their physical health?

Several laboratory tests can be used to monitor HIV. The three common tests for people living with HIV, which are also provided in Sri Lanka, are:

- CD4 count
- Viral load test

These four blood tests are the most comprehensive tests available to monitor the health of individuals living with HIV. Depending on each person's health and whether they are on a treatment regimen, these two tests are done once the patient is virologically suppressed. Because these tests are used to monitor a person's overall health through comparisons of tests over time, newly diagnosed PLHIVs need to get this series of tests at baseline for future comparisons.

What is a CD4 test, and what does it do?

A CD4 test measures the number of CD4 cells in the body, which reflects the health of a person's immune system. For someone without HIV, a normal CD4 count typically falls between 500 and 1,600 cells per microliter of blood. In Sri Lanka, the absolute CD4 count is a key marker of immune health for people with HIV, with higher counts indicating a stronger immune system. This test helps healthcare providers understand the immune status of people living with HIV and make treatment decisions.

How often should someone do a CD4 test?

In Sri Lanka, the recommendation is to have a CD4 test as soon as someone is diagnosed with HIV. After the initial test, a CD4 count is typically done every three to six months or as frequently as the healthcare provider advises. The turnaround time for results can vary: a rapid CD4 test can provide results within the same day, while traditional tests may take up to two weeks to process, depending on the clinic's resources and location.

When should a person living with HIV start antiretroviral treatment?

The World Health Organization (WHO) recommends a "treat all" approach, which advises that all people living with HIV (people living with HIV) should start antiretroviral (ARV) treatment as soon as possible after diagnosis, regardless of CD4 cell count. The Sri Lankan Ministry of Health has adopted this approach as part of its national HIV treatment guidelines. Previously, ARV treatment was only initiated when a person's CD4 count fell below 500.

Starting treatment for all people living with HIV, regardless of CD4 count, has two key advantages.

First, it reduces the risk of people dropping out or disappearing from care before treatment begins, as immediate treatment offers a clear path to manage their health right after diagnosis.

Second, it helps prevent further HIV transmission, as individuals on ARV treatment who achieve an undetectable viral load are unlikely to transmit the virus to others. This approach supports individual and public health goals by promoting early viral suppression[42].

What is a viral load test, and what does it measure?

The viral load test measures the amount of HIV in the bloodstream, expressed as the number of HIV viral copies per milliliter of blood. In Sri Lanka, as in other settings, there are two main types of viral load tests, and results from different test types should not be directly compared. Therefore, consistently using the same test type to monitor viral load accurately over time is essential.

[42] Ministry of Health Sri Lanka. National STD/AIDS Control Programme. A guide to ART treatment. Colombo: Ministry of Health; 2020

What does it mean if a person is said to have an undetectable viral load?

A person living with HIV who is not on treatment typically has thousands to millions of HIV particles per milliliter of blood. However, a person who has been on antiretroviral treatment (ART) for several months can achieve what is called an "undetectable viral load." An undetectable viral load indicates that the treatment is effective and that the person is adhering well to ART.

Importantly, research has demonstrated that people with an undetectable viral load cannot transmit HIV to their sexual partners, a concept known as "Undetectable = Untransmittable" (U=U). This breakthrough underscores the public health benefits of achieving and maintaining viral suppression through consistent ART.

If a person's viral load is undetectable, can they stop using condoms with their partner?

However, it is essential to remember that having an undetectable viral load does not mean that a person is cured of HIV; the virus is still present in their body, including in blood and, for men, in semen. Viral levels can fluctuate between viral load tests, which are usually conducted every 6–12 months or as the physician prescribes.

Whether or not to use condoms depends on how much certainty a person with HIV and their partners wants regarding the prevention of HIV transmission. While an undetectable viral load effectively prevents HIV transmission to sexual partners, it does not protect against other sexually transmitted infections (STIs). For this reason, even people with an undetectable viral load are encouraged to take steps to protect their health, including use a condom to prevent STIs.

How often does a person with HIV need to do a viral load test?

After someone is diagnosed with HIV, the health care provider will conduct or refer them to do a viral load test. After that, they should have a viral load test every six to twelve months and also two to eight weeks after starting or changing HIV medicines.

What is an opportunistic infection?

Opportunistic infections are brought on by organisms that usually do not cause disease in a person with a healthy immune system but affect only people with a poorly functioning or suppressed immune system, such as people with advanced HIV infection or AIDS. These organisms need an "opportunity" to infect a person, and HIV immune suppression provides the opportunity (see Table 9 below).

Table 9: Opportunistic infections occurring at different levels of CD4 count[43]

CD4 count	Disease
200–500/µL	Pneumonia (usually caused by bacteria)
	Tuberculosis in the lungs
	Oral, vaginal, rectal, penile Candida infections
	Shingles (viral skin infection)
	Oral hairy leukoplakia- Oral Thrush
	Kaposi's sarcoma
100–200/µL	All of the above plus:
	Pneumonia due to Pneumocystis Pneumonia (PCP)
	Chronic diarrhoea
50–100/µL	All of the above, plus:
	Encephalitis (usually due to toxoplasmosis)
	Esophagitis due to yeast infection or a virus
	Meningitis (usually due to Cryptococcus)
	Tuberculosis outside the lungs
	Chronic herpes simplex virus infection
	Primary brain lymphoma

[43] https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/potential-related-health-problems/opportunistic-infections/.

<50/µL	All of the above, plus:
	Widespread infection due to Mycobacterium avium complex
	Retinitis, diarrhoea and encephalitis due to cytomegalovirus
also:	

Can opportunistic infections be treated?

Opportunistic infections can be treated and prevented; when a person is on ART and under regular medical supervision, such infections are unlikely to occur.[44] Treatment depends on the type of infection.

What is a Full Blood Count test?

The Full Blood count (FBC) test is a measure of all the components that make up blood. This test measures the amount of white blood cells, haemoglobin, haematocrit and platelets in the bloodstream. With this test, a high white blood cell count can suggest that the body is fighting an infection that may be undetectable; a low red blood cell count with the haemoglobin and haematocrit could be the result of anaemia from the HIV medications; and a low platelet count could affect blood clotting. The doctor will decide if the HIV positive person need the test and when to do it depending on the situation.

How often should a full blood count test be done?

This test is different from the viral load test or the CD4 count because it does not show a direct progression or condition related to HIV. But it does help determine the overall health of the individual. It is recommended that someone taking ART should do a full blood count test every three months. This test takes one day for the laboratory to process.

☞See Annex 1 for details on the services available in your area.

Apart from adhering to ART, how can people living with HIV stay healthy?

One of the best ways to cope with HIV other than taking ART—is to work towards achieving a healthy, happy and relaxed life. Clients must be advised to work towards getting and staying

[44] For information on prevention of opportunistic infections, see https://www.thebody.com/article/aids-and-opportunistic-infections

healthy, reducing harm to themselves and others and taking control of their personal well-being. Finding the right balance for their body and lifestyle can make living well with HIV a reality. This includes:[45]

1. Eating a balanced diet based on fresh and unprocessed foods, with lots of vegetables and fruits.
2. Being extra aware and protective of personal hygiene and overall health. Wash hands frequently, bring along hand sanitizer and wear face masks in crowded, dusty or polluted places.
3. Practice food safety, ensure meat and fish are thoroughly cooked, carefully wash or peel fruits and vegetables, avoid foods that are past their best-by date, and pay attention to warnings about food contamination.
4. Some food can interfere with HIV treatments. Your clients should ask their doctor if they should avoid any specific food.
5. Getting sufficient minerals and vitamins: some people with HIV have been found to have difficulty extracting minerals and vitamins from food so that vitamin supplements might be a good idea.
6. Maintaining a healthy weight. Many people believe people with HIV lose weight quickly, but many people with HIV have trouble keeping their weight down.
7. Recommend to your clients that they consume sufficient antioxidants. Antioxidants are important because they neutralize molecules called “free radicals” inside the body. Free radicals start oxidation, which damages healthy cells in the body. HIV can intensify this process of cell damage. Antioxidants protect against cell damage. The body makes antioxidants, but it can be helped by consuming foods rich in antioxidants. These include blueberries, red peppers, spinach, black and green tea, and dark chocolate. Antioxidants also can be taken in supplement form.
8. Exercise can lead to a more substantial body, higher self-esteem, less stress, better sleep, better heart- and lung function, and fewer mental problems, such as anxiety and depression.

[45] Taken from https://www.thebody.com/content/40480/living-with-hiv-aids.html

What kind of support do people living with HIV need?

Apart from the medical support and treatment discussed previously, people who are diagnosed with HIV need social and psychological support. Many of them are in shock when they are diagnosed and need counseling and information about how to live their life with HIV. Community service providers are tasked with looking after newly diagnosed people and helping them stay or get back on their feet.

Can I still consume alcohol after an HIV diagnosis?

Having a few drinks can relieve stress and allow you to catch up with friends. However, excessive alcohol consumption can be dangerous. It can deplete essential vitamins and minerals from your body. It also can be hard on your liver. Too much alcohol can lead you to reduce your perception of risk, and because sex and alcohol often go together, alcohol can lead you to make choices you may regret, like not having safer sex.

Alcohol is a well-known depressant, and depression is an issue with which many people with HIV struggle. Clients should, therefore, proceed with caution when it comes to alcohol; if they feel that alcohol is affecting their decision-making and their quality of life, they should speak to their doctor about ways that they can regain control of their alcohol use.[46]

Can I still smoke tobacco after an HIV diagnosis?

Clients should be reminded that smoking tobacco has been shown to lead to heart disease and cancer and can make breathing-related conditions, including asthma and emphysema, much worse. Besides this, the nicotine present in cigarettes is highly addictive. Quitting may be the best thing a newly diagnosed client can do for their health and well-being.[47]

Can I still have sex after having been diagnosed with HIV?

Yes, of course! But in the context of HIV, clients need to think about the health of their partner(s), too. Because sex is, for the most part, a social act that takes place between or among people, the client's sexual health is inescapably linked to the sexual health of others. It is, therefore, essential to take measures to prevent transmitting HIV infection to a lover or sex

[46] Taken from https://www.thebody.com/article/hiv-and-alcohol

[47] ibid.

partner. There are several ways of doing this; the most important one is for the client to take their antiretroviral treatment faithfully, which will radically reduce and ultimately eradicate the chance they transmit HIV to others.

For clients who are HIV-positive and not yet virally suppressed, remind them that using condoms during anal sex is another crucial way to reduce the risk of HIV transmission. If they are in a committed relationship, they should discuss with their partner whether the partner would be willing to go on antiretroviral medication as well (i.e., enroll in PrEP) to prevent infection.

How can a Person Living with HIV(PLHIV) make sex safer?

This question is covered throughout this guide, but to recap, sexual contact with another person can be made safer in the following ways:

1. Take **ART** faithfully to keep the viral load low or undetectable.
2. If your client is in a steady relationship with someone who is HIV-negative, they should use condoms consistently or consider suggesting that their **partner enrol in PrEP** (see Chapter 13).
3. Use a **latex condom with a water-based lubricant** and use a new condom with each new partner and with each new act of anal or vaginal sex.
4. If your client likes both the insertive and receptive roles in anal sex, you can suggest they consider **sticking to the receptive role only** because this dramatically reduces the chance of virus transmission to sex partners in case of condom failure or if condoms are not used.
5. Use a **latex glove** and, if necessary, a water-based lubricant when engaging in other penetrative sex (fisting or fingering).
6. **Clean sex toys** with soap and water after each person uses them.

What are the barriers to prevention for people living with HIV?

The following are significant barriers to preventing HIV transmission (either re-infection or transmission to others) for people living with HIV.

First, **disclosure** (telling others about HIV status). People who were recently diagnosed with HIV should get advice on whether and how to disclose their HIV status—in most cases, disclosure to 'strangers' is not recommended. They can get this advice from other people living with HIV (such as peer supporters or support groups) or from HIV counselors or other health care providers (see Annex 1 for details of service providers in your area). See some advice on disclosure in Chapter 16).

Second, some people with HIV have no or limited access to antiretroviral treatment. This means they cannot suppress the viral load in their blood, semen, and rectal fluids. **Enrolling in ART** is the single best way for newly diagnosed people living with HIV to reduce the risk of onward transmission. It is vital for people who prefer not to disclose their HIV status to their sexual partners.

Third, access to condoms, dental dams, and/or lubricants can be problematic. Condoms may be difficult for individuals to find in the "heat of the moment," so stress to friends and clients that they should **always be prepared** by having condoms with them at all times.

What is the role of social support for people living with HIV?

People with HIV have been found to benefit from social and psychological support where it is available, especially from support groups of people who are also living with HIV. PLHIV Peer Support Groups are NGOs Lanka Plus and Positive Hopes Alliance[46] (See Annex 1). PLHIV often benefit from small group discussions and skills-building exercises that are combined with individual counseling. Support combined with healthcare provider-delivered prevention messages is also helpful.

Is it true that using ART medicines causes weight loss?

No, this is a misconception. However, it is true that for some persons living with HIV, medication can cause side effects that may lead to weight loss, such as lactic acidosis (see Chapter 18), or, in case of hepatotoxicity, the client may lose appetite, and this can cause them to lose weight. Hence, weight loss is never the direct result of ART, but it can be an indirect result of it, but only for a small minority of people taking ART.

Suppose a client loses weight after having started ART. In that case, it is essential to discuss this with the HIV doctor as this may be an indicator that there is a more serious side effect at work.

How do health supplements, like protein or steroids (for bodybuilding) and ART, interact?

Vitamin pills and **protein powders** are fine to use, but your client should follow the instructions that are included in the pack (i.e., do not rely on them as a food substitute).

Bodybuilders sometimes use creatine as a supplement to increase muscle but its benefits are unclear. Creatine will increase creatinine levels in the blood, which is routinely monitored for people on antiretroviral treatment, as creatinine clearance is a measure of kidney function. People should not use creatine if they already have kidney problems. Suppose a client uses creatine for body-building purposes. In that case, it is crucial to tell the client's HIV doctor if the client's HIV treatment regimen includes tenofovir (or Truvada or Atripla, which both contain tenofovir). The reason is that creatine levels are an essential monitoring test for these medications.

The use of **steroids** is not recommended in combination with ART without medical supervision, as steroids can cause drug interactions when taken with HIV medication. They need to be used very cautiously as they may cause liver toxicity and can also cause other side effects such as elevated blood pressure, angina, and weakening of the heart muscle.

In short: any supplement or medication that the client is taking, whether obtained over the counter, prescribed, or unregulated, must be reported and discussed with the client's HIV doctor and pharmacist.

Can ART and hormones used for gender-affirming care be taken together?

See Chapter 22 on Transgender health.

Can ART cause side effects?

Yes, sometimes ART can cause side effects[48], most of which are temporary and not severe. Most side effects from ART are manageable, but a few can be severe. Overall, the benefits of ART far outweigh the risk of side effects. In addition, newer ART cause fewer side effects than treatments used in the past. As ART options continue to improve, people are less likely to experience side effects from their ART.

Before starting ARt, community service providers should carefully discuss possible side effects with their clients and encourage them to discuss the possible side effects with their doctor.

Do all ART cause the same side effects?

Different ART can cause other side effects. In addition, people taking the same ART can have various side effects. Many people living with HIV using ART do not experience any side effects at all. Side effects from ART can last only a few days or weeks or continue for much longer. Some side effects may not appear until many months or even years after starting an ART.

If your client takes ART, encourage them to tell you and/or their doctor about any side effects. Some side effects, like headaches or occasional dizziness, may not be serious. Other side effects, such as swelling of the throat and tongue or signs of damage to the liver, can be life-threatening and should be immediately reported to the HIV doctor.

What are the common short-term side effects of ARV medicines?

People starting an ARV medicine for the first time may have side effects that last a couple of weeks. These short-term side effects can include:

- Feeling tired
- Nausea
- Vomiting
- Diarrhea

[48] Information on side effects in this and following pages has been taken from: https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-medicines-and-side-effects#:~:text=Some%20side%20effects%20from%20HIV,years%20after%20starting%20a%20medicine.

- Headache
- Fever
- Muscle pain
- Occasional dizziness
- Insomnia
- Rash

Sometimes, side effects that may not seem serious, such as fever, rash, nausea, or fatigue, can signify a life-threatening condition. Any **swelling of the face, eyes, lips, throat, or tongue** is considered an allergic reaction to the medicine requiring immediate medical attention.

HIV infection itself, another medical condition, or other medicines a person is taking can also cause side effects. Drug interactions between ARV medicines or with other medicines a person is taking can also cause side effects.

What to do if a client has side effects?

If side effects occur, the client must share this with their HIV doctor immediately so that the cause can be determined and ways to treat or manage the side effects can be recommended.

If there are any side effects, the client should NOT cut down on, skip, or stop taking their ART unless the doctor tells them to. Stopping ART allows HIV to multiply and damage the immune system. A damaged immune system makes it harder for the body to fight off infections and certain HIV-related cancers. Stopping ART also increases the risk of drug resistance.

What are some long-term side effects of ART?

Some side effects from HIV medicines can appear months or even years after starting a medicine and can continue for a long time. Examples of long-term side effects include:

- Kidney damage, including kidney failure
- Liver damage (hepatotoxicity, see below)
- Heart disease
- Diabetes or insulin resistance

- An increase in lipids levels in the blood (hyperlipidemia, see below)
- Changes in how the body uses and stores fat (lipodystrophy, see below)
- Weakening of the bones (osteoporosis, see below)
- Nerve damage (peripheral neuropathy)
- Mental health-related effects, including insomnia, depression, and suicidal thoughts

What are ways to manage side effects from ART?

When taking ARt, help the client to plan ahead. Before starting ART, the client has to talk to the doctor about possible side effects. The HIV doctor needs to understand the client's lifestyle and habits. This information will help the doctor recommend medicines best suited to the client's needs.

Depending on the HIV medicines prescribed, the HIV healthcare provider will:

- Tell the client which specific side effects to look out for.
- Offer the client suggestions on how to deal with those side effects. For example, the client should eat smaller meals more often and avoid spicy food to manage nausea and vomiting.
- Tell the client about the signs of life-threatening side effects that require immediate medical attention, such as allergic reactions such as swelling of the mouth and tongue.

The client should tell the doctor if they have any side effects that bother them or do not go away. The doctor may then recommend that the client change some of the ART medicines that caused this particular side effect.

What is hepatotoxicity?

One important but fortunately quite rare side effect of ART medications is hepatotoxicity. Hepatotoxicity is the medical term for damage to the liver caused by a medicine, chemical, herbal, or dietary supplement. It can be a side effect of some ART medicines. In some cases, hepatotoxicity can be life-threatening.

People taking ART should know about the potential side effects of some ARt they can recognize symptoms if their medication is doing them harm. Doctors monitoring the liver's functioning (health) is part and parcel of ART.

How can I know if my medicines could damage my liver?

If the client wants to know more about this, he or she can consult the AIDS Info Drug Database at https://clinicalinfo.hiv.gov/en/drugs to find information about a specific ART medicine. This includes potential side effects on the liver or other organs.

How is hepatotoxicity detected?

Liver function tests (LFTs) are a group of blood tests used to check for damage to the liver. Before treatment with ARV medicines begins, LFTs are done to check for already-existing liver damage. The risk of hepatotoxicity is more significant in people who already had liver damage before they started taking ART. If LFT results show pre-existing liver damage, HIV medicines that may cause hepatotoxicity should be avoided. There are many other ARV medicines available to use instead.

Once treatment with ARV medicines begins, healthcare providers use regular LFTs to monitor for signs of hepatotoxicity.

What is a rash?

A rash is an irritated skin area, sometimes itchy, red, and painful.

Why do people with HIV develop rash?

Possible causes of rash in people with HIV include:

- HIV infection itself
- Other infections
- ARV medicines
- Other medicines
- Other reasons not related to HIV infection

HIV infection

In undiagnosed people, rash may be a symptom of acute HIV infection. Acute HIV infection is the earliest stage of HIV infection, and it generally lasts for 2 to 4 weeks after infection with HIV.

Other infections

The rash may be a symptom of other infections. HIV destroys the infection-fighting cells of the immune system. Damage to the immune system puts people with HIV at risk of infections, and rash is a symptom of many diseases.

Medicines

Many medicines, including medicines used to treat HIV and other infections, can cause a rash.

A rash is among the most common side effects of ART. HIV medicines in all ART drug classes can cause a rash. (ARV medicines are grouped into drug classes according to how they fight HIV; see the beginning of Chapter 17).

Rash due to ART is often not severe and goes away in several days to weeks without treatment. But sometimes, when an ARV medicine is causing a rash that does not go away, it may be necessary to switch to another ARV medicine.

Tell your client to let the doctor know if the client shows signs of a rash. In rare cases, a rash caused by an ARV medicine can be a sign of a serious, life-threatening condition.

What are serious rash-related conditions?

Rash can be a sign of a serious hypersensitivity reaction. A hypersensitivity reaction is an unusual allergic reaction to a medicine. In addition to rash, signs of a hypersensitivity reaction can include fever, difficulty breathing or swallowing, dizziness or light-headedness, and kidney damage.

Stevens-Johnson Syndrome (SJS) (also called *erythema multiforme major*) is a rare but life-threatening hypersensitivity reaction reported with use of some ART. Symptoms of SJS include fever; pain or itching of the skin; blisters that develop on the skin and mucous membranes, especially around the mouth, nose, and eyes; and a rash that starts quickly and may spread.

A severe hypersensitivity reaction can be life-threatening and requires immediate medical attention. SJS must be treated immediately. Immediately go to the emergency room or call an ambulance if a client presents with symptoms of SJS.

Chapter 18: Tuberculosis and other opportunistic infections

What is Tuberculosis, and how is it transmitted?

Tuberculosis (TB) is an infectious disease caused by Mycobacterium *tuberculosis*. It primarily affects the lungs, but it can spread to other parts of the body, such as the lymph nodes, bones, and brain. TB is spread through the air when someone with active TB in the lung and coughs, sneezes, speaks, or sings. People nearby may inhale the bacteria and become infected, especially in crowded or poorly ventilated spaces. TB is more likely to spread in close-contact settings, making it a significant concern in communities with limited access to healthcare and high-density living environments.

How are HIV and Tuberculosis related to each other?

HIV and TB are often referred to as "co-infections" because they commonly affect the same individuals. HIV weakens the immune system, which makes people more susceptible to TB infection and allows latent (inactive) TB infections to become active. In people with HIV, TB is the leading cause of death worldwide, as it progresses more quickly due to the weakened immune system. The risk of developing active TB is estimated to be around 15-22 times higher in people living with HIV compared to those who are HIV-negative. This close relationship means that TB screening and prevention are essential components of HIV care in Sri Lanka and globally.

How is Tuberculosis treated or prevented for newly diagnosed people living with HIV?

For people living with HIV in Sri Lanka, it is essential to screen for TB as soon as they are diagnosed with HIV. Early detection and treatment of TB can significantly reduce complications and prevent the spread of infection. In cases where a person is diagnosed with both HIV and active TB, immediate TB treatment is critical.

For those who do not have active TB, preventive therapy may be provided to prevent latent TB from becoming active. Preventive therapy usually involves a course of antibiotics, such as isoniazid, which helps reduce the risk of TB activation. Regular monitoring and follow-ups are essential for people on TB preventive therapy to ensure adherence and check for any side effects.

How long does it take to treat someone with Tuberculosis?

The standard treatment duration for drug-sensitive TB is six months. This involves an initial two-month intensive phase with a combination of antibiotics, followed by a four-month continuation phase with fewer drugs. It is essential that clients adhere to the full course of treatment to prevent the development of drug-resistant TB, which is harder to treat and requires longer, more complex therapy. In cases of multidrug-resistant TB (MDR-TB), treatment can take 18 months or longer, depending on the drugs used and the patient's response.

Can Tuberculosis and HIV be treated at the same time? If not, which should be treated first?

Yes, TB and HIV can and should be treated simultaneously, but the timing of ART depends on the patient's clinical condition. For people diagnosed with both active TB and HIV, TB treatment is usually started first to control the infection. ART is typically initiated within the first two to eight weeks after beginning of TB treatment, depending on the person's CD4 count and overall health. Starting ART too soon can increase the risk of immune reconstitution inflammatory syndrome (IRIS), which occurs when the immune system responds too strongly to infections, leading to complications. However, delaying ART too long can be risky, especially for those with low CD4 counts. Therefore, healthcare providers should carefully coordinate treatment.

What are the most common opportunistic infections for people with AIDS in Sri Lanka?

In Sri Lanka, people with AIDS are at risk of several opportunistic infections (OIs) due to their weakened immune systems. The most common OIs include:

- **Tuberculosis (TB)**: The most significant opportunistic infection among people with AIDS, TB is often the first serious illness in people with AIDS in Sri Lanka.
- **Pneumocystis Carinii Pneumonia (PCP)**: This fungal infection affects the lungs and is common in people with advanced HIV, particularly those with low CD4 counts.
- **Oral and Esophageal Candidiasis (Thrush)**: Caused by fungi *Candida*, this infection can occur in the mouth, throat, or esophagus, causing pain and difficulty swallowing.

- **Chronic Diarrhea**: Persistent diarrhea caused by infections like *Cryptosporidium*, which is common among people with weakened immune systems.
- **Cytomegalovirus (CMV)**: This virus can lead to severe complications, including retinitis, which can cause blindness, as well as infections in other organs.
- **Herpes Simplex Virus (HSV)**: Chronic or severe outbreaks of herpes can occur in people with low CD4 counts, affecting areas like the mouth, genitals, and anus.
- **Cryptococcus Meningitis**: This fungal infection affects the brain and can be life-threatening in people with low CD4 counts.

These infections highlight the importance of regular health monitoring, ART adherence, and preventive care for people with HIV/AIDS. Ensuring prompt treatment of opportunistic infections and maintaining a strong immune system through ART are essential strategies in HIV care and support.

What is Pneumocystis Carinii Pneumonia (PCP), its symptoms, and how is it treated?

PCP is caused by a fungus that is commonly found in the environment and can be inhaled. In healthy people, the immune system easily controls this fungus, but in people with weakened immune systems, like those with HIV, it can cause severe lung infections. Symptoms of PCP include a dry cough, shortness of breath, chest pain, and fever. People with PCP may also experience fatigue and difficulty breathing, which can worsen over time if untreated.

What are oral and esophageal candidiasis (thrush) and, its symptoms?

Thrush is caused by *Candida* yeast, a fungus that generally lives in the body but can overgrow in people with weakened immune systems, such as people living with HIV. It commonly affects the mouth, throat, and esophagus. Symptoms of oral thrush include white patches on the tongue, inner cheeks, and throat, which may cause a burning sensation or discomfort. Esophageal thrush, which affects the esophagus, can lead to pain when swallowing and difficulty eating.

What is chronic diarrhea, and what are its symptoms?

Infections from parasites, bacteria, or viruses, such as Cryptosporidium, Giardia, or Cytomegalovirus, often cause chronic diarrhea in people with HIV. These infections are

typically contracted through contaminated food, water, or contact with infected individuals. Chronic diarrhea can significantly impact the quality of life and lead to complications.

Symptoms of chronic diarrhea include frequent, watery stools, abdominal cramps, nausea, and unintentional weight loss. Persistent diarrhea can also lead to dehydration and malnutrition if not addressed.

What is Cytomegalovirus (CMV), and what are its symptoms?

Cytomegalovirus (CMV) is a common virus many people contract in childhood. In healthy individuals, CMV usually remains dormant. However, in people with weakened immune systems, like those with HIV, CMV can reactivate and cause severe complications.

The symptoms of CMV vary depending on which organs are affected. CMV retinitis, which affects the eyes, can cause blurred vision, floaters, and even blindness if untreated. CMV can also infect other parts of the body, leading to symptoms like abdominal pain, diarrhea, and fever.

What is Herpes Simplex Virus (HSV) and what are the symptoms?

Herpes Simplex Virus (HSV) Type 1 and 11 are transmitted through direct contact with infected skin, mucous membranes, or bodily fluids. It is spread through kissing, sexual contact, or other close personal interactions with someone who has an active outbreak. In people with weakened immune systems, HSV can cause more severe and prolonged outbreaks.

Symptoms include painful sores or blisters, typically on the mouth (cold sores) or genitals. In individuals with HIV, HSV infections can also affect areas around the anus and may be more intense, with extended healing times.

What is Cryptococcal Meningitis, and what are its symptoms?

Cryptococcal meningitis is a fungal infection caused by *Cryptococcus neoformans* in soil and bird droppings. People can inhale the fungal spores, which can spread to the brain in those with weakened immune systems, leading to meningitis, a life-threatening inflammation of the membranes around the brain and spinal cord.

Symptoms of cryptococcal meningitis include severe headaches, neck stiffness, sensitivity to light, fever, and confusion. If untreated, the condition can lead to serious neurological complications or death.

Chapter 19: Supporting HIV/STI Clinic Consultants and doctors in providing ARV Treatment to people living with HIV

How can community service providers of PLHIV support ART adherence for people living with HIV in Sri Lanka?

Some trained community service providers can help provide adherence counseling to help clients of PLHIV understand the importance of taking ART as prescribed. They address concerns and barriers to adherence, such as fear of side effects or misunderstandings about the medication. Educating clients on the consequences of non-adherence, including drug resistance and treatment failure, is also part of their role. This guidance builds trust and encourages clients to stay committed to their treatment plans.

How do community service providers of PLHIV Organisations, facilitate communication and connections to care?

PLHIV, Community service providers can act as a bridge between clients with their consent, and healthcare providers, ensuring that clients stay connected to care. They remind, clients of upcoming appointments, assist with prescription refills, and advocate for their needs within the healthcare system. This role is particularly valuable for clients who may hesitate to engage in care due to stigma or fear of discrimination, providing them with a supportive and accessible link to essential services.

What is the role of home visits in supporting ART adherence?

Home visits, with the consent of the HIV positive person and the STD clinic Doctors advice, allow community service providers of PLHIV to provide personalized support, assess a client's living environment, and identify any factors that could impact ART adherence, such as unstable housing or limited family support. Home-based visits help build trust and rapport, offering a more comfortable setting for clients to discuss challenges. During these visits, community service providers can offer counseling, connect clients to peer networks, and make referrals for additional support, including nutrition, stigma counseling, and other medical or non-medical needs.

How do community service providers of PLHIV networks assist in supporting people with HIV?

PLHIV networks offer peer support, helping clients feel understood and less isolated by connecting them with others facing similar challenges. This partnership is effective in linking people with HIV to necessary health services and supporting them in managing any co-occurring health conditions or opportunistic infections.

What role does treatment literacy play in ART adherence?

Treatment literacy involves educating clients on HIV, ART, and the benefits of adhering to treatment. Community service providers provide clear information about how ART works, what side effects to expect, and strategies for managing them. By correcting misinformation and addressing stigma, they empower clients to take ownership of their health, improving ART adherence and fostering a proactive approach to managing HIV.

How can community service providers and people living with HIV networks help track and re-engage clients who stop taking their ART?

Community service providers play a critical role in supporting Public Health Inspectors (PHI) track clients who have stopped attending appointments or picking up medications. Using their community connections and understanding of local social contexts, they reach out to clients who are lost to follow-up. By providing support and encouragement, community service providers help clients reconnect with healthcare services, thereby reducing dropout rates and improving long-term health outcomes.

How does virtual technology assist in supporting ART adherence?

Community service providers use tools like mobile apps, text messaging, and social media to stay connected with clients, with the directions given by the STI clinic. Through these platforms, they can send appointment reminders, offer virtual support, and share information, making it easier for clients to stay engaged in care. Technology-based interventions are effective in reaching individuals who may face geographical barriers or prefer not to meet in person.

What advocacy roles do community service providers fulfill to improve HIV services?

Community service providers advocate for enhanced HIV services by sharing insights from their work directly with clients and sharing this information with ART doctors and people who are in charge of STI/HIV services. Their firsthand knowledge is invaluable to help to inform program design and highlight areas where services could be improved, particularly around adherence support. Advocacy efforts contribute to policies that address the specific needs of people living with HIV, helping shape a more responsive and supportive healthcare environment.

How do community service providers support rapid ART initiation?

Rapid ART initiation involves starting treatment as soon as possible after diagnosis, often on the same day. Community service providers educate newly diagnosed clients about the benefits of early treatment and help address logistical challenges, like transportation or childcare, to facilitate quick access to ART. This support is essential for ensuring that clients begin treatment without delay, reducing the risk of complications, and improving their long-term health outcomes.

Why is collaboration between community service providers and healthcare providers important for ART adherence?

Collaboration allows community service providers and ART doctors to align on client needs, improving treatment retention and overall well-being. Community service providers of people living with HIV provide critical community-based support, while healthcare providers offer medical expertise. Together, they ensure that people living with HIV receive comprehensive care, addressing both clinical and social factors that impact adherence, such as stigma, access to information, and consistent follow-up.

How are clients registered at STD clinics?

All clients receiving care at STD clinics are registered in the Electronic Information Management System (EIMS), which records, manages, and analyzes patient data in real time. There are two types of registration procedures:

- **Short Registration:** STD Clinic staff can order HIV testing after a short registration process for clients who need it.
- **Full Registration:** This involves a more detailed process that includes collecting demographic information, reasons for testing, risk factors, and other relevant details.

What happens after a client is diagnosed with HIV at an STD clinic?

After a confirmed HIV diagnosis, the patient is transferred from STI care to HIV care. This transfer is recorded in both paper formats and the EIMS system. If the clinic where the diagnosis was made is not an ART center, the patient is transferred to their preferred ART center.

What assessments and investigations are done as a baseline for new HIV clients?

A comprehensive assessment is done to evaluate the patient's clinical status, including the presence of opportunistic infections and other health conditions. Baseline investigations assess the patient's immunological and virological status, as well as screen for STI, comorbidities, and opportunistic infections. These tests may include:

- **CD4 Count:** This test measures the number of CD4 cells.
- **Viral Load:** This test measures the amount of HIV in the blood.
- **Tests for Opportunistic Infections:** May include tests for tuberculosis, cryptococcal meningitis, and other infections that affect people with weakened immune systems.
- **STI Screening:** Tests for infections like syphilis, hepatitis B and C, and other STI.
- **Other Tests:** Blood tests to check the health of the liver and its functions and serum creatinine for kidney function, blood sugar, lipid profile, and other relevant health indicators, as needed.

PART D: Understanding Client Issues and Key Population Dynamics

Chapter 20: Understanding Sexual Orientations and Gender Identities/Expressions (SOGIE)

What is SOGIE?

SOGIE stands for "Sexual Orientation, Gender Identity, and Expression," and now often includes "Sex Characteristics" (SOGIESC), acknowledging intersex individuals. SOGIE represents the diversity of sexual and gender experiences.

What is Sexual Orientation?

Sexual orientation refers to a person's lasting pattern of romantic or sexual attraction towards others, essentially answering the question, "Who do you feel attracted to?"

What are the different types of Sexual Orientation?

1. **Heterosexual (Straight):** Attraction to the opposite sex or gender.
2. **Homosexual (Gay/Lesbian):** Attraction to the same sex or gender. “Gay” is often used for men but can refer to both genders; “Lesbian” specifically relates to women.
3. **Bisexual:** Attraction to both males and females.
4. **Asexual:** Limited or no sexual attraction to any gender.
5. **Pansexual:** Attraction to others regardless of gender.

Why Do Some People Hide Their Sexual Orientation?

Due to stigma and discrimination in Sri Lanka, some people may hide their sexual orientation to conform to societal expectations or family pressures. In both Singhalese and Tamil communities, family honor and societal expectations play a prominent role in individual behavior. The pressure to marry and produce children is firm, as both Tamil and Sinhalese families see it as a social and familial duty. This pressure can lead LGBTQ+ individuals to hide their orientation or enter heterosexual marriages to "save face."

What is Gender Identity?

Gender identity is a person's inner sense of being male, female, or something else. This may or may not align with the sex assigned at birth. In Sri Lanka, gender roles are traditionally defined

in line with the sex assigned at birth, which can add pressure on individuals whose identities differ from these expectations.

What Does "Transgender" Mean?

"Transgender" describes individuals whose gender identity doesn't match their birth-assigned sex. Common terms include:

- **Transgender Woman:** Assigned male at birth but identifies as female.
- **Transgender Man:** Assigned female at birth but identifies as male.

What is "Cisgender"?

Cisgender individuals have a gender identity that aligns with the sex assigned at birth.

What is Gender Expression?

Gender expression is how people present their gender in ways like clothing, language, hairstyle, and behavior.

Why should gender identity and sexual orientation be handled with sensitivity?

Prejudice against gender and sexual minorities often stems from a lack of understanding. This stigma can lead to exclusion from fundamental rights, including access to stigma-free and client-friendly healthcare. Supporting clients to feel good about themselves is critical for their health and well-being.

There's a noticeable urban-rural divide in attitudes toward LGBTQ+ people in Sri Lanka. There is a small but growing acceptance in urban areas like Colombo, partly due to exposure to international influences and progressive ideas. Tamil and Sinhalese communities may hold more conservative views in rural areas.

Only individuals can determine their orientation and identity. Avoid assumptions and treat all clients with respect. People may explore or change their self-identity over time, and it is essential to acknowledge this and to support them through this process if needed. If someone does not feel welcome because of negative attitudes towards their gender or sexual orientation, they will be less likely to make use of available HIV services.

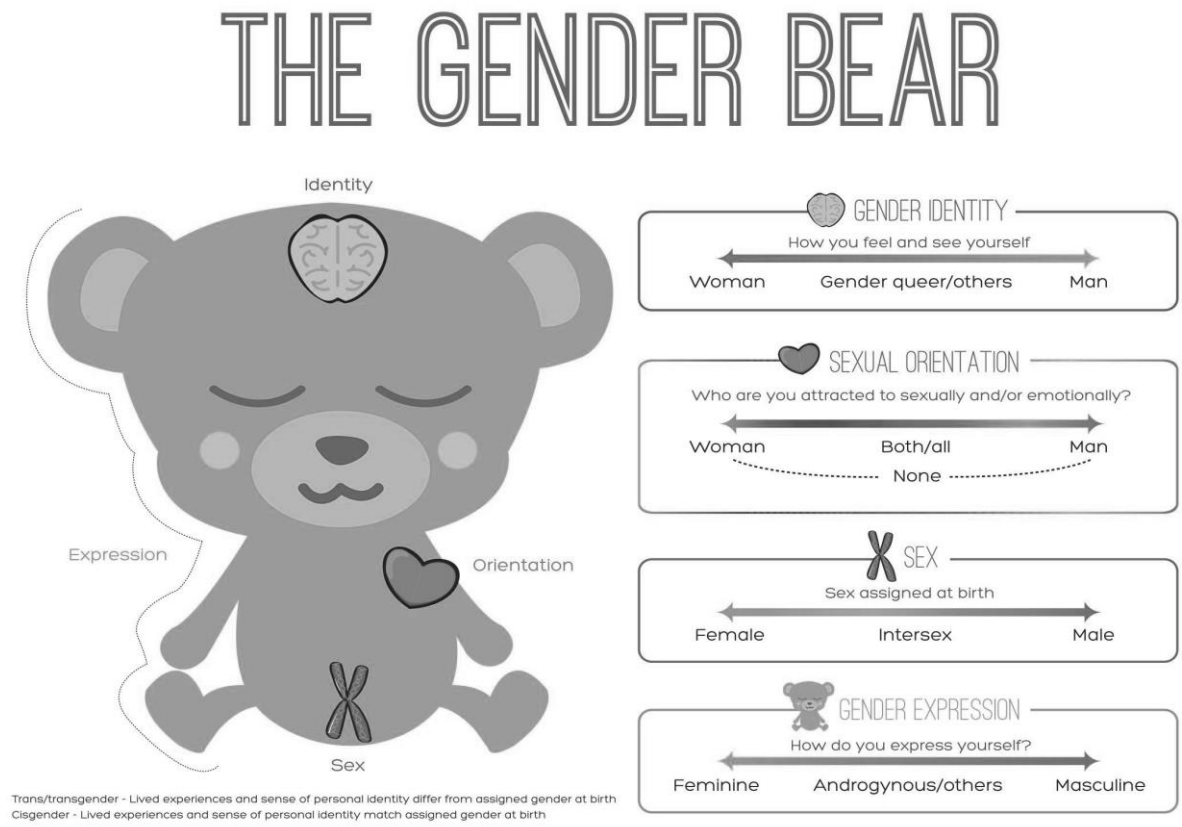
Why is self-acceptance and self-love important?

Stigma can lead to shame, low self-esteem, and poor health choices, particularly in HIV prevention and treatment. Remind clients that everyone deserves respect and access to health services.

Table 10: Myths and truths about sexual and gender minority people

MYTH	TRUTH
Homosexuality or transgenderism is a disorder (illness).	In the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA), homosexuality was dropped from the list of "mental illness" in 1987 (DSM3 revised). DSM5 dropped the term "gender identity disorder" for the less encompassing "gender dysphoria" in 2013. This diagnosis is made only if a transgender person experiences distress due to incongruence between their true gender identity and the gender assigned at birth. The World Health Organization (WHO) removed homosexuality from its International Classification of Diseases (ICD) in 1992 (ICD10). Since June 2018 (ICD11) it no longer considers gender incongruence as a mental disorder.
Homosexuality is unnatural or 'against the religion'.	This myth is widespread in both Sinhalese and Tamil communities, often linked to religious beliefs. However, neither Buddhism, Islam or Hinduism explicitly condemns homosexuality in their core teachings. Ancient texts from both religions suggest a more complex understanding of sexuality, with historical tolerance for diverse sexualities. The perception of homosexuality as "unnatural" or "sinful" is primarily a colonial import; pre-colonial South Asia generally exhibited more nuanced views on sexuality.
Homosexuality are transgenderism are caused by a lack of male hormones or an imbalance in hormones	There is ample scientific evidence and overall consensus among scientists that masculine or feminine hormone levels in the blood have nothing to do with sexual orientation or with gender

	identity. Such hormones only regulate the femininity or masculinity of the body, not that of the mind or 'heart'.
Gay men are not 'real men' and lesbian women are not 'real women'	In both Sinhalese and Tamil communities, there are entrenched gender roles. Gay men may be perceived as less masculine, and lesbians as less feminine, due to their attraction to the same sex. This myth enforces rigid ideas about what it means to be a "man" or "woman," ignoring the fact that sexual orientation and gender identity are separate.
Lack of male role models or too many female role models lead boys to become homosexual or transgender.	The wide and varied backgrounds of all the different people who are homosexual and transgender disproves this myth. Many grew up in all-male environments and had plenty of male role models. Overall society (media, education system, religion etc.) is dominated by heterosexual/cisgender narratives and media—so why would external influences lead to homosexuality/ transgenderism?
It can be cured or treated	There is scientific proof that so-called "conversion therapies" to "cure" homosexuality does a) not work, b) are harmful to the people who are forced into it. They cause great emotional and psychological turmoil and despair, which is why such 'therapies' have been rightfully banned in many countries.
Homosexuality or transgenderism is caused by sin in a previous life, by karma or by a curse	These are mere popular beliefs and superstitions. There is no evidence or reason to believe these.
Homosexual or transgender people are bad or sinful people	People should never be judged by their sexual orientation or identity because this is something they cannot choose or change. Goodness or badness of an individual is (and should) be determined by how they behave as well as by how they treat others in society. Someone's sexual orientation or gender identity is simply not related to this.



☞See Chapter 27 on stigma for more on this issue.

☞See Chapter 22 for more on transgender specific issues

Chapter 21: Dynamics of men who have sex with men & HIV

What is meant by the term men who have sex with men (MSM)?

MSM stands for "Men who have sex with Men". MSM is an inclusive public health term used to define sexual behaviour between males, regardless of their sexual- or gender identity, their motivation for engaging in sex or their identification with any or no particular community. The words "man" and "sex" are interpreted differently in diverse cultures and societies as well as by the individuals involved.

Although the term men who have sex with men was initially intended to encompass a range of settings and contexts where male-to-male sex occurs, without delving into identity politics, it has often been criticized for reducing individuals to one aspect of their personhood—the fact that they have sex with men. In Sri Lanka, this clinical classification has historically included transgender women under the men who have sex with men category, as societal and institutional frameworks have failed to recognize or affirm their gender identity as women, leading to misclassification and potential stigma. This has led to transgender women being classified as men who have sex with men, as well as their sexual partners—who usually are 'straight' men who are usually not part of male homosexual subcultures or networks.

Some progress has been made in Sri Lanka where transgender women are now treated as a separate key population.

How many men who have sex with men are there?

Academics have estimated that between 3% and 5% of sexually active adult men have sex with other men regularly and that up to 15% have experience with other men at least once in their lifetime, though not frequently.[49]

There are about 73,800 men who have sex with men and 2200 estimated transgender women in Sri Lanka[50].

[49] C. Caceres et al., "Estimating the number of men who have sex with men in low and middle income countries", in *STI*, 82(Suppl III), 2006, pp. iii3–iii9.

[50] Information taken from https://www.aidscontrol.gov.lk/dashboard/public/index.php/country-scenario/epidemic-scenario/dashboard?yearId=9

Do all men who have sex with men identify as gay or bisexual?

The term “men who have sex with men” refers to a sexual behaviour, and hence is not about sexual or gender identity or orientation. Gay or bisexual men who are sexually active are all covered by the term men who have sex with men, but there are many men who have sex with men who do not call themselves gay, homosexual or bisexual. They may prefer to label themselves as heterosexual, despite their engagement in homosexual behaviour.

For that reason, it is important not to package all HIV services for MSM as services for “gay or bisexual men” as this might not appeal to these other men who have sex with men who are more hidden and discreet; such men often having a family and are in a marriage to a woman.

Why do some men have sex with men even if they do not identify as gay or bisexual?

Some men simply enjoy the sexual behaviour; for example, they like the sensation and pleasure that comes with anal or oral penetration, and they do not care whether they experience this behaviour with a woman or with another man. Some men have sex with men in all-male environments only, like jails, marine/fishing ships, armed forces (army, navy, air force),

factory/construction hostels or boarding schools; they may justify this by saying they do this because there are no women available there. Such men may or may not actually prefer women, but they do not have a girlfriend or have no access to women, so they have sex with men instead. Some heterosexual men may also have sex with other men as a form or sex work, simply to earn money.

Are young boys/adolescents who 'play with each other' gay/homosexual?

In South Asian contexts, studies have shown that social structures, such as gender segregation and conservative views on premarital sex, lead to restricted opportunities for heterosexual exploration among adolescents. This, in turn, can result in same-sex experimentation among young men. Most boys or young men later identify as heterosexual and stop engaging in same-sex behavior once they have access to relationships with women, while others may continue such relationships, reflecting a more fluid or complex understanding of their sexual orientation.

Are men who have sex with men more at risk for HIV than heterosexual men who do not engage in MSM?

Yes. Globally, MSMs are 28 times more likely to acquire HIV than the general population, due to various risk factors (see below). According to NSACP, the majority of diagnosed Sri Lankan people living with HIV became infected via male-to-male sex. MSM and transgender women therefore remain by far the most affected and at-risk population for HIV in Sri Lanka. They also face high levels of stigma, discrimination and violence, which form important barriers to their ability to have safe sex, access HIV testing or enroll or adhere to ART.

What are the reasons MSM are at the highest risk for HIV?

This is due to various factors which increase HIV risk for MSM compared to heterosexual men as listed and briefly addressed below:

FACTOR	EXPLANATION
Biological	Unprotected anal sex carries at least a 10 times higher risk of transmission compared to vaginal sex. This is because the skin/tissue inside the anus/rectum is thin and more easily torn, creating an entry point for HIV into the bloodstream. Also, undiagnosed STI, especially in the rectal area, increases the risk of HIV infection.
Sex role	Unprotected receptive anal intercourse is the riskiest sexual behaviour for HIV transmission, followed by insertive anal intercourse. If men who have sex with men would stick to just one role, the epidemic would have been much smaller (similar to the heterosexual epidemic). However, many men who have sex with men sometimes are versatile (both receptive and insertive) or often are bottom when they are young, then change to top when they become older, and some may change their preferred behaviour back from top to bottom when they get older. These mechanisms are an important cause for the more pronounced spread of HIV in MSM at population level compared to the situation in heterosexual people.
Behavioural	Many MSM depend on casual partners to fulfil their sexual needs. This is partly because they are unable or not allowed (for societal reasons) to have socially-accepted long-term relationships. Actual and internalised stigma also contribute to MSM believing that long-term stable relationships between men are not possible or somehow not natural. Condom and PrEP use are generally low, and many MSMs do not know their HIV/STI status. Substance (alcohol and drug use) also play a role: they often lead men to "forget" about using condoms. This includes the rise of "chemsex" (see Chapter 25).
Age	Studies around the world have shown that MSMs start to have sex at a younger age than their heterosexual counterparts. In Sri Lanka, young people under the age of 16 cannot have an HIV or STI test without parental consent, although there are some ways around this if the healthcare provider decides it is in the best interest of the child to have a test (See Chapter 6). Young MSMs are likely to be much more hesitant to tell their parents about their sexual behaviours than

	heterosexual youth. Therefore, young MSMs lack access to healthcare for HIV/STI. This is increasingly leading to late diagnosis and treatment for STI and HIV.
Legal	Laws that criminalise sexual behaviour make MSMs less likely to access HIV services for fear of their sexual orientation and identity being revealed or registered with government clinics. Even if they do seek healthcare services, they may not reveal all their risky behaviours during consultations with health care providers due to that same fear. Even at STD clinics, doctors focus on the health of the penis when a male client comes in, and often neglect to ask about rectal symptoms of STDs, and clients often are too shy or ashamed to report such symptoms. Untreated STDs enhance the likelihood of an HIV infection occurring manifold.
Sociocultural	Stigma and discrimination cause MSMs to be less likely to access HIV services. This may also affect their mental health, which in turn affects their health seeking behaviour and/or adherence to medication negatively.

Chapter 22: Dynamics of transgender people and their health

What is transgender?

People whose assigned sex at birth differs from their gender identity are referred to as "transgender". Such persons often want to adapt physically, socially and legally to their true gender identity, but not all may choose to do so or have the opportunity to do so, especially in more conservative countries.

A person assigned the male sex at birth but has a female gender identity is called a "transgender woman" or a "trans woman". A person assigned the female sex at birth but who has a male gender identity is called a "transgender man" or a "trans man".

Is being transgender the result of a mental illness?

No. In the latest World Health Organisation (WHO) classification of illnesses, called the International Classification of Diseases – ICD11, being transgender is not classified as a mental illness.

How many transgender people are there?

This is not known. Some scientists have estimated that 1 in 12,000 men and 1 in 25,000 women are transgender by nature, but not all of them will follow their desire to be different by crossing the gender divide. Doing so depends on the possibilities and opportunities in the environment in which they live and other factors. It is estimated that there are 2200 estimated number of transgender women in Sri Lanka[51].

This Chapter focuses on "transgender women" or "trans women".

What is transitioning?

Transitioning is a comprehensive process during which a person moves from the assigned sex at birth towards the gender that is in line with their true self. It encompasses various medical processes by which the body of a transgender woman comes to be more in line with her true gender identity. This may involve the use of hormone therapy and gender affirming surgery.

It should also include and start with medically backed counselling and other psychotherapeutic approaches to prepare and guide the person undergoing gender transitioning for the changes in psyche and in the social environment that they will need to come to terms with. Often, transgender people have to deal with negative reactions from their family or others in their social environment.

Unfortunately, comprehensive medical services suitable for transgender women are not officially available in Sri Lanka. Many transgender women go abroad to have access to such services. This will depend on the individual and whether they have sufficient money. Often the services that they are able to access/afford may not be properly suitable or medically comprehensive.

Do all transgender women choose to transition?

Not all transgender women choose to physically transition; many choose to live life as a woman without undergoing medical procedures for transitioning.

[51] Sri Lanka Global Fund Funding Request Form 2020-2022.

What is some typical Sri Lankan cultural expressions/terminologies related to transgender people?

In Sri Lanka, cultural terminologies related to transgender identities reflect a mix of traditional and modern understandings. Here are some of the common terms:

1. **Nachchi**: This term is often used in Sinhala to refer to transgender women or effeminate men, typically those who are assigned male at birth but express themselves in a feminine way. While sometimes used with respect, it can also carry derogatory connotations, depending on the context and tone.

2. **Ponnaya**: This is a slang term in Sinhala often used to refer to transgender women or effeminate men. However, it is frequently used in a derogatory way and is considered offensive. It reinforces stereotypes about gender expression and sexual orientation, highlighting the stigma that transgender people face in Sri Lankan society.

3. **Ali**: In Tamil, the term “Ali” (sometimes spelled as "Aravani" in South India) can refer to transgender individuals, particularly transgender women. This term is used in Tamil-speaking communities across South Asia, including in some parts of Sri Lanka. It has roots in the historical recognition of gender diversity in Tamil culture, though it may also carry stigmatizing associations in certain contexts.

4. **Thirunangai**: Originally from Tamil Nadu in South India, “Thirunangai” translates to "respectable woman" and is used by some Tamil-speaking transgender women in Sri Lanka to refer to themselves in an affirming way. It emphasizes respect and acceptance within the transgender community, though it is less commonly known in mainstream Sri Lankan society.

5. **Transgender / Trans**: Increasingly, the English terms "transgender" or "trans" are being adopted, especially among younger generations and in urban areas. These terms are seen as neutral or empowering alternatives to more stigmatizing local terms. They reflect a growing awareness of gender diversity and a shift toward internationally recognized terminology.

6. **Hijra**: Although primarily associated with India and Bangladesh, the term “Hijra” may sometimes be recognized in Sri Lanka, especially in urban or border areas. The Hijra community is a traditional gender-diverse group that often includes transgender women

and non-binary individuals. In Sri Lanka, however, it is not a formalized community as in other South Asian countries.

These terminologies reflect the complexity of gender identity within Sri Lankan culture, blending historical recognition of gender diversity with modern understandings. While some terms carry stigma, there is also a growing movement toward using language that respects transgender identities, particularly in urban centers and among advocacy groups.

What type of support do clients who have undergone transition procedures need?

Due to the lack of formalized medical services for transgender women in Sri Lanka, many resort to taking hormones without medical supervision. For transgender women who have taken hormone replacement therapy without proper medical supervision some medical tests may be necessary to ensure that the body can handle the treatment well or which alternative types of treatment will work best.

Advise your clients to always obtain advice from a trained specialist or medical doctor, if they have access to one.

Gender affirming surgery may also have medical complications. Clients who have undergone such surgery should be linked to transgender-friendly healthcare providers. Once again, unfortunately, in Sri Lanka such services are not officially available.

Why is peer support important for transgender women?

For many transgender women the role of peer support from other transgender women in their circle of friends is particularly important to their wellbeing. Being connected to transgender organisations or networks where other trans women provide them with increased confidence, with friendship, support and advice in a world that often looks down on them. Younger transgender women often find support and guidance from older transgender women, who have more experience on how to overcome some of the obstacles in transgender life.

Why are transgender people often at increased risk for HIV?

Transgender women are often at increased risk for HIV because of their involvement in unprotected anal sex with multiple partners. In addition, they are reluctant to seek HIV services due to their often-marginalized position in society. Health care professionals may not know how to deal with transgender people; they may stigmatize or discriminate against them or even refuse them services. Many transgender people need to get by in life by selling sex. This is because other forms of employment (or access to education) are often blocked to them, due to societal stigma and discrimination, discriminatory requirements by educational or employing institutions that may not allow them to dress in the work- or study uniform aligned with their gender, as well as rejection by their families. This leads many transgender people to have low self-esteem, mental health problems and low skills to negotiate safer sex, which all lead to greater exposure to HIV risk than most other people.

In order to reduce the risk of HIV, holistic interventions are needed that include social support, mental health care and measures to reduce stigma and discrimination, so that transgender women have equal education and employment opportunities and are able to live satisfying, healthy, productive and fulfilling lives.

Can ART and hormones used for changing sex/gender be taken together?

Yes, ART can generally be taken together with gender-affirming hormone therapy (such as estrogen or testosterone) used by transgender individuals. However, it is important to consider potential interactions:

- **Drug Interactions:** Some ART medications may interact with hormone therapy, affecting the levels of either the hormones or the ARTs in the bloodstream. This can impact the effectiveness of either treatment or lead to increased side effects. For example, certain ARTs may reduce the effectiveness of estrogen, meaning dose adjustments might be necessary.
- **Monitoring and Adjustment:** Regular monitoring by a healthcare provider is essential. This includes checking hormone levels, viral load, and liver function to ensure both treatments are effective and safe. Adjustments to dosages of either ART or hormones may be needed based on individual response and side effects.
- **Individualized Care:** Each person's treatment plan should be tailored to their specific needs. Open communication with healthcare providers about all medications being taken is crucial for managing any interactions and achieving the best possible health outcomes.

In summary, ART and gender-affirming hormones can be safely used together under medical supervision. Regular monitoring and potential dosage adjustments help ensure the effectiveness of both treatments.

What to do if a transgender client has mental health problems?

Community service providers must realize that they are not qualified to provide mental health services, but they can try to connect clients with mental health problems to the nearest Government Hospital Psychiatric Clinic or to support groups that may be available for transgender people. If needed, these NGOs and support groups can assist in making a referral to a transgender-friendly counsellor, social worker or psychologist. If a client is in crisis, the community service provider should accompany him/her to the NGO or support group, as they may feel unable or shy to go there by themselves. The Gender Recognition Certificate issued by the ministry of Health has given many opportunities for the communities to be recognise and enjoy all the rights in Sri Lanka.

Chapter 23: Supporting People Who Engage in Sex Work

What is Sex Work?

Sex work is the act of exchanging money, goods, drugs, or services for sex.

Who are people who engage in sex work?

People who engage in sex work can be male, female, transgender, or of any sexual orientation or gender. They can be any race, come from any cultural or religious background, and can have any sexual orientation and gender identity. In Sri Lanka, people who engage in sex work are one of the key populations most vulnerable to HIV transmission.

How is sex work organized in Sri Lankan society?

Sex work in Sri Lanka is diverse, occurring in settings from the street to hotels, bars, spas, and online spaces. Female, male, and transgender people engaged in sex work navigate this underground economy within unique social and economic frameworks, each facing particular challenges. Social and legal stigmatization complicates their lives, exposing them to exploitation and limiting their access to support and healthcare.

How many people engage in sex work in Sri Lanka?

It has been estimated that there are 30,000 women[52] and 6,000 men[53] engaged in sex work in Sri Lanka. The number of transgender people involved in sex work is not exactly known—the total transgender population has been estimated to be 2200 individuals, and a significant number is believed to be engaged in sex work due to a lack of alternative income generation opportunities.

Why do people engage in sex work?

People engage in sex work for many different reasons. Many people engage in sex work willingly and by their own choice. They see it as a convenient, flexible, and lucrative source of income. However, there are also people who engage in sex work due to lack of choice, and are

[52] NSACP, KP SOP, 2020.

[53] Schütte C, Navaratne K, Hales D, Ranatunga D. Readiness Assessment for transition and sustainability planning for Sri Lanka's AIDS response. 2020. Report prepared for UNAIDS. Available from: https://www.aidscontrol.gov.lk/images/Sri-Lanka-HIV-TRA-Report--FINAL-Oct-8-2020-3.pdf

more or less forced by circumstance. They may have limited or no other options for employment. There may also be family circumstances, poverty, lack of education/qualifications/skills and even lack of citizenship (for migrants) which lead people to engage in sex work in order to survive. Some people have been forced into sex work as a result of human trafficking or were coerced to work in sex work by gangs/syndicates/mafia or by their partners, pimps or even loan sharks to whom they owe money.

For transgender women in Sri Lanka, social exclusion and stigma affects most aspects of their lives, including attainment of legal employment and other opportunities. For some of them sex work provides their only reasonable means for a livelihood. Some cisgender women in Sri Lanka may turn to sex work after being abandoned by or losing their husbands, especially when they have children to feed.

Why are people who engage in sex work often at increased risk of HIV?

People engaged in sex work are at increased risk for HIV because they often engage in unprotected sexual intercourse and because they often have more sexual partners than average. They also are subjected to an increased threat of violence in sexual encounters, there are often no condoms or PrEP available when they have sex, and clients may ask them to use substances during sexual encounters, further increasing the risk of condomless sex occurring. Finally, people who engage in sex work, for reasons of their working rhythm, and because of stigma by some health care workers, often face obstacles accessing health care services.

People who engage in sex work are often pressured by their clients to have unprotected sex: they argue that using condoms will decrease their pleasure; that they will not be able to maintain an erection; that it will take too long for them to achieve orgasm (see Table 5 (Chapter 12) for a list of ‘excuses’ not to use condoms). Clients may also offer financial incentives, paying people who engage in sex work more for sex without condom. In some cases, clients may use coercion and violence to force people who engage in sex work to have unprotected sex.

Harassment by uniformed services and the stigma attached to sex work hinder accessibility of HIV and other health services. Sex work is often represented in a negative and stigmatizing way in mainstream society media. This is also reflected in the attitudes of health care workers. For this reason, people who engage in sex work often avoid seeking treatment for STI and

reproductive health issues at public health care clinics. Even when they do seek treatment, they may not be willing to be frank about their sexual health issues with the healthcare providers.

Are people engaged in sex work severely affected by HIV in Sri Lanka?

Females engaged in sex work have so far largely escaped the HIV epidemic in Sri Lanka. The most recent IBBS (2018)[54] found an HIV prevalence of 0.24%; the 2019 Sentinel Surveillance report found a prevalence of just 0,1%[55]. However, STI rates among females engaged in sex work remain high, indicative of inconsistent condom uses and considerable HIV risk.

[54] NSACP/MOH, Integrated Bio-Behavioural Surveillance Report, 2018. Available from: https://www.aidscontrol.gov.lk/images/publications/research_documents/Final-draft-IBBS-Report-June-2018-minimised.pdf

[55] HIV Sentinel Survey 2019. Available from: https://www.aidscontrol.gov.lk/images/publications/suvellance_reports/HIV-sentinel-surveillance_Annual_Report_2019.pdf

Is sex work legal in Sri Lanka?

No, sex work is illegal in Sri Lanka. The country's laws prohibit activities related to sex work, including solicitation, brothel-keeping, and living off the earnings of sex work. This criminalization applies to all forms of sex work, whether it involves female, male, or transgender people engaged in sex work.

The **Vagrants Ordinance** of 1841 and the **Brothels Ordinance** of 1889 are two key pieces of legislation that criminalize sex work. Under these laws, police regularly conduct raids on suspected sex work establishments, and people engaged in sex work are at risk of arrest, harassment, and detention.

While these laws target the act of sex work itself, they often leave people engaged in sex work without protection from exploitation, violence, and health risks. The illegality of sex work also

increases stigma and marginalization, making it challenging for people engaged in sex work to access healthcare, legal support, and safe working conditions.

Why do healthcare workers sometimes stigmatize people who engage in sex work?

Sex work is often represented in a hostile and stigmatizing way in mainstream society. This is also reflected in the attitudes of most healthcare workers in Sri Lanka. Discrimination and stigma from healthcare workers come in many forms. It can range from being overt to being unintentional or even subconscious. Many healthcare workers are not aware of how their attitudes stigmatize people who engage in sex work. Healthcare workers must provide good healthcare to all clients regardless of their profession.

What are common myths about sex work?

Addressing myths about people who engage in sex work can dispel stereotypes about them.

1. **People who engage in sex work are insatiable sex addicts or maniacs.**

   This is not true. Sex work is a profession, and many people engage in it because it is a viable source of income or due to limited alternative job opportunities and how they value their lives. Others may be forced or coerced into it due to circumstances.

2. **People who engage in sex work were abused as children.**

   Many assume that childhood abuse leads people into sex work, but people enter sex work for various reasons, and they come from diverse backgrounds, not necessarily involving abuse.

3. **Sex work and human trafficking are the same thing.**

   While some individuals in sex work are victims of trafficking, many choose to engage in this profession voluntarily. It is important to distinguish between consensual sex work and exploitation.

4. **All transgender women are involved in sex work.**

   This is a common stereotype, but it is false. Many transgender women in Sri Lanka pursue successful careers in other fields. However, societal discrimination and lack of

opportunities push some transgender individuals into sex work as one of few viable income options.

5. **People who engage in sex work are often drug users.**

   Similar to other professions, some people in sex work use drugs, but this is not universally true. Many people engaged in sex work do not use drugs and lead healthy lifestyles.

6. **All people engaged in sex work are foreign immigrants.**

   In Sri Lanka, many people assume people engaged in sex work are immigrants or foreigners, but most are Sri Lankan citizens. This myth likely arises from stereotypes associated with tourist areas.

7. **People who engage in sex work do not use condoms.**

   Many people engaged in sex work use condoms consistently and are proactive about safer sex practices, often at higher rates than the general population. Sex workers frequently access HIV/STI services to protect their health.

8. **People who engage in sex work are uneducated.**

   Some people engaged in sex work may have limited formal education, but many are educated and informed, and some have even completed higher education. There are various reasons that drive people into sex work.

9. **All people engaged in sex work are single and childless women.**

   Many people engaged in sex work have families, spouses, and children and engage in sex work to support their loved ones. The idea that people engaged in sex work are all young, single women is a misconception.

10. **Sex work is only for young people.**

    Sex workers come from a range of age groups, and many people continue this work into their middle age. This myth often fuels discrimination against older people engaged in sex work who are seen as “too old” for the profession.

11. **People who engage in sex work cannot have stable, loving relationships.** Many people engaged in sex work maintain stable, loving relationships and view their

work as separate from their personal lives, similar to professionals in other fields. Their relationships can be as strong and fulfilling as anyone else's.

12. **All people who engage in sex work are poor.**

    Not all people engaged in sex work come from underprivileged backgrounds. Some achieve financial security or even wealth through their work, allowing them to invest in properties, education, and savings for the future.

13. **Religious people are never involved in sex work.**

    This is not true; a person's religious beliefs do not preclude them from engaging in sex work. Some people engaged in sex work are religious and engage in prayer and ritual for protection and good fortune. Additionally, many clients of people engaged in sex work are religious.

14. **People who engage in sex work are unclean or diseased.**

    While people engaged in sex work are at higher risk for certain infections, they also tend to access healthcare and STI/HIV testing more frequently than the general population. They often prioritize their health to remain able to work, making this stereotype inaccurate. It can, however, occur that some street-based people engaged in sex work may not have continuous access to water and sanitation.

15. **People who engage in sex work spread HIV and STI.**

    This myth unfairly blames people engaged in sex work for disease spread. Many people engaged in sex work take precautions to stay healthy and are diligent about condom use. Often, it is clients who attempt to engage in unprotected sex.

16. **Sex workers are homewreckers who steal husbands and break up families.** In Sri Lankan society, women involved in sex work are often unfairly blamed for marital infidelity. However, most clients of people engaged in sex work seek short-term encounters, not long-term relationships, and responsibility for infidelity lies with both partners, not solely the sex worker.

Why do some people who engage in sex work not seem to care about HIV?

Some people engaged in sex work face many day-to-day challenges and hardships. Some live on the street; others suffer from drug addiction; others face violence from clients or lovers or

harassment by police or other law enforcement forces. Some are desperate to find enough money to care for a child or parent(s).

In such a context, it is not surprising that HIV is low on their list of priorities. It is important to understand the life context of clients who engage in sex work, and to address reducing HIV risk or accessing HIV treatment in the context of a wider support plan that addresses the clients' immediate and pressing concerns.

How to motivate people who engage in sex work to lower their risk of HIV infection?

People who engage in sex work should be encouraged to use condoms consistently, with all their clients. This will not only prevent HIV and STI infection, but also pregnancy. It is in their own interest to stay healthy, as their livelihood depends on staying healthy.

Since people who engage in sex work are at a higher risk for HIV exposure, they should be encouraged to test for HIV and other STI at least every 3 months. If people who engage in sex work are diagnosed with HIV early, and gain access to treatment early, it will improve their health and improve their life expectancy. Getting on treatment sooner also decreases (and eventually, when their viral load becomes undetectable, eliminates) the risk of people who engage in sex work unwittingly passing their infection on to others.

How can you provide relevant knowledge and information to clients engaging in sex work?

Community service providers should talk to their clients who engage in sex work, aiming to dispel common misconceptions associated with condoms (Chapter 12), PrEP (Chapter 13), HIV (Chapter 9-10) and STI (Chapter 11). Community service providers and counsellors should provide risk-reduction counselling to decrease the chance of getting HIV or other STI (See Chapter 14). There are several factors that can influence the success of risk reduction counselling. It is vital to maintain confidentiality, being non-judgemental, and creating an enabling environment where people who engage in sex work feel comfortable to discuss their health and social support needs.

What are the most important rights for people engaged in sex work?

People who engage in sex work should be aware that all basic human rights apply to them as well. Particularly, they should be aware of the following rights, even when considering that sex work is illegal in Sri Lanka.

- the right to express themselves;
- the right to speak out about their rights and needs;
- the right not to be exploited, bullied or subjected to abuse by clients, pimps or partners;
- the right to health care and welfare services without being discriminated against;
- the right to assemble and form support groups;
- the right to inheritance;
- the right to justice.

What to do if a client who engages in sex work is subject to violence or exploitation?

If a client seems to be subjected to violence or exploitation, the community service provider or counsellor needs to handle this carefully. Never do something without the agreement or approval of the client. One option would be to provide the client with the telephone number of a local hotline where they can obtain further support. Also, Annex 1 may provide referral addresses for local legal or social support that a client can pursue.

Chapter 24: Meeting the Special Health Needs of Beach Boys

Who Are Beach Boys, and Why Are They Vulnerable to HIV?

Beach Boys, sometimes called "tourist service providers," are men who spend time in beach areas, often working with tourists. This can range from guiding and entertaining to offering sexual services for both men and women. Beach boys are considered to be vulnerable to HIV and other STI due to certain high-risk behaviors common in their interactions with tourists[56]. While condom use with tourists is relatively high (67.7%), consistent condom use is low, at 35%. For instance, nearly all beach boys in Galle reported having sex with a tourist, but only about a third consistently use condoms[67]. This inconsistency in condom use, coupled with a high number of partners, increases their vulnerability to HIV and other STI.

How Prevalent is HIV Among Beach Boys?

Sri Lanka has a generally low HIV prevalence. Specific data on beach boys is limited. The 2014 IBBS survey in Galle saw that while no HIV or syphilis cases were detected among beach boys, their high-risk behaviors suggest that without strong prevention measures, HIV and STI could make inroads in this population[67].

Why Focus on HIV Prevention for Beach Boys?

Beach boys face unique barriers to HIV prevention. Tailoring prevention messages and services specifically for them helps make sure these men get the support they need. This approach encourages safer behaviors and builds understanding among community service providers about what resonates best with beach boys.

Why can reaching Beach Boys be challenging?

Mobility: Beach boys often move from one location to another, making it harder to stay in touch with them.

Stigma and Discrimination: They may experience stigma related to their occupation or sexual orientation, making them hesitant to seek help (see below).

[56] IBBS 2014; IBBS 2018

Trust Issues: Many beach boys distrust community service providers or healthcare providers, often because of past negative experiences or worries about being reported.

How to Build Trust with Beach Boys?

Building trust with beach boys starts with treating them with respect and dignity, avoiding any judgment about their choices or behaviors. It is essential to clearly explain how their privacy will be protected, which helps reassure them about confidentiality. Listening attentively to their questions and concerns and responding openly fosters openness and honesty. Involving peer educators from within the beach boy community makes prevention efforts more relatable and trusted, as messages come from people who understand their experiences firsthand.

Why are Beach Boys facing Stigma and Discrimination?

Beach boys in Sri Lanka often face negative views because of their connection to the tourism industry and the perception that they engage in sex work. This is highly stigmatized in Sri Lanka's conservative society. When beach boys interact with tourists in public, locals may see them as behaving in ways that go against cultural norms, which makes them seem morally "bad" or "corrupt." There is also a common belief that beach boys have a high risk of carrying HIV and other infections. Misunderstandings about HIV add to this stigma, as many people wrongly fear they could catch it from casual contact.

The stigma around beach boys is also fueled by economic resentment. Some locals feel that beach boys make money from tourists in ways that seem unfair or opportunistic. Additionally, because there is a belief that some beach boys engage in same-sex relationships with male tourists, they face even more prejudice. People may also assume that beach boys are involved in drugs or alcohol, which leads to further negative stereotypes about them. All these factors

combine to isolate beach boys from the community and make it harder for them to find acceptance and support.

How can Stigma and Discrimination of Beach Boys be addressed?

Combating stigma requires showing positive, non-judgmental attitudes when interacting with beach boys. Providing accurate information to dispel myths about HIV and STI is essential, as education can help break down harmful misconceptions. Advocacy plays a role as well, as supporting beach boys' rights and promoting respect within their communities can create a more inclusive and supportive environment.

Improving Access to HIV Testing for Beach Boys

Making HIV testing accessible involves a few strategies tailored to beach boys' needs. Community-based testing, where testing is offered directly within their communities, ensures they can access services without traveling far. Mobile clinics bring testing to locations that are convenient for beach boys. Self-testing kits offer a private, easy way for them to know their status. It is important to continually reassure them about confidentiality to encourage more people to come forward for testing.

Keeping Beach Boys Engaged in HIV Prevention

To sustain beach boys' involvement in HIV prevention, community service providers should maintain regular contact. Providing ongoing support, such as counseling and referrals, helps address their needs. Empowering peer educators from within the community can also build a supportive network that reinforces prevention messages and fosters engagement.

Innovative Approaches to Reach Beach Boys

Leveraging digital tools like social media and mobile apps allows community service providers to reach beach boys more effectively. Online platforms make it easier to connect with beach boys, share important information, and even send reminders for testing. Using mobile technology ensures that HIV prevention messages are accessible and can reach beach boys wherever they are operating.

Collaborating with Other Groups for Better Outcomes

Partnerships enhance HIV prevention efforts by strengthening networks and resources. Linking with STD clinics ensures smoother referrals and better access to care. Working with community organizations like NGOs leverages existing local support systems. Engaging local authorities also helps reduce stigma, encouraging policies that support beach boys and make it easier for them to access necessary services.

Chapter 25: Understanding Chemise,

Sexualized Drug Use and its links to HIV transmission[57]

What is Chemise/Sexualized Drug Use?

Chemise refers to a phenomenon where participants are engaged in a prolonged sexual activity while under the influence of certain drugs consumed before and/or during sex. In Asia, the definition of chemsex (local terms: high fun, chemfun) seems to be adjusted to reflect the local pattern that may involve different drugs such as crystal methamphetamine, mephedrone (3 MMC or 'cat/meow'), GHB/GBL, ecstasy, 5-methoxy-n or foxy, cocaine and ketamine. It may also include associated drugs such as inhaled nitrates (poppers), sildenafil (Viagra), benzodiazepine and cannabis (ganja) and cannabinoids ('salts', 'spice'). Chemise events happen through private gatherings and through online connections and are sometimes called 'party and play' or 'hi-fun'[58].

Are Chemise Drugs Legal in Sri Lanka?

No, most drugs associated with chemsex are illegal in Sri Lanka. Possession, use, or distribution of these substances can result in serious legal consequences. Law enforcement in Sri Lanka may use urine tests to detect drug use, which can be evidence in legal cases

Why Do People Use Chemise or Party Drugs?

People engage with Chemise drugs for various reasons, such as reducing inhibitions, enhancing confidence while having sex, increasing sexual pleasure, and increased stamina while having sex for prolonged periods of time.

What Health Problems Can Chemise Drugs Cause?

Using chemsex drugs poses numerous health risks, partly related to the combination in which they are taken and in which quantities. These health risks can be physical

[57] This chapter is based on an unpublished document written by Pascal Tanguay for the Asia-Pacific Coalition on Male Sexual Health. They never published the document formally.

[58] See: https://www.aidsdatahub.org/sites/default/files/resource/chemsex-asia-2021.pdf

(dehydration/overheating, increased or reduced heart rate leading to cardiac arrest and oral/dental problems), psychological (addiction, anxiety, depression, withdrawal symptoms), and social consequences (social isolation and deterioration of the social and work environment related to addiction). Chemise can increase the risk of HIV and other STI, alongside other physical and mental health issues.

What Factors Affect the Harm of Chemise Drugs?

The risks associated with chemsex drugs depend on several factors, such as:

- The amount and frequency of use
- Mixing with other substances
- Method of intake
- Personal physical and mental health

Even small amounts of these drugs can be harmful, especially if taken by someone who is unwell or unaccustomed to the drug.

What Are Common Chemise Drugs?

Common drugs used in chemsex include:

- **Crystal Methamphetamine (Ice)**: A stimulant known for increasing energy and libido, therefore prolonging sexual activity.
- **GHB/GBL**: A depressant that can create relaxation but has a high risk of overdose.
- **Ketamine**: Used as an anesthetic, it can cause disassociation and relaxation.

Each drug has specific effects and risks, and it is essential to understand that their use carries both health and legal risks.

Table 11: Chemise / party/chemsex drugs

COMMON NAME (STREET NAME)	MODES OF DELIVERY	TYPICAL EFFECTS	TYPICAL DURATION
Crystal methamphetamine (Christine, Tina, T, crystal, ice)	Snorted as powder, smoked in pipe, or injected	Stimulation: exhilaration, alertness, disinhibition; agitation, paranoia, confusion, aggression	4 to 12 hours
Amphetamine	Swallowed in tablet form, smoked, or injected	Stimulation: exhilaration, alertness, disinhibition; agitation, paranoia, confusion, aggression	4 to 8 hours
GHB/GBL (G, Gina, liquid ecstasy)	Swallowed diluted in liquid	Sedation and anaesthetisation: euphoria, disinhibition; drowsiness	Up to 7 hours

Ketamine (Special K, K, kitkat, horse trank)	Swallowed, snorted or injected	Sedation, dissociation, disinhibition, agitation, anxiety, agitation, confusion	45-90 minutes

A number of other drugs have been commonly associated with parties - ecstasy, cocaine, mephedrone, speed, sedatives, poppers, erectile dysfunction medication, the rest of this Chapter will focus on the four drugs listed in the table above.

Additional factual information about illicit drugs can be found online at http://www.druginfo.adf.org.au/drug-facts/drugs-the-facts.

What are the Different Ways to Use Party/Chemise Drugs?

- Swallowing/Drinking:
  Some drugs can be swallowed, though drugs like crystal meth can irritate the stomach. The effects take longer to start but may last longer. Poppers should never be ingested, as they can be harmful.
- Smoking:
  Smoking drugs requires additional tools and can harm the lungs and those nearby. Smoking in enclosed spaces can lead to second-hand smoke exposure for others.
- Snorting (Tooting):

  Drugs in powder form can be snorted through straws or rolled paper, but this can spread infections if shared. Tilting the

head back and using water afterward may reduce irritation. It is advisable to use a decongestant after snorting.

- Rectal Use (Shafting):

  Some people insert drugs into the rectum, which leads to quick absorption but can irritate the area. Caution is needed to avoid injury, especially if using a syringe (without a needle).

- Injecting (Slamming)

  Injecting drugs is the riskiest method. It is essential to use sterile equipment each time and avoid sharing needles or other injecting tools to prevent infections like HIV and hepatitis C.

How can the potential harm of Chemise be reduced?

- Prevention:
  Since Chemise drugs can be highly addictive and the health effects of chemsex severe, preventing (especially young) men who have sex with men and transgender people from starting a habit of engaging in Chemise is recommended.

- Be Informed:

  Understanding the effects and risks of drugs can help reduce harm.

- Use Trusted Sources:

  It is safer to only obtain drugs from known sources to avoid contamination and unknown strengths. Note: Using, Selling, Exchanging, and dealing any type of substances is illegal in Sri Lanka.

- Maintain Health:

  Eating well, staying hydrated, and getting enough rest before and after drug use help support the body and reduce negative effects. Hydration is essential, especially if dancing or exerting energy.

- Plan Ahead:

  Decide in advance what drugs to use and set boundaries. Prepare necessities like water and snacks ahead of time, avoid driving under the influence, and allow recovery time between sessions.

- Stick with Friends:

  Having a friend nearby who knows what drugs are being used can help in an emergency. It is wise to keep someone informed, even if they are not present.

- Provide Condoms and Lubricants:

  Having a supply of condoms and water-based lubricants readily available helps encourage safer sex practices.

- Avoid Mixing Drugs:

  Mixing drugs, especially depressants and stimulants, can be dangerous and increase the risk of overdose. Space out doses to stay aware of consumption.

- Don’t Self-Medicate the Comedown:

  Avoid using more drugs to counter the effects of a comedown, as this increases the risk of dependence.

- Limit Frequency and Duration:

  Frequent, prolonged use increases risks of paranoia, weight loss, depression, and other health issues. Take breaks to allow the body to recover.

- Consider PrEP and PEP for HIV Prevention:

  Those who regularly engage in chemsex may want to consider PrEP for ongoing protection against HIV. In case of accidental exposure, PEP can also help if taken promptly.

- Regular STI Testing:

  Routine screening for STI, including HIV and hepatitis C, is recommended to ensure early treatment if needed.

How Can Drug Overdoses Be Prevented or Managed?

Overdoses are often associated with depressants like heroin, but stimulant drugs can also cause dangerous reactions, sometimes called **overamping**. Overamping may lead to physical symptoms (like an irregular heartbeat) or psychological effects (like paranoia or extreme anxiety), and it varies from person to person. Factors like lack of sleep, dehydration, and mixing drugs can increase the risk.

Signs of Overheating (Hyperthermia):

Overheating is a serious risk with stimulant drugs. Symptoms include hot, dry skin, nausea, dizziness, confusion, and, in severe cases, fainting or hostility. If left untreated, it can lead to organ failure.

How to Respond to Overheating:

1. Slow down the person's activity and move them to a cool place with good airflow.
2. Use ice packs, mist, fans, or a cool shower to lower their temperature.
3. Have them drink water or electrolyte drinks.
4. Apply cool cloths under the armpits, behind the knees, or on the forehead.

If symptoms worsen or the person becomes unconscious, **call an ambulance** immediately.

Specific Overdose Risks (G-Hole and K-Hole):

Certain drugs like GHB/GBL and ketamine can cause intense effects, often called a "G-hole" or "K-hole," which may lead to blackouts or memory loss. GHB/GBL, in particular, requires precise dosing, as even a slight overdose can be dangerous.

What Are the Links Between Chemise and HIV?

Chemise is associated with several HIV-related risks:

1. **Adherence to HIV Medication**: People living with HIV may struggle to take their medication consistently while engaging in chemsex, leading to poorer health outcomes.
2. **Drug Interactions**: Some chemsex drugs can interact negatively with HIV medications, making it essential for those who use both to discuss this with a healthcare provider.

3. **Higher Risk Behaviors**: Chemise can lower inhibitions, potentially leading to condomless sexual practices, which increase the risk of HIV transmission.

If you're living with HIV and engage in chemsex, consider talking to your doctor or health professional to manage potential risks effectively.

Chapter 26: Dealing with drugs, addiction, and harm reduction

What is addiction?

Addiction is defined as "the compulsive use of substances or engagement in harmful behaviours, often despite evidence to the user of their negative effects, which could include becoming ill or even dying."

Addiction is a chronic or recurrent condition that can be caused by genetic, biological, pharmacological, and/or social factors.

☞See Annex 1 for a list of providers of counselling to deal with addiction in your city/district.

How can drug use and dependency be understood?

A person who uses drugs occasionally is not dependent or addicted. A person who is addicted does have to use all the time, which is the definition of addiction: which is that they continue to use drugs regardless of the negative consequences.

Why do people use drugs?

People use drugs for various reasons, including a desire for pleasure, escape from trauma or pain (self-medication), loneliness/social isolation or their involvement in heavy and monotonous work/jobs. There are many risk factors outside of an individual's control that make them more or less susceptible to becoming addicted. Genetics, poverty, class, racism, social isolation, past traumas, sex-based discrimination, and stress explain why some people are more likely to use drugs than others.

Should drug use be criminalized?

Drug use is criminalized in almost all countries around the world. However, the laws and policies designed to control illicit substances are one of the many factors that contribute to drug-related harms and risks[59]. Studies have shown that criminalisation, stigmatization, abusive policing practices, the denial of life-saving medical care and the denial of harm

[59] World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. *World Health Organization*. 2016.

reduction interventions make drug-related risks worse[60]. Instead, there is a need to offer people who use drugs treatment alternatives or address the reasons behind their dependency on drugs. From a public health and social welfare perspective, drug use should therefore not be criminalized.

Criminalizing policies reinforce the marginalisation of people who inject drugs, while also creating barriers and discouraging them from accessing harm reduction and healthcare services.

Why can it be difficult to stop using drugs once one is addicted?

People can have various motivations for using drugs. Drugs can be used as an escape from daily problems, for enjoyment, to experiment, or to fit in. It can be very easy to become addicted to some illicit substances, making it difficult to quit.

Without knowledge about or access to rehabilitative support and resources, people who use drugs may not have the knowledge, support, and motivation to quit. Therefore, it is important to provide harm reduction interventions as part of a comprehensive response to drug use (see Chapter 10).

What does addiction have to do with HIV and STI?

Addiction to drugs or alcohol is a potential risk factor for HIV infection or HIV risk. People who are high on drugs often have a lower perception of personal risk and a high desire for intimacy and closeness to others. Drug dependence itself can also be a factor that increases

[60] Csete J, Kamarulzaman A, Kazatchkine M, Altice F, Balicki M, Buxton J, et al. Public health and international drug policy. *Lancet*. 2016;387(10026):1427-80 and Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C, Hickman M. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *Lancet*. 2010;376(9737):285-301.

HIV risk. For instance, a drug-dependent person who sells sex and is offered money or drugs in exchange for unprotected anal intercourse is more likely to agree to this than a male sex worker who is not drug-dependent.

Also, outside the context of sex work, people who are under the influence of alcohol or drugs tend to have lower inhibitions and lower protective fear-levels when it comes to sex. Many men who have sex with men or transgender people who have condomless sex do so under the influence of alcohol, especially after having gone out to drink at entertainment venues (see Chapter 25 on chemsex).

The way drugs are taken can also be a risk factor whereby sharing needles for injecting drug use can be a route for HIV/STI transmission. Injecting drug use can be a risk factor for HIV transmission if needles and/or syringes are shared among people who use drugs. In some Asian cities, injecting drugs was limited to people using heroin, but in recent years crystal meth and other chemsex-related drugs are also increasingly injected.

Why are people who inject drugs often at higher risk of HIV?

Needle sharing is the main factor for this. If a person living with HIV has used a needle, infected blood in the needle or syringe can be injected into the next person who uses that same needle/syringe. Sterile needles and syringes are not always accessible and there is often a lack of education around safe injection practices.

What are the risks of injecting drugs?

Injecting drugs has the following risks:

- Potential overdose (which can be fatal);
- Blood-borne infections can be transmitted, such as Hepatitis B, C and HIV, if needles/syringes are shared;
- Damage to veins and skin infections at the point of injection.

What is harm reduction?

Harm reduction refers to a set of policies, programs and practices that aim to reduce the consequences of drug and alcohol abuse. It acknowledges that licit and illicit drug use is a part of our world, and simply abstaining from drugs is not a realistic solution or choice for everyone.

Harm reduction involves a range of non-judgemental approaches aimed at providing and enhancing the knowledge, skills, resources and supports for individuals in making informed decisions to be safer and healthier (see Chapter 14).

Why is harm reduction important?

Harm reduction ensures that people who use psychoactive substances are treated with respect, and without stigma. Access to good treatment is a fundamental human right, but many people with drug addictions are unable to get treatment. Harm reduction programs are often a practical, feasible and cost-effective approach to minimizing the risks associated with drug use, including the transmission of HIV, hepatitis, and overdoses.

Is just using clean needles enough to prevent HIV transmission?

No! Even when making use of a Needle & Syringe Program (NSP) there are still risks in injecting drugs. Using the NSP service only ensures the client has access to clean needles and syringes to use every time they inject. Proper counselling and education are necessary to ensure needles and syringes are not shared between users.

How can the risk of injecting drugs be minimized / What are safer injecting tips?

People who inject drugs should ensure they always stay hydrated (drink enough fluids). To minimize risk, effective vein care is important to reduce the risk of abscesses, infections and complications related to self-injection. This includes the following:

Before injecting:

- Ensure that the hands are clean.
- Use only new needles and syringes of the proper size.
- Use clean water, alcohol or any other disinfectant to sterilize the area of skin being injected.
- Apply a warm compress to help plump up the vein.
- Always use a tie. Pump up the vein by opening and closing the fist.
- Ensure you are in a safe space so that there is no risk of being rushed, which could cause careless mistakes.

When injecting:

- Do not inject veins/blood vessels which are pulsating.
- Inject above the valve of the vein to prevent circulation problems, scar tissue and infection.
- Rotate injection sites to reduce the risk of a collapsed vein (use varied locations to inject). Start with veins closest to the wrist and work you way up. This way if the bottom part of the vein collapses, the remaining part of the vein can be used.
- Inject slowly and carefully.
- Inject in the direction of the flow of blood to the heart.
- Use a low dosage for the first time.
- Don't withdraw blood repeatedly.
- Avoid injecting tablets, as there will still be undissolved particles that will damage your veins/blood vessels.

After injecting:

- Stop the bleeding with clean, sterile cotton.
- Cover the needle with its cap.
- Keep the used needle safe, ensuring other people do not accidentally get pierced by it.

How do we support people who inject drugs to lower their risk of HIV?

People who inject drugs need access to HIV testing, STI screenings, hepatitis screenings, risk reduction counseling and referrals to harm reduction programs, and needle and syringe exchanges.

The World Health Organization (WHO), in collaboration with UNAIDS and UNODC, outlines a comprehensive **package of 9 harm reduction interventions** for addressing **HIV among people who inject drugs**. These are often referred to as the **comprehensive package**[61]:

1. **Needle and syringe programs (NSPs):** These programs distribute sterile needles and syringes to reduce sharing and reuse.
2. **Opioid substitution therapy (OST) and other evidence-based drug dependence treatment:** Includes methadone, buprenorphine, and similar medications for opioid dependence.
3. **HIV testing and counseling (HTC):** Voluntary and confidential testing to diagnose HIV early and link to care.
4. **Antiretroviral therapy (ART):** Ensuring access to ART for those who test positive.
5. **Prevention and treatment of sexually transmitted infections (STIs):** Regular screening and treatment to reduce co-morbidities.
6. **Condom programs:** Promotion and distribution of condoms for safer sexual practices.
7. **Targeted information, education, and communication:** Peer education, community-based initiatives, and harm reduction education.
8. **Prevention, vaccination, diagnosis, and treatment of viral hepatitis:** Hepatitis B vaccination, diagnosis, and treatment of hepatitis B and C.
9. **Prevention, diagnosis, and treatment of Tuberculosis (TB):** Integrated TB services, as people who inject drugs are at increased risk for TB.

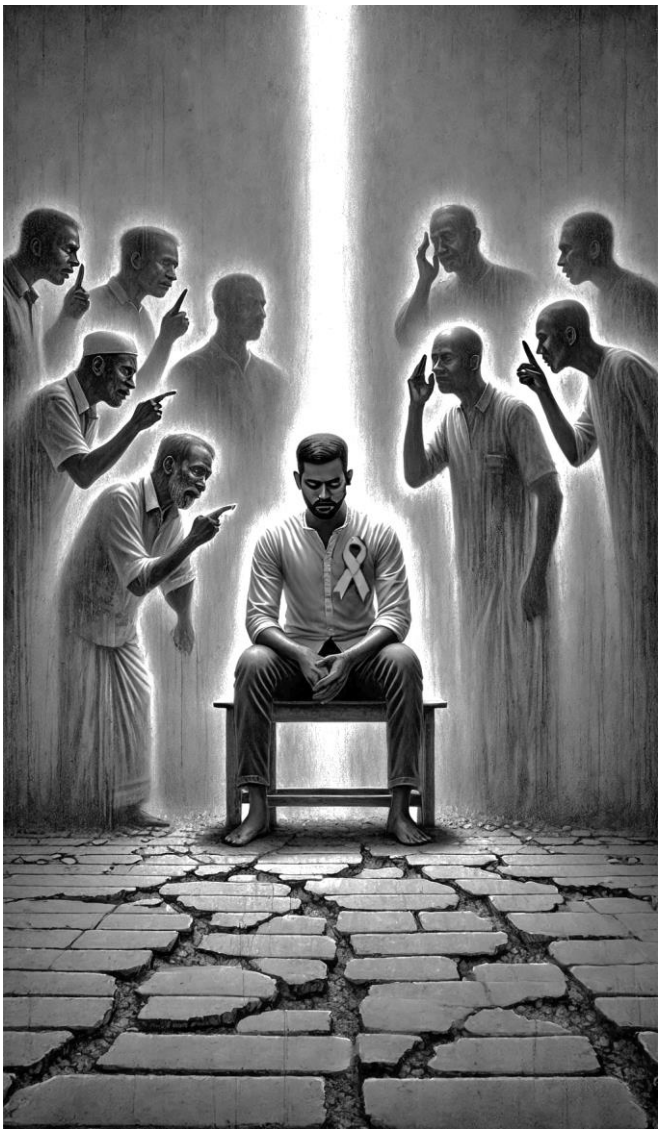
Some sources expand this list to include a **10th intervention**, focusing on **overdose prevention and management** (e.g., naloxone distribution programs). This inclusion recognizes the rising burden of opioid overdose among people who inject drugs.

An 11th intervention is provision of mental health care and social support.

[61] See: WHO, UNODC, UNAIDS. **Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users**. Updated 2012.

Chapter 27: Countering Stigma and Discrimination

What is Stigma?



Social stigma refers to social disapproval directed at individuals or groups who are seen as different from mainstream norms. This often results in marginalization, meaning affected individuals may be excluded from full access to education, healthcare, or job opportunities, or may be confined to less desirable neighborhoods.

In What Forms Does Stigma Exist?

Stigma can manifest in various forms:

1. **Physical Appearance**: People with visible signs of disability or illness.
2. **Personal Traits or Behaviors**: Individuals involved in sex work, drug use, or being part of the LGBTQI+ community.
3. **Group Membership**: This form of stigma, sometimes called “tribal stigma,” is based on ethnic, religious, or national affiliations that differ from the majority.
4. **Internalized Stigma**: People may internalize the negative perceptions they face, leading to self-stigma. For instance, someone who has faced discrimination for being gay may withdraw from social settings due to anticipated rejection.

What Forms of Stigma Do Key Populations Face?

Key populations in Sri Lanka may face specific types of stigmas:

1. **Sexual Orientation and Gender Identity**: People may be judged for being gay, lesbian, transgender, a-sexual, or for not conforming to heteronormative gender norms.
2. **Sexual Behavior**: Stigma may be directed at individuals based on presumed behaviors, such as having multiple sexual partners.
3. **Engagement in Sex Work**: There is strong societal disapproval toward those involved in sex work, often accompanied by moral judgment.
4. **Disease-Related Stigma**: People with HIV, TB, Syphilis, or other STIs face stigmatization rooted in fear and misinformation about transmission.
5. **Drug Use**: Individuals who use drugs may be labeled as addicts and face severe discrimination, limiting their access to support services.

Do Individuals from Key Populations Also Stigmatize Each Other?

Yes, stigma exists within marginalized communities themselves:

1. **Ethnicity or Skin Color**: Ethnic or racial bias persists within key populations.
2. **Rural or Socioeconomic Background**: People from rural areas or lower economic backgrounds may experience discrimination from people in cities/urban areas.
3. **Sex Work and Drug Use**: Engagement in sex work or drug use can lead to discrimination within communities of gay men or people engaged in sex work, for example.
4. **HIV Status**: Those living with HIV are often stigmatized by others within their community who do not have HIV. Therefore, maintaining the confidentiality of the people living with HIV is very important.
5. **Identity Conflicts**: For example, bisexual individuals may face rejection from both heterosexual and homosexual communities, and transgender people may face discrimination from other MSM.

What is HIV-Related Stigma?

HIV-related stigma arises because people often associate HIV with deviant or 'bad' lifestyles, such as prostitution, homosexuality and drug use. By comparison, diseases like the flu carry no social stigma since they lack such associations.

How Can Stigma Be Reduced?

Reducing stigma involves education, openness, and compassion:

1. **Increase Knowledge**: Educating people can reduce irrational fears and make people see the common humanity between themselves and members of key populations.
2. **Foster Openness**: Normalizing discussions about HIV and about key populations can help normalize discourses in mainstream society.
3. **Promote Understanding**: Highlighting the social and economic factors driving HIV and the disadvantaged position this results in for key populations can change perceptions. Training community leaders, such as journalists, religious leaders, and teachers, can be effective.

How Can I Respond to Stigma?

There are several strategies for individuals facing stigma:

1. **Ignore It**: Stay focused on personal goals and ignore negative comments.
2. **Use Humor**: Sometimes a lighthearted response can defuse the situation.
3. **Seek Support**: Talking to friends, mentors, or spiritual guides can help.
4. **Keep a Journal**: Writing about experiences can help process emotions.
5. **Join Support Groups**: Finding a community of understanding people can build resilience.
6. **Confront It Safely**: If safe to do so, confront stigma by correcting misinformation, discussing it openly, or seeking help from advocacy groups. Legal avenues may be available in some cases.

How Can I Build My Self-Esteem?

Counselors or community service providers can guide clients in self-esteem building:

1. **Encourage Positive Interactions**: Praise others and acknowledge their strengths; this often leads to reciprocal positive reinforcement.
2. **Use Positive Self-Talk**: Challenge negative thoughts and affirm positive attributes.
3. **Accept Mistakes**: Understand that mistakes are learning opportunities.
4. **Focus on Strengths**: Remind yourself of your talents and skills, especially when feeling low.

Chapter 28: Mental health and its role in the HIV pandemic

What is the definition of mental health?

The World Health Organization has defined mental health as: "A person's condition about their psychological and emotional well-being in which the individual realizes his or her abilities, can cope with normal stresses of life, can work productively and fruitfully and can contribute to his or her community."

How is mental health linked to HIV?

Mental health issues can affect individuals in the community, both in their risk or vulnerability to HIV, as well as in other areas of their lives. Community service providers need to recognize clients who cannot function normally, for example, if they are not interested in life or show signs of extreme sadness or a lack of motivation to work or study. These are common signs of depression. Depression has been shown to reduce people's likelihood to prevent them from becoming HIV positive. There is also a link between depression and the ability of a person living with HIV to adhere to ART. This is simply because they are unhappy, and they, therefore, care less about their health and well-being. Key population members who are living with HIV are more vulnerable to poor mental health, as they may feel alienated from others in their community. Mental health is also linked to drug/alcohol use in many different ways, either as a way to escape from mental health problems, to forget sorrows and stress, or to find temporary joy and relief.

Why are mental health issues common among people living with HIV and key population members?

The issue of mental health is relevant because people living with HIV and key population members are subjected to the following:

- High levels of internalized and experienced stigma (see Chapter 27);
- Discrimination;
- Hesitation in accessing health care due to experiences of stigma, anticipated stigma, or fears of high healthcare costs;

- Family objection and rejection of a person's drug use, involvement in sex work, gender or sexual orientation, or HIV status;
- Lack of work satisfaction and lack of confidence by co-workers, which may lead to unemployment;
- Unsafe work spaces and a lack of civil, social, and public health protection;
- Exposure to violence, including police harassment, interpersonal violence, and violence from the community;
- Increased vulnerability to HIV and STI and other health issues.

When an individual experiences any of the above, they are at higher risk of developing a mental health issue.

What is Mental trauma, and what are the effects of trauma?

A traumatic event is any experience that can provoke extreme emotions, thoughts, and behaviors and leave a lasting mental and emotional impact.

Common effects of trauma are:

- Difficulty in sleeping or regular nightmares;
- Irritability;
- Actively avoiding reminders of the traumatic event;
- Developing phobias or fears that were not present beforehand;
- Withdrawing socially from others;
- Using alcohol and drugs to numb feelings.

What is depression, and what are the common symptoms of it?

Depression is a common but serious mood disorder. Though it is ordinary for most people to have 'ups and downs', depression is categorized as a mental illness, which is categorized by the inability to function in the activities and situations of daily living. Depression symptoms can vary from mild to severe and can include:

- Feeling sad, hopeless, lonely;

- Being unable to enjoy things that would usually be pleasurable;
- Feeling tired and having no energy;
- Feeling worthless, guilty, or bad about oneself;
- Sleeping poorly – either sleeping too much or too little;
- Experiencing a change in eating habits – either eating too much or too little;
- Contemplating or planning suicide;
- Having difficulty concentrating and poor memory retention;
- Experiencing changes in patterns of sexual behaviours;
- Having suppressed rage or anger.

What is anxiety and what are its symptoms?

At its extreme, anxiety can lead to the experience of immense fear, often leading to panic (and panic attacks) whereby a person experiences intense apprehension and a sense of loss of control.

Anxiety disorders vary and can manifest symptoms both mentally and physiologically, including:

- Increased heart rate;
- Rapid breathing;
- Restlessness;
- Trouble concentrating;
- Difficult sleeping;
- Shaking or trembling;
- Nausea or gastrointestinal problems.

Anxiety is a prevalent type of mental disorder—the individual experiences fear regarding real or perceived situations. Most people with anxiety will try to avoid exposure to whatever causes the anxiety, which may impact their ability to function in society.

How do depression and anxiety affect key populations?

Depression and anxiety can have many adverse effects on key population members. If an individual is unable to work because he or she is depressed, too anxious, or lack of motivation and self-esteem, they will be unable to earn a living. For HIV-positive individuals, depression can affect treatment adherence, which has a significant impact on their overall health. Furthermore, someone who is depressed may be less motivated to practice safe sex and could potentially get into a risky situation.

Anxiety can limit an individual's willingness to engage with others, which may include health care service providers. People who experience high levels of anxiety or depression may further be at risk of turning to alcohol and other substances to cope with their intense feelings.

How can community service providers support mental health issues among key populations?

Mental health is a critical factor in the successful treatment and prevention of HIV amongst key populations. Healthcare workers may have varying levels of capacity to manage mental illness. Comprehensive mental health support may be beyond the scope of community service providers, but there is still a lot of support that they can provide.

Community service providers can support mental health issues through:

- Listen, listen, listen. Letting your clients express themselves can already help them feel better. Listening indicates that you tell your client: "You are important!"
- Providing clients with a welcoming and safe environment to discuss their problems.
- Community service providers should be familiar with referral networks and resources available in their community, including psychotherapy and counseling.

What to do if a client is in an acute mental health crisis?[62]

If a client is approaching or already in a mental health crisis, it is important to act swiftly and effectively. If your instincts tell you a situation is dangerous, it probably is. Call the1990 emergency services immediately. Your goal in an emergency is to stabilize the situation and get the person to professional help as quickly as possible.

Do not try to manage the situation alone – Sometimes, having another party present or on the phone with your loved one defuses the situation.

Keep instructions and explanations straightforward – Say, "We're going to the car now," not, "After we get in the car, we'll drive to your doctor's office so she can examine you."

Respond to delusions by talking about the person's feelings, not about the delusions – Say, "This must be frightening," not "You shouldn't be frightened – nobody's going to hurt you."

Don't stare – Direct eye contact may be perceived as confrontational or threatening.

Don't touch unless absolutely necessary – Touch may be perceived as a threat and trigger a violent reaction.

Don't stand over the person – If the person is seated, seat yourself to avoid being perceived as trying to control or intimidate.

Don't give multiple choices or ask multi-part questions – Choices will increase confusion. Say, "Would you like me to call your psychiatrist?" not "Would you rather I called your psychiatrist or your therapist?"

Don't threaten or criticize – Acute mental illness is a medical emergency. Suggesting that the person has chosen to be in this condition won't help and may escalate tension.

Don't argue with others on the scene – Conduct all discussion of the situation quietly and out of the person's hearing.

Don't whisper, joke or laugh – This may increase agitation and/or trigger paranoia.

[62] This content was taken from http://www.treatmentadvocacycenter.org/component/content/article/186-old-get-help/1613-get-help-crisis-response

What to do if a client is suicidal?

IF THERE IS A SUICIDE THREAT: **Remember: It is a myth that people who threaten to kill themselves do not do it**.

ASSUME that any suicide threat is serious and treat it as a danger to the person's life. A previous suicide attempt increases the likelihood that the person will act on the threat.

ASK the person in a calm, quiet setting whether he/she is thinking about suicide. Your questions can be indirect ("Do you ever think you should never have been born?") or direct ("Do you feel like you want to die?")

FOLLOW UP if the answer to these general questions is "Yes" and ask about specific suicide plans. When does the person plan to commit suicide? How? Has the person already acquired the means, e.g., pills, gun, etc.

DETERMINE the imminence of the danger based on the answers to these questions. A college freshman who describes a suicide plan for graduation day in four years is probably not in danger. A college senior who is graduating the next day is. Act accordingly.

CONTACT the person's mental health or medical providers and repeat exactly what the person has told you.

HIDE all vehicle keys and any means that could be used for self-harm, e.g., medications (including over-the-counter drugs), knives including kitchen knives, guns, ropes.

KEEP the person sober. Suicide completers have high rates of positive blood alcohol. Intoxicated people are more likely to attempt suicide using more lethal methods. Be aware that the combination of alcohol and Tylenol can be lethal. Be sure there is no Tylenol available if the person is drinking.

DO YOUR BEST to persuade the person to get help voluntarily. Dial the hot-line number, drive to the clinic, take a taxi to the emergency room of a hospital. Do whatever is necessary to make getting help easy.

CALL emergency services if the suicide attempt appears likely.

What to do if a psychotic client threatens to assault me?

DO NOT underestimate the risk. People who are acutely psychotic, especially if also delusional and abusing alcohol or street drugs, are not predictable and are capable of extreme violence.

DISCUSS the situation with the person's social worker and/or psychiatrist. Make sure they are aware of the person's threatening or assaultive behaviour. If possible, put your concerns in writing to them and cc the message to others in a position of responsibility: Written notification is much more difficult to ignore.

SAFE-PROOF your home. Have a room to which you can retreat and be safe if needed. It should have a secure lock and a telephone.

CLEARLY SPELL OUT the consequences for the person if they become assaultive (e.g., may no longer live at home). Be prepared to carry out these consequences.

MINIMIZE alcohol or street drug use in whatever ways are possible. Substance abuse is often a trigger for assaultive behaviour.

IF threatened by someone with **manic-depressive illness** (bipolar disorder), remain calm, keep conversation to a minimum and exit the situation.

IF threatened by someone with **schizophrenia:**

- stay calm,
- remain physically distant (give the person lots of space),
- avoid direct eye contact,
- sympathize,
- try to find something on which you both agree.

DO NOT ALLOW yourself to become trapped. Always remain physically between the person and the open door.

DO NOT HESITATE to call the police.

Chapter 29: Migration, Mobility and HIV

How does migration and mobility contribute to the spread of HIV in Sri Lanka?

Migration and mobility can increase HIV risk because people moving between regions or countries often face disrupted social support networks and may engage in higher-risk behaviors. Migrants may experience loneliness, economic hardship, or limited access to healthcare, which can make them more vulnerable to HIV. Studies show that migrant populations have higher rates of HIV transmission due to these factors.

Which groups of people in Sri Lanka are most affected by migration-related HIV risks?

Several groups are particularly vulnerable, including:

- **Labor migrants**: Sri Lankan workers who go abroad, especially to the Middle East, face increased risk due to isolation and limited access to sexual health services.
- **Return migrants**: Individuals returning from high-prevalence regions may bring HIV back to their families and communities.
- **Seasonal and internal migrants**: People moving within Sri Lanka for work (e.g., in construction, factory) may have limited access to HIV prevention services and support networks.

Why are labor migrants at higher risk for HIV?

Sri Lankan labor migrants often work in isolated or restrictive environments, particularly in the Middle East, where laws and social norms limit their access to health services, including HIV prevention and treatment. Loneliness, lack of support, and lack of recreational outlets can increase the likelihood of engaging in high-risk behaviors, such as unprotected sex or sex with multiple partners.

How does the stigma surround HIV affect migrants and mobile populations?

HIV-related stigma can be especially intense for migrants, who may already be seen as outsiders. This stigma discourages them from seeking testing, treatment, or preventive measures out of fear of discrimination or deportation. Many migrants avoid testing for HIV

before returning to Sri Lanka, which increases the risk of spreading the virus to their communities and families.

Are there specific challenges for migrants returning to Sri Lanka who are living with HIV?

Yes, returning migrants living with HIV face unique challenges:

- **Stigma**: Family and community rejection can be common, particularly if the individual is believed to have contracted HIV abroad.
- **Economic Burden**: There is no economic burden on the health care in Sri Lanka as all the Health Care is free, but there may be issues due to the loss of income and rejection by the family and the community.

How does mobility within Sri Lanka affect HIV transmission?

Internal mobility, particularly for work in sectors like construction, factories, tourism, and plantations, can contribute to HIV spread. Workers moving between regions may lack stable healthcare access, which includes testing and preventive services. The transient nature of their work can lead to casual or transactional sexual relationships, increasing the risk of HIV transmission.

What is being done to address HIV risks among migrants and mobile populations in Sri Lanka?

Sri Lanka's National STD/AIDS Control Programme (NSACP) has initiatives to reach migrants and mobile populations, including:

- Providing HIV testing and counseling at ports of entry and certain workplaces.
- Conducting outreach and awareness programs in high-mobility sectors, such as tourism and construction.
- Collaborating with international organizations to provide pre-departure and post-arrival HIV education for Sri Lankan labor migrants.

What are the main barriers to HIV prevention and treatment for migrants in Sri Lanka?

Migrants face several barriers:

- **Limited Healthcare Access**: Migrants, especially in-migrants, may lack access to consistent healthcare.
- **Legal and Policy Restrictions**: Some host countries restrict access to healthcare for migrant workers, making it difficult to get tested or treated for HIV.
- **Language and Cultural Barriers**: Lack of culturally and linguistically appropriate services can deter migrants from seeking care.

How does gender play a role in migration-related HIV risk?

Gender significantly influences migration-related HIV risk. Male migrants, particularly labor migrants, are more likely to engage in high-risk behaviors due to social isolation, while female migrants may be vulnerable to exploitation or coercive sexual situations, especially in domestic work. Gendered expectations can also influence whether migrants seek testing or treatment, as men may avoid it due to stigma, and women may fear judgment or repercussions.

How can HIV services be improved for migrants and mobile populations in Sri Lanka?

Improving HIV services for migrants involves:

- **Increasing Access**: Expanding healthcare outreach to high-mobility sectors and providing services at key migration points.
- **Education and Awareness**: Providing culturally sensitive information on HIV prevention and treatment for migrants before departure and upon return.
- **Reducing Stigma**: Community-based programs to reduce stigma related to HIV and migrant populations.
- **International Collaboration**: Working with host countries to ensure that Sri Lankan migrants have access to HIV prevention and treatment services abroad.

Chapter 30: Challenges Community Service Providers can face and how to address them

What are common challenges CSP faces in their work?

CSPs often face many difficulties in their day-to-day work. These can include having too much work to do, not enough resources, and sometimes facing unhelpful attitudes from others. CSPs may find that some people in the community or even some staff at healthcare facilities don't fully understand or support their role. On top of that, CSPs often face stigma and discrimination because they work with key populations who may face judgment from society.

How to deal with police harassment during CSP fieldwork?

Police interference can be a serious issue. Before fieldwork begins, CSP supervisors or coordinators must establish a good relationship with local police officers. They can work with the police to help them understand the important work CSP does and build some trust. Supervisors can also ensure that CSPs have identification and any necessary documentation when out in the field. If police harassment happens, CSPs should let their supervisors know so they can follow up with the appropriate authorities.

How do we address a situation where STI Clinic staff are not cooperative with the CSP team?

Sometimes, clinical staff may not understand the CSP's role or may not be open to working together. In these cases, the CSP supervisors should talk with the consultant at the STD clinic to explain the CSP team's goals and how everyone is working toward better health outcomes for the community. This helps ensure that clinical staff and CSP can work as a team.

How do we address clients with no funds to pay for their transportation or acute care needs?

Many clients face financial problems and may lack money for transportation or urgent medical needs. CSPs can ask their supervisors if any resources or emergency funds could help clients. Some local organizations or charities may also offer support, and CSP can guide clients to these services where possible.

How can burnout due to a high workload be prevented?

It is easy to feel overwhelmed by too much work, but burnout can be avoided by setting healthy boundaries. Taking short breaks, managing time effectively, and balancing work and personal life are all important. CSP supervisors should encourage these practices and help ensure CSPs aren't overloaded. If CSPs feel burned out, it is good to talk to a supervisor and see if they can get support, such as time off or mental health resources.

What to do when a client makes sexual or romantic advances to the CSP?

If a client shows romantic or sexual interest, CSP should stay professional and set clear boundaries. They can gently but firmly let clients know their relationship is strictly professional. If the client doesn't respect this boundary, the CSP should inform their supervisor and try to avoid one-on-one interactions with that client—for example, by referring the client to another CSP.

What to do when encountering child abuse or underage clients?

CSPs may encounter situations involving abuse or underage clients. In Sri Lanka, the legal age of consent is 16, so any clients under this age should be handled carefully. If a CSP suspects abuse or is unsure about how to handle a young client, they should immediately report it to their supervisor, who can take further action. CSPs should be aware of the reporting process and know that supervisors will support them in these sensitive situations.

What innovative approaches can help increase HIV testing yield?

As a CSP, you can help increase testing reach by using different ways to connect with people. For example, some clients may prefer community-based testing (testing in places they feel comfortable) or even using HIV self-testing kits (either testing with the help of the CSP or all by themselves). Virtual outreach, like talking to clients online, is also an option for reaching

people who might not be comfortable meeting in person. These new approaches can help you get more people in a way that feels safer for them.

Why is it essential to continuously repackage and adapt our messages to clients?

Different groups have different needs, so it is helpful to think about what each group might respond to best. For example, some groups might need more specific messages or a different approach to make them feel understood. By paying attention to who you are working with and what matters to them, you can make your messages and support more effective.

How can existing peer-led models be strengthened to improve testing rates?

There are several ways you can make your work more impactful:

- Try to expand your social networks to reach more people in different places. Sometimes, talking to people in other areas can help you find more clients. You can also speak to existing clients and ask them to help connect you to new people who may not have been tested yet.
- Tailor your behavior changes and counseling messages to each client. Consider what might motivate them personally and try to adapt your conversations to match. This means that initially, you may need to listen to your client more than talk to learn what is important to them.
- Use community mobilization approaches, such as connecting with groups or community leaders, to build trust and bring in more people who might need testing. Community leaders may help you spread messages about the importance of HIV/STI testing via their networks and refer their network members to you.
- Ask your supervisor for regular refresher training based on this Guidebook if you feel it would help improve your skills and effectiveness in increasing testing yields.
- Use risk profiling in your outreach work, focusing more on people you think might be at higher risk. This way, you’re more likely to help those who need it most.

Chapter 31: Reporting Achievements

What is the Client Registration Form, and why is it important?

The Client Registration Form is filled out by the Out Reach Worker or the Peer Educator (PE) at the outreach or field sites. This form is crucial because it collects each client's Unique Identifier Code (UIC) according to the UIC guidelines. It also captures essential information about the client's risk category, health status, risky behaviors, and basic demographics. This information helps track each client's health needs and provides a foundation for further support and interventions.

The Client Registration Form can be found in Annex 3.

What is the Clinic Escort/Referral Form for HIV/STI testing, and why is it necessary?

The Clinic Escort/Referral Form for HIV/STI testing has two parts. Part 1 is filled out by the ORW or Peer Educator at the field site, while Part 2 remains blank until it reaches the STD clinic. The Peer Educator uses this form to escort or refer a client to an STD clinic, where the client hands it over to the clinic staff. The STD clinic staff then complete Part 2 of the form and retain it. This form is essential for tracking the referral process and ensuring clients receive proper care. The data collected helps in further analysis when entered into a computer system by the Management Assistant.

The Clinic Escort/Referral Form can be found in Annex 4.

What is the Daily Record Form for Peer Educators, and why does it matter?

The Peer Educator completes the Daily Record Form at the outreach site, and one form is filled out for each working day. This form replaces the previous "Peer Calendar." Once completed, it is handed over to the Field Supervisor, who submits it to the Management Assistant for data entry. This form is vital as it records the daily activities of the Peer Educator, helping to monitor the progress and reach of peer-led outreach efforts.

The Daily Record Form can be found in Annex 5.

What is the Outreach Rapid HIV Test Result Form, and why is it used?

Clinic staff complete the Outreach Rapid HIV Test Result Form. This form records the number of rapid HIV tests conducted each day, along with the results and whether a client was referred

to or escorted to an STD clinic for HIV screening. This data is vital for tracking testing activity and outcomes, providing insights into testing uptake and HIV positivity rates in the community.

The Outreach Rapid HIV Test Result Form can be found in Annex 6.

What is the Condom and Lubricant Stock Management Form, and why is it essential?

The OR Coordinator or the Management Assistant at the clinic completes the Condom and Lubricant Stock Management Form monthly. This form tracks the stock levels of condoms and lubricants, helping ensure a consistent supply is available for distribution. Proper stock management is essential to supporting ongoing prevention efforts, as it ensures that CSP has the resources needed to meet client needs effectively.

The Condom and Lubricant Stock Management Form can be found in Annex 7.

What is the KP Prevention Reporting Format, and why does it exist?

The KP Prevention Reporting Format reports on seven key indicators related to HIV prevention among key populations. These indicators are calculated by analyzing the data collected across all the reporting forms. This reporting format is essential for monitoring and evaluating the performance of HIV prevention programs at each STD clinic, allowing for data-driven adjustments to improve program outcomes.

The KP Prevention Reporting Format can be found in Annex 8.

Annex 1: Overview of common sexually transmitted infections

CHLAMYDIA

What is chlamydia?

Chlamydia trachomatis is a bacterium that can cause an STI. Chlamydial infection is common among young adults and teenagers. However, many people do not know that they have chlamydia because they may not have any symptoms.

How does someone get chlamydia?

Chlamydia is transmitted through unprotected sexual contact (primarily vaginal, oral or anal) with an infected person and from mother to baby.

What are some symptoms of chlamydia?

About 75% of women and 50% of men with chlamydia **have no symptoms of infection.**

In men, symptoms of chlamydia, when they do appear, may include:

- discharge from the penis;
- burning with urination; and
- swollen and/or painful testicles.

How do people protect themselves from getting chlamydia?

The chance of becoming infected with chlamydia can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- use latex or polyurethane condoms during sex;
- limit the number of sex partners or sexual acts;
- if a person has recently been treated or is being treated for chlamydia infection, they must make sure their sex partners also receive treatment in order to prevent getting infected again or infecting other people; sex partners should receive treatment even if they do not have any symptoms; and

- it is best to not share sex toys, but if it is done, cover them with a new condom every time they are used with different partners.

How is chlamydia diagnosed?

A variety of laboratory tests can be used to diagnose chlamydia infection. Tests are done with either a urine sample or a sample obtained from a woman's cervix or a man's urethra using a cotton swab.

Usually, these tests are not readily available, and clients are typically treated syndromically for both gonorrhoea and chlamydia at the same time. Testing can still be done at private clinics or labs, even without symptoms, for a fee, of course.

Is there a treatment or cure for chlamydia?

Chlamydia can be easily treated and cured with antibiotics. It is important to make sure sex partners also receive treatment to prevent getting infected again or infecting other people. People being treated should avoid having sex to reduce the chances of getting the infection again or transmitting it to someone else.

GONORRHOEA

What is gonorrhoea?

Gonorrhoea is an infection caused by a bacterium. Gonorrhoea can lead to infection of the penis, rectum, and throat.

How does someone get gonorrhoea?

Gonorrhoea is transmitted through unprotected sexual contact (vaginal, anal or oral sex) with an infected person and also from mother to baby.

What are some symptoms of gonorrhoea?

Gonorrhoea may affect the genitals, rectum or throat. Many women and men with gonorrhoea have no noticeable symptoms, especially with infection of the rectum or throat.

Symptoms of gonorrhoea, when they do appear, may include:

- discharge from genitals;

- pain or burning with urination or increased frequency of urination;
- redness or swelling of the genitals
- infection of the rectum can occur from having unprotected receptive anal sex; although often there are no symptoms of rectal infection when they do occur, they may include rectal discomfort, anal itching, pain, discharge or bleeding; and
- infection of the throat can occur following unprotected oral-genital sex with an infected partner, resulting in a sore throat.

How do people protect themselves from getting gonorrhoea?

The chance of becoming infected with gonorrhoea can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- use latex or polyurethane condoms during sex;
- limit the number of sex partners and sexual acts;
- a person who has recently been treated or is being treated for gonorrhoea must make sure their sex partners also receive treatment to prevent getting infected again and infecting other people; sex partners should receive treatment even if they do not have any symptoms; and
- it is best to not share sex toys, but if it is done, cover them with a new condom every time they are used with different partners

Can infection with gonorrhoea lead to other health problems?

When left untreated, gonorrhoea can increase the risk of acquiring or transmitting HIV. In addition, gonorrhoea can enter the bloodstream, leading to an infection throughout the body, often causing pain and swelling in the joints.

In men, untreated gonorrhoea can affect the testicles, leading to swelling and pain. Related complications can lead to infertility.

How is gonorrhoea diagnosed?

A variety of laboratory tests can be used to diagnose gonorrhoea. Tests are done with either a urine sample or a sample obtained from a woman's cervix or a man's urethra, using a cotton swab. If rectal or throat infection is suspected, samples may also be taken from those areas.

Is there a treatment or cure for gonorrhoea?

Gonorrhoea can be easily treated and cured with antibiotics. Many men self-treat by buying antibiotics at a pharmacy. This is not recommended and has resulted in gonorrhoea becoming resistant to almost all useful drugs in many places. Therefore, anyone who has gonorrhoea (or any other STI) should see their doctor. The doctor will know the latest and most effective drugs to treat it. Because men and women infected with gonorrhoea often also have chlamydia, treatment for chlamydia is usually provided as well. It is important to make sure the sex partners also receive treatment to prevent getting infected again and infecting other people. Avoid having sex while being treated, to reduce the chances of getting the infection again or transmitting it to someone else.

HEPATITIS B

What is hepatitis B?

Hepatitis B is a serious liver disease that is caused by the hepatitis B virus (HBV). It is very infectious and can be transmitted sexually or from contact with infected blood or body fluids and from mother to baby. Although HBV can infect people of all ages, young adults and adolescents are at greatest risk. HBV directly attacks the liver and can lead to severe illness (both as an acute illness and also chronic long-term liver damage, including cancer) and, in some cases, death. Although there is no cure for hepatitis B, there is a safe and effective vaccine that can prevent the infection.

How does someone get hepatitis B?

HBV is very infectious and is spread through contact with the blood and other body fluids (including semen, vaginal secretions) of infected individuals. It can be transmitted through:

- sexual contact (vaginal, anal or oral) with an infected person;
- sharing needles and other drug injecting equipment;

- use of **contaminated** razors, piercing or tattooing needles, cupping (bekam) equipment;
- pregnancy and/or birth resulting in perinatal exposure (exposure of the baby to the virus);
- occupational exposure to blood or other body fluids of an infected person (needle-stick injuries); and
- hepatitis B can also be transmitted by other means, such as blood transfusion, shared items, such as unclean toothbrushes, and use of unclean skin-cutting tools or surgical equipment.

Although it is rare, household transmission (transmission without recognized blood, sexual or perinatal exposure) of hepatitis B has been documented, primarily among young children who live with family members who are hepatitis B carriers. It is believed that the virus is most likely transmitted by unrecognized exposure to mucous membranes or minor cuts in the skin.

Unlike hepatitis A, hepatitis B is not spread through food or water.

What are some symptoms of hepatitis B?

Many people with hepatitis B have no or only mild symptoms. However, some people experience flu-like symptoms or may develop jaundice (yellowing of the skin). Symptoms of hepatitis B include:

- fatigue;
- nausea or vomiting;
- fever and chills;
- dark urine;
- light stools (poo);
- yellowing of the eyes and skin (jaundice); and
- pain in the right side, which may radiate to the back.

What are the risk factors for hepatitis B?

The primary risk factors for hepatitis B include:

- engaging in condomless sex, particularly unprotected receptive anal sex;
- having sex with more than one partner or with a partner who has or has had more than one partner or who has injected drugs;
- sharing needles and injecting drug equipment;
- snorting: intranasal cocaine uses with shared straws (via blood contacting with nasal membrane)
- recent history of STI;
- having a blood transfusion or treatment with infected blood products
- getting a tattoo or piercing;
- undergoing cupping (bekam) treatment
- having a job (such as a health care worker) that exposes people to blood or other body fluids; and
- traveling or living in areas with high rates of HBV infection (including South-East Asia).

How do people protect themselves from getting hepatitis B?

Although there is no cure for the HBV, there is a safe and effective vaccine that can prevent hepatitis B. This vaccine has been available since 1982 and is given in a series of three shots. It provides protection against hepatitis B in 90–95% of those vaccinated. Getting vaccinated is the best way to reduce the risk of getting hepatitis B. The vaccine is usually given by means of injection, which has to be repeated one month and six months after the first shot. The vaccine protects for many years; after that, it can be repeated if need be.

It is recommended the vaccine be administered to:

- individuals who engage in high-risk behaviours (including unprotected sex, sex with multiple partners and sharing injecting or snorting equipment);
- all babies;
- adolescents;
- individuals who live with people infected with HBV; and

- individuals who live in areas with high rates of HBV infection.

In addition, other ways to reduce the risk include:

- using latex or polyurethane condoms during sex (whenever there is a chance that a sex partner is susceptible to HBV, including unvaccinated or previously uninfected regular partners);
- limiting the number of sex partners;
- avoiding sharing needles and injecting-drug equipment;
- avoid sharing drug snorting equipment
- avoiding skin-piercing or tattoos;
- avoiding cupping (bekam) treatment
- practising universal precautions by health care workers; and
- using care when handling any items that may have HBV-infected blood on them (such as razors, toothbrushes, nail clippers, sanitary napkins and tampons).

Can infection with hepatitis B lead to other health problems?

The majority of individuals have self-limited infections, experience complete resolution and develop protective levels of antibodies. A small number of individuals (5–10%) are unable to clear the infection and become chronic carriers. Of the chronic carriers, 10–30% will develop chronic liver disease or cirrhosis. In addition, chronic carriers can infect others throughout their life, and their risk for developing liver cancer is 200 times greater.

How is hepatitis B diagnosed?

Hepatitis B can be diagnosed by a blood test. Routine blood tests that include testing for liver function may indicate infection. In addition, a specific blood test for the virus can give a definitive diagnosis of hepatitis B.

Is there a treatment or cure for hepatitis B?

There is no specific treatment or cure for acute hepatitis B, and no drugs have been shown to alter the course of infection once someone becomes ill. However, for individuals with chronic

hepatitis B, interferon therapy and antiviral drugs may help. Sometimes, liver transplantation is necessary for severe cases.

Symptoms of hepatitis B can be treated. For example, restricting fat consumption and drinking clear liquids can help relieve symptoms, such as nausea, vomiting and diarrhoea. In addition, it is recommended that individuals with hepatitis B:

- get plenty of sleep/rest;
- drink plenty of fluids;
- eat a well-balanced nutritious diet which avoids highly processed foods with artificial additives
- don't drink alcohol or use dangerous drugs
- avoid smoking and strong toxic fumes
- Maintain a healthy lifestyle of exercise to avoid obesity

HEPATITIS C

What is hepatitis C?

Hepatitis C is a serious liver disease that is caused by the hepatitis C virus (HCV). It is very infectious and can be transmitted mainly from contact with infected blood and from mother to baby. HCV directly attacks the liver and can lead to severe illness (both as an acute illness and also chronic long-term liver damage, including cancer) and, in some cases, death. There is now a cure for hepatitis C, but there is no vaccine that can prevent the infection. The affordability and availability of the meds for curing hepatitis C remains an issue in Sri Lanka with a long waiting list for treatment currently.

How does someone get hepatitis C?

HCV is very infectious and is spread mainly through contact with the blood of infected individuals. It can be transmitted through:

- sharing needles and other drug injecting equipment;

- snorting: intranasal cocaine uses with shared straws (via blood contacting with nasal membrane)
- use of **contaminated** razors, piercing or tattooing needles, cupping(bekam) equipment
- pregnancy and/or birth resulting in perinatal exposure (exposure of the baby to the virus);
- unprotected sex where there is significant trauma to cause bleeding
- occupational exposure to blood or other body fluids of an infected person (needle-stick injuries); and
- hepatitis C can also be transmitted by other means, such as blood transfusion/dialysis, shared items, such as unclean toothbrushes, and use of unclean skin-cutting tools or surgical equipment.

What are some symptoms of hepatitis C?

Many people with hepatitis C have no or only mild symptoms, and it may take a long time before symptoms show, if at all. Symptoms of hepatitis C include:

- flu-like symptoms, fever, and chills;
- fatigue;
- nausea or vomiting;
- headache;
- dark urine;
- light stools (poo);
- yellowing of the eyes and skin (jaundice);
- night sweating, muscle, and joint pain; and
- pain in the right side, which may radiate to the back.

What are the risk factors for hepatitis C?

The primary risk factors for hepatitis C include:

- sharing needles and injecting or snorting drug equipment;
- recent history of STI;
- having a blood transfusion or treatment with infected blood products
- getting a tattoo or piercing;
- undergoing cupping (bekam) treatment;
- having a job (such as a health care worker) that exposes people to blood or other body fluids; and
- engaging in condomless sex, particularly rough unprotected receptive anal sex which causes trauma/bleeding; with more than one partner or with a partner who has or has had more than one partner or who has injected drugs;

How do people protect themselves from getting hepatitis C?

As there is no vaccine for HCV, ways to reduce the risk of HCV transmission include:

- avoiding sharing needles and other injecting drug equipment;
- avoid sharing drug-snorting equipment
- avoiding skin-piercing or tattoos;
- avoiding cupping (bekam) treatment;
- practicing universal precautions by health care workers;
- using latex or polyurethane condoms during sex, limiting the number of sex partners, and avoiding rough sex that can cause bleeding; and
- Use care when handling items that may have HBV-infected blood on them (such as razors, toothbrushes, nail clippers, sanitary napkins, and tampons).

Can infection with hepatitis C lead to other health problems?

15% of infected individuals will experience complete resolution without any treatment. However, 85% will develop chronic infection whereby there will be fatty liver as well as scarring and fibrosis of the liver. 10-20% may reach cirrhosis over 20 to 30 years (could be

faster with alcohol/drugs or con infection with HIV), whereby 3-6% may develop end-stage liver disease and 1-5% may develop liver cancer *(Hepatocellular carcinoma: HCC)*

How is hepatitis C diagnosed?

Hepatitis C can be diagnosed by a blood test. Routine blood tests that include testing for liver function may indicate infection. In addition, a specific blood test for the virus can give a definitive diagnosis of hepatitis C.

Is there a treatment or cure for hepatitis C?

There is a cure that can effectively cure HCV within 4 to 8 weeks of taking a daily pill. This cure has recently been made more affordable in Sri Lanka with the government introducing compulsory licensing for one of the meds. However, treatment availability remains limited, and there is a long waiting list. As such, continued advocacy for this is ongoing. As reinfection is possible after HCV is cured, those who are at risk should continue taking precautions.

HERPES

What is herpes?

Herpes is a common, often recurrent infection caused by the herpes simplex virus (HSV), discussed previously, and there are two subtypes: HSV-1 and HSV-2. Both HSV-1 and HSV-2 can cause blisters and ulcers on the mouth, face, and genitals or around the anus. Once a person is infected with herpes, they remain infected for life. However, the virus often remains latent and does not cause long-term symptoms.

How does someone get herpes?

Herpes spreads through intimate skin contact with an infected individual and from mother to baby. Although the virus can be spread through contact with lesions or secretions, most transmission occurs from unrecognized lesions or asymptomatic shedding. The virus can be transmitted when the infected partner does not have an active outbreak of blisters, ulcers, or other symptoms. Some individuals may never have symptoms and may not know they are infected with the herpes virus. However, they can still transmit the virus to others. Oral herpes (caused mainly by HSV-1) can be spread through kissing. Genital herpes (mainly caused by HSV-2) is transmitted through sexual contact (vaginal, anal and oral). The virus (HSV-1 or HSV-2) can be transmitted from oral to genital regions and vice versa during oral sex.

What are some symptoms of herpes?

Many individuals infected with herpes never have any symptoms and do not know they are infected. The initial herpes infection may be accompanied by flu-like symptoms, such as fever, fatigue, headaches, muscle aches, and swollen glands (lymph nodes), in addition to blisters and ulcers on and around the genitals, thighs, buttocks, and anus or on the lips, mouth, throat, tongue, and gums. Lesions may also be found within the vagina and on the cervix. In the case of genital infection, there may also be pain and itching where the sore is located or burning with urination. These blisters eventually crust over, form a scab, and heal, usually within one to three weeks.

Once the initial infection has resolved, some people experience outbreaks of genital blisters, ulcers or small sores, which can occur on the penis, vulva, anus, buttocks and/or thighs. Itching and tingling in the genitals are often an early warning sign that an outbreak is soon to occur. The frequency and severity of outbreaks varies from one person to the next. Sores that occur during recurrent episodes generally last three to seven days and are not as painful as those of the initial infection, and systemic symptoms are rare. However, some people may experience recurrent, painful genital ulcers. In addition, people with suppressed immune systems (with HIV infection) may experience severe, persistent ulcers.

How do people protect themselves from getting herpes?

The chance of becoming infected with herpes can be reduced by avoiding risky sexual behaviors. To reduce the risk:

- Use latex or polyurethane condoms during sex. While this may help reduce the risk of transmission, transmission may still occur if herpes lesions are on parts of the body not covered by the condom.
- Limit the number of sex partners and sexual activities.
- Avoid any sexual contact with a partner who has sores until the sores are completely healed.
- Avoid having sex just before or during a herpes episode since the risk for transmission is highest at that time. If possible, people should encourage their partner to let them know at the first sign of any recurrence so that they both can avoid sex then.

- If possible, ask any potential sexual partners if they have ever had a herpes episode, and encourage them to see a health care provider or clinic for more information, even if they do not have any symptoms.

What triggers a herpes episode?

Once infected with HSV, recurrent episodes of herpes symptoms can be triggered by several factors, including:

- stress;
- sunlight; or
- sickness or fever.

Can infection with herpes lead to other health problems?

Although genital herpes usually causes mild symptoms, some people may experience recurrent painful genital ulcers, which can be especially severe in people with a suppressed immune system. As with other STI, herpes may also increase the risk for transmitting or acquiring HIV infection.

How is herpes diagnosed?

Herpes can be diagnosed by testing a sample from an ulcer or blister. However, there is no readily available and useful diagnostic blood test for the virus, and there is no certain diagnosis for asymptomatic individuals.

Is there a treatment or cure for herpes?

There is no cure for herpes. Once infected with herpes, they carry the virus for life. This **does not mean** that the person will have herpes trouble for the rest of their life: Symptoms may or may never come back. Specific antiviral drugs and creams (such as acyclovir) may be used to decrease the severity of the symptoms, duration, and frequency of recurrences. Infected individuals can also avoid some of the known causes of recurrences. During an episode, symptomatic relief may be obtained by keeping the area clean and dry, taking pain relievers (such as aspirin, acetaminophen, paracetamol, or ibuprofen), and, for genital herpes, by taking baths (sitting in a tub with warm water covering the hips).

HUMAN PAPILLOMAVIRUS- HPV

What is human papillomavirus?

Human papillomavirus (HPV) is a virus with more than 100 subtypes that can cause a range of diseases, including warts (or papilloma) and anogenital cancer. Although some types of HPV cause common warts on hands and feet, genital HPVs are sexually transmitted and can cause warts in the genital and anal areas of both men and women. HPV causes almost all cases of cervical cancer in women.

How does someone get HPV?

The virus is passed by direct contact during sex with a wart or skin that is infected with the virus and from mother to baby. It is possible to get the warts on the hands and in the mouth through contact during foreplay or oral sex. About 50% of individuals who are infected with HPV never develop genital warts but are still capable of transmitting the virus to others.

What are some symptoms of HPV?

HPV may cause warts with many different characteristics. They may appear small or large, flat or raised, single or multiple; sometimes the warts may not even be visible. The most common places to notice warts are outside the vagina, on the penis and around the anus. In women, HPV can lead to the development of warts inside the vagina and on the cervix as well. In about half of all cases, persons infected with HPV do not have any warts.

How do people protect themselves from getting HPV?

The chance of becoming infected with HPV can be reduced by avoiding risky sexual behaviors. To reduce the risk:

- use latex or polyurethane condoms during sex (this may help reduce the risk of transmission, but transmission may still occur if warts are on parts of the body not covered by the condom); and
- limit the number of sex partners and sexual activities.

How can someone tell the difference between anal warts and hemorrhoids?

Sometimes people are not sure whether they are suffering from anal warts (caused by HPV) or whether they have a problem with hemorrhoids. When you see them, genital or anal warts cannot easily be mistaken for hemorrhoids. Anal warts are white or pink; hemorrhoids are blue-red-purple; warts have a cauliflower-like surface, first soft, later more firm or hard; hemorrhoids have a smooth surface and are soft; anal warts can be single or in groups, significantly when growing larger, and both can cause some itching or burning. Warts are not painful, but hemorrhoids can become very painful when a blood clot and inflammation develop. Hemorrhoids can cause some bleeding in the poo. It is best to have a medical professional assess the situation so proper treatment can be provided. Anal warts can grow to a large size if left untreated. Some anal lumps will turn out to be cancer, so a medical assessment is essential.

How is HPV diagnosed?

Many people who have HPV show no apparent signs of infection. However, if warts are present, a doctor can diagnose HPV infection by their characteristic appearance and the history of how they developed. In women, to look for warts on the cervix or in the vagina, a doctor may use a colposcope, which is like a microscope. In addition, Pap smear results may be suggestive of HPV infection. There are now a number of tests that can detect high-risk subtypes of HPV, but they are expensive. Cheaper versions are currently in development.

Is there a treatment or cure for HPV?

There is currently no cure for HPV infection. Once an individual is infected, they can carry the virus for life, even if the genital warts are removed. Some people, however, can clear the virus from their body. Vaccines against HPV given to all the girls at the age of 12 rears by the MOH office at government and private schools in Sri Lanka.

If left untreated, some genital warts may disappear. There are a number of effective treatments for removing genital warts. According to the US Centers for Disease Control and Prevention, none of the following treatments is better than the others, and more than one treatment may be needed to effectively remove warts. These include:

- podofilox gel, which is a client-applied treatment for external genital warts;

- imiquimod cream, which is a client-applied treatment for external genital warts and perianal warts;
- chemical treatments (including trichloroacetic acid and podophyllin), which a trained health care provider must apply to destroy the warts;
- cryotherapy, which uses liquid nitrogen to freeze off the warts;
- laser therapy, which uses a laser beam to destroy the warts;
- electrosurgery, which uses an electric current to burn off the warts;
- surgery, which can cut away the wart in one office visit; and
- interferon is an antiviral drug that can be injected directly into warts.

Each of these treatments has advantages and disadvantages that should be discussed with a healthcare provider.

SCABIES/CRABS[63]

What is scabies?

Scabies is caused by a mite (a tiny insect resembling a crab, hence its slang name). The female mite tunnels into the skin and lays eggs. After a few days, the eggs hatch into mites, causing itching and a rash.

How does someone get scabies?

Close skin-to-skin contact with an infected person causes scabies transmission. The mites live in the skin but die shortly if they are away from the skin. Most cases are probably caused by holding hands with an infected person. The hand is the most common site to be first affected. Sleeping in the same bed and sexual contact are other common ways of passing on the mites.

What are the symptoms of scabies?

Itching is often severe. Itchy skin tends to be in one area at first (often the hands) and then spreads to other parts of the body. The itch tends to be worse at night and after a hot bath. A rash usually appears soon after the itch starts. It is typically a blotchy red rash that can appear

[63] Text slightly adapted from http://www.leeds.ac.uk/lsmp/healthadvice/scabies/scabies.html.

anywhere on the body. It is often most obvious on the inside of the thighs, parts of the abdomen, and the ankles. Mite tunnels may be seen on the skin as fine, dark or silvery lines about 2–10 mm long. The most common areas where they occur are the loose skin between the fingers, the front of wrists and elbows, groin, armpits, under breasts, scrotum, and penis. The itch and rash of scabies are due to an allergy to the mites.

These symptoms usually take two to six weeks to occur after a person is infected (as the allergy develops). Some people may not know that they are infected and may pass the mite on to others before they have any symptoms. Some people believe that they are covered in mites. This is usually not so. Commonly, there are just a few mites on the skin. However, the allergy to mites can cause someone to itch all over and for a rash to appear in many body parts. The rash and itch can be extreme in people who also have HIV infection.

Who should be treated?

The affected person and all household members and sexual partners of the affected person, even if they have no symptoms, should be treated. It can take up to six weeks to develop symptoms after someone becomes infected. Close contacts may be infected but have no symptoms and may pass on the mites. **Note:** Everyone who is treated should be treated at the same time.

What is the treatment for scabies?

The usual treatment is a cream or lotion that kills the mites. This can be bought at a pharmacy or obtained with a prescription. It is easy to apply and normally works well if used properly. Reapply the same treatment seven days after the first application to ensure that all the mites are killed. Follow the instructions on the packet.

Clothes, towels, and bed linen should be machine washed (at 50°C or above) after the first application of treatment to prevent re-infestation and transmission to others. Items that cannot be washed can be kept in plastic bags for at least 72 hours to contain the mites until they die.

An infected person will still be itchy for a while after successful treatment. It is expected to take up to two or three weeks for the itch to disappear after the mites have been killed by treatment. A soothing cream like crotamiton may help until the itch eases. An antihistamine medicine, such as chlorpheniramine, may also be useful to help people sleep if itching is a problem at night (particularly for children).

SYPHILIS

What is syphilis?

A bacterium causes syphilis. It is a complex disease that causes various symptoms at different stages of infection. If left untreated, syphilis can have many serious complications. Fortunately, it is easy to treat once diagnosed.

How does someone get syphilis?

Syphilis is transmitted through unprotected sexual contact (vaginal, anal or oral) with an infected person and from mother to baby. In particular, the syphilis bacterium is transmitted through direct contact with syphilis sores, which mainly occur in the genital area of both men and women. Because the sores are usually painless, people may not know they are infected.

What are some symptoms of syphilis?

Primary or early symptoms: The first symptom of syphilis infection is usually a small painless sore (chancre) in the area of sexual contact (penis, vagina, anus, rectum, or mouth). The sore usually appears about two to six weeks after exposure and disappears within a few weeks.

Secondary symptoms: Shortly after the sore heals, a rash all over the body (including the palms of the hands and soles of the feet), swollen lymph nodes, fever, or tiredness may be noticed. These symptoms also disappear within a few weeks. Even though the initial symptoms of syphilis clear up on their own, the syphilis bacterium will remain in the body if not treated.

Latent syphilis: During the latent stage of syphilis, there are no symptoms, but the bacterium is still in the body. This stage can be detected only through the use of a blood test.

Late syphilis: Many years after infection, syphilis can produce symptoms related to the severe damage that it can cause to the heart, brain, and other organs of the body.

How do people protect themselves from getting syphilis?

The chance of becoming infected with syphilis can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- use latex or polyurethane condoms during sex;
- limit the number of sex partners and sexual activities; and

- If a person has symptoms suggestive of syphilis or thinks they may have been exposed to it, they should seek medical attention immediately.

Suppose someone has recently been treated or is being treated for syphilis. In that case, they must make sure their sex partners also receive treatment to prevent getting infected again or infecting other people. Sex partners should receive treatment even if they do not have any symptoms.

Can infection with syphilis lead to other health problems?

Syphilis is a severe infection for both men and women. It spreads through the whole body. Without proper antibiotic treatment, the disease can cause heart disease, dementia, paralysis, and death. Infection with syphilis also increases the risk of transmitting or acquiring HIV infection.

How is syphilis diagnosed?

Syphilis can be diagnosed in several ways. A sample from a syphilis sore can be examined under a special microscope. Usually, syphilis is diagnosed with a simple blood test.

Is there a treatment or cure for syphilis?

Syphilis is treated and cured with the antibiotic penicillin. People who have had syphilis for less than one year can be cured with one dose of penicillin. For people who have had syphilis longer, more doses of penicillin are required.

It is essential to make sure sex partners also receive treatment to prevent getting infected again or infecting other people. People who are being treated should avoid having sex to reduce the chances of getting the infection again or transmitting it to someone else.

Return for follow-up testing at three and six months after treatment for early syphilis, and at six and 12 months after treatment for secondary syphilis.

Annex 2: Overview of common Terms

ART adherence

ART (anti-retroviral treatment) adherence refers to a person's ability to stick to their treatment with antiretroviral medication. It is a key task of HIV community service providers to help clients living with HIV to adhere to ART.

Community Service Organization (or Community-Based Organization)

A non-governmental organization that is locally oriented, often more informal and less regulated compared to an NGO. CSOs often focus on specific issues at the community level, whereas NGOs can operate more broadly and at the provincial or national level.

Community Service Provider

A community service provider is a CSO/NGO worker who provides HIV services to key population members. This can be an outreach worker, peer. educator, or outreach coordinator. Since key populations are highly stigmatized in Sri Lanka, Community Service Providers play an essential role to ensure they have and retain access to HIV/STI prevention, HIV/STI testing/counselling and HIV/STI treatment services.

HIV case management

Case management provides a holistic service that offers social, mental, educational and logistical support to a client from the immediate moment after initial diagnosis with HIV until the achievement of ART adherence whereby the client is able to be independent with the added hope of viral suppression and the tailored provision of other health- and social support services with the consent of the client.

HIV services cascade

Refers to a comprehensive set of HIV services to provide key population members with HIV prevention education and tools (including condoms, PrEP and PEP) and HIV and STI testing, and for those testing positive, HIV and STI diagnosis, treatment, care and support. Community service providers who do outreach or peer education help clients enter into the HIV service cascade, and community service providers working on supporting people living with HIV/case

management help newly diagnosed clients to move from one HIV service level to the next, and prevent them from disappearing from the system.

Hotspots

Locations where key populations like to gather, e.g., cruising spots for men who have sex with men or sites where females engaged in sex work offer their services.

Key populations

Key populations are groups who are disproportionately affected by HIV and face significant barriers to accessing prevention, treatment, and care services. These include men who have sex with men, transgender people, people engaged in sex work, people who inject drugs, and context-specific groups, such as young men involved in transactional relationships in tourism settings (e.g., "beach boys").

Linkage to STI HIV care

Linkage to care refers to the most critical task of community service providers: linking people in need to HIV services. HIV services include HIV prevention education and information, HIV counseling and testing, HIV treatment, and other HIV care and support services.

Men who have sex with men

Men who have sex with men is an inclusive public health term used to define sexual behavior between males, regardless of their sexual orientation - or gender identity, their motivation for engaging in sex, or their identification with any or no particular community. The words “man” and “sex” are interpreted differently in diverse cultures and societies as well as by the individuals involved. The term men who have sex with men was intended to cover a large variety of settings and contexts in which male-to-male sex takes place without getting into identity politics. However, questions have been raised about how the term may be disempowering by zooming in on just one aspect of their personhood: the fact that they have sex with men.

Needle & Syringe Program

A Needle and Syringe Program is a policy to reduce the harm caused by sharing used needles and syringes by people who inject drugs. The strategy involves providing clean needles and syringes to people who inject drugs and encouraging the safe disposal of used needles without risking arrest by the authorities.

Non-governmental organization

A formal organization registered with the government, operating as an independent entity focused on development-, advocacy- or humanitarian work. They often have. They have a broader focus than a CSO (see above) and often depend on foreign funding.

Outreach worker/peer educator

A trained person who works to help prevent HIV transmission among networks of key populations (who are people at higher-than-average risk for HIV infection) and who links these people at risk to HIV testing services. They do this by providing information and education and by helping key population members access HIV counseling and testing services. The ultimate goal of HIV outreach is to ensure that undiagnosed people living with HIV are supported in accessing Antiretroviral (ARV) therapy as well as social support services.

People engaged in sex work.

People who are involved in sex work have sex in exchange for money, favors, drugs, or goods. This can be their only source of income or support or a complementary source of income or benefit. People involved in sex work can be women, men, or transgender persons. People engaged in sex work usually have an increased risk of getting HIV if they engage in unprotected anal or vaginal sex since they usually have a larger-than-average number of sexual partners and may be less able to negotiate safer sex with their sexual partners.

People who inject drugs

People who inject drugs refer to the behavior of individuals at risk of acquiring HIV and other blood-borne infections due to unsafe injection practices, such as reusing and sharing previously used needles or syringes.

Reactive HIV test result

A reactive HIV test result refers to an HIV screening test that shows a non-negative result; the term ‘positive’ is avoided at this stage until a second (confirmation) test can be completed. A person with a reactive test result, therefore, urgently needs to conduct another test to be confirmed HIV positive.

Transgender person

A transgender person is a person who was assigned a specific sex at birth but identifies as a different gender. Transgender persons may or may not embark on a process to transform their bodies in line with their true gender. Transgender people may or may not choose to affirm their gender identity through various social, medical, or legal processes. This could include changes in clothing, hairstyles, speech, hormone therapy, or different levels of gender-affirming surgeries. Not all transgender people seek or need medical interventions, and each person's journey is unique.

U=U

U=U means ‘Undetectable is Untransmittable’ and refers to the fact that when a person with HIV is on treatment for a certain amount of time, the amount of HIV in their bodily fluids becomes so low that HIV transmission becomes impossible, even if they engage in unprotected sex. U=U is an important message to reduce the fear and stigma of people living with HIV, and it should also help encourage the uptake of ART among those newly diagnosed.

Unique Identifier Code

A way to identify and track service users without recording their names or other identifying information. It is critical to track whether some clients may be lost to follow-up and to assess the effectiveness of cross-service referrals as part of overall quality control.

Viral suppression

Viral suppression is the goal of antiretroviral treatment, which is achieved when antiretroviral therapy reduces a person's viral load (HIV RNA) to an undetectable level. Viral suppression does not mean a person is cured; HIV remains in the body. If ART is discontinued, the person's viral load will likely return to a detectable level. Viral suppression is essential as it is a sign

that the treatment is working well and that the person taking treatment has become unable to transmit HIV to others.

95-95-95 targets

Global targets to control the HIV epidemic 95-95-95 targets are that 95% of people living with HIV (people living with HIV) in a country or population must have been tested and know their HIV status; 95% of diagnosed people living with HIV must be enrolled on Antiretroviral Treatment (ART), and 95% of those on ART must have achieved viral load suppression. The Government of Sri Lanka has committed to achieving these targets by 2030.