

HIV and AIDS in Emergencies: A Sri Lanka Case Study

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* Disclaimer: The views presented in this paper are those of the authors and do not necessarily represent the views of the World Food Programme and UNAIDS

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List of Acronyms

ADB	Asian Development Bank
ART	Anti-retroviral Therapy
BSS	Behavioural Surveillance Survey
CATAW	Coalition for Assisting Tsunami Affected Women
CFA	Ceasefire Agreement
CNO	Centre for National Operations
COJ	Companions on a Journey
CPA	Centre for Policy Alternatives
DHS	Demographic and Health Survey
FAO	Food and Agriculture Organisation
FCCISL	Federation of Chambers of Commerce and Industry of Sri Lanka
FGDs	Focus Group Discussions
FSW	Female Sex Workers
FTZs	Free Trade Zones
GDP	Gross Domestic Product
GNP	Gross National Product
HDI	Human Development Index
IDP	Internally Displaced Persons
IDU	Injecting Drug Use
ILO	International Labour Organisation
IOM	International Organisation for Migration
JBIC	Japan Bank for International Cooperation
KAP	Knowledge, Attitude and Practices
KIs	Key Informant
LTTE	Liberation Tigers of Tamil Eelam
MARP	Most-at-risk-populations
MDG	Millennium Development Goals
MO-STD	Medical Officer of Sexually Transmitted Diseases
MO-STI	Medical Officer of Sexually Transmitted Infections
MSM	Men who have sex with men
NCED	National Council for Economic Development
NDDCB	National Dangerous Drugs Control Board
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
OCHA	United Nations Office of Coordination and Humanitarian Assistance
PHI	Public Health Inspector
PHM	Public Health Midwife
PLHIV	People Living with HIV
SGBV	Sexual and Gender Based Violence
SLRC	Sri Lanka Red Cross
STIs	Sexually Transmitted Infections
TRO	Tamil Rehabilitation Organisation
UNDAC	United Nations Development and Assessment Coordination
UNAIDS	Joint UN Programme on HIV
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

Executive summary

The present report explores existing evidence on the ways in which the 2004 Asian tsunami affected vulnerabilities to contracting HIV, the coping strategies of PLHIV and others affected by the emergency and HIV-related programming and services in Sri Lanka. The report forms part of a broader ODI study on HIV in Emergencies, which is being carried out in collaboration with WFP and supported by UNAIDS.

Background and context:

Sri Lanka is considered a low prevalence country in the South Asian region with less than 0.1% of the general population infected with HIV. According to the National STD/AIDS Control Programme (NSACP), the HIV prevalence rate has remained less than 1% even amongst most-at-risk-populations (MARP) such as female sex workers (FSW), men who have sex with men (MSM) and their sex partners. As of December 2007, the number of people registered as HIV positive with the NSACP was 957. However, according to UN estimates, there are between 3000 to 5000 people living with HIV in Sri Lanka.

There are several factors which appear to contribute to the low HIV prevalence in Sri Lanka. These include high levels of education, relatively strong gender equality indicators, good access to health services including STI services, low levels of STIs even amongst persons engaging in unprotected sex with multiple partners, low levels of injecting drug use and it being an island state. Still, Sri Lanka also has risk factors which could potentially increase the rates of HIV transmission such as the ongoing ethnic conflict and large Internally Displaced Persons (IDP) community, internal and external migration for employment, increasing number of sex workers, large number of sexually active youth, low levels of knowledge about HIV, high levels of stigma and low levels of condom use and the country's reputation for sex tourism.

The tsunami that hit Sri Lanka on December 26, 2004 had a massive human, physical, economic and social impact and was the largest and most destructive natural disaster in the history of the country (ADB, JBIC and WB 2005). It caused over 30,000 fatalities, displaced over half a million people and ruined the livelihoods of over 200,000 people (Frerks and Klem 2005). Fishing communities living close to the shore in simple houses and shelters bore the brunt of the impact. The tsunami also had a negative impact on the tourist industry, but it is possible that the influx of international humanitarian aid workers in the immediate aftermath of the tsunami may have worked to some extent to counteract this.

The tsunami and its aftermath created an 'emergency within an emergency' as it hit coastal areas in the North and East that had already suffered over 25 years of civil war between the state, dominated by the Sinhalese majority, and the Liberation Tigers of Tamil Eelam (LTTE), a separatist insurgency claiming to represent the Tamil minority. Prior to the tsunami, more than 350,000 people had already been forced to leave their homes in the north and east of the country, and many children were already missing out on school (Save the Children 2006).

Despite the tsunami and a civil conflict of more than 25 years, Sri Lanka has seen a steady increase in its economy. In 2007, Sri Lanka's per capita income exceeded US\$ 1000.00, a rate higher than most of its neighbouring countries (UNDP 2007a). Still, the conflict has slowed economic development and progress especially in the northern and eastern provinces and poverty remains a concern for Sri Lanka with more than 5.6% living below the poverty line of US\$ 1.00 per day and more than 41% living below the poverty line of US\$ 2.00 per day (UNDP 2007b).

Sri Lanka has health indicators which are comparable to and better than some middle income countries. Universal free health care, both preventive and curative, and including the provision of prescribed drugs, is available to all Sri Lankans, although access to and the quality of services are

more limited in the districts of the Northern and Eastern provinces. In recent times, there has been a surge in the use of private hospitals due to overcrowding, long waits and queues at public hospitals (CPA, 2007).

The Sri Lankan government incorporated HIV prevention into its STI control programme in 1985 and renamed the programme as the National STD/AIDS Control Programme (NSACP) under the Ministry of Health.¹ At present there is no comprehensive national policy on STI and HIV/AIDS even though a draft policy is available and in the process of being finalised.² Access to VCT is available at district level clinics (there are 30 STD clinics in different parts of Sri Lanka) and at the National STD/AIDS Control Programme (NSACP). ART and medication for opportunistic infections are provided for free to all patients by the government. World Bank funding is used to provide free ARVs which cost approximately US \$250.00 per month per patient.

The Sri Lankan cultural context precludes open discussion of any issue related to sexuality and/or sexual behaviour outside of marriage. People, especially women, are expected to remain virgin until marriage and extra marital sex, even though it takes place, is rarely acknowledged. Awareness programmes on HIV/AIDS, more often than not, are also conducted to promote abstinence till marriage and then being faithful to one faithful partner. Condoms are promoted and distributed only amongst the so-called MARP. Both sex work and homosexuality are illegal and punishable by law.

Programmatic Response:

The initial emergency response to the tsunami was spontaneous, uncoordinated but largely successful (EU, 2005). Access to food, water, basic health care and shelter appears to have been adequate in the initial relief phase, with few exceptions, although the situation in IDP camps is perceived to have deteriorated in the longer-term recovery phase.

The assessment found that there did not appear to be a systematic emergency response to address sexual health among populations affected by the tsunami. Very little was done to prevent the potential spread of HIV in the emergency phase. Provision of food, water, sanitation, basic health care and shelter overshadowed concerns about sexual health in IDP camps and villages. Sri Lanka's relatively low HIV prevalence rate was the main reason given for this. HIV prevention was seen as an unnecessary burden on already over stretched field staff and a waste of resources.

National STD and HIV clinics and services continued to operate during the post-tsunami period, although some hospitals and STI clinics were severely damaged, including one visited by the assessment team in Galle District. Findings suggest that two to three months after the tsunami, IOM and some I/NGOs such as the Sri Lanka Red Cross (SLRC), the Salvation Army, ActionAid and FPA began to incorporate HIV awareness and prevention into their health programmes in IDP camps and villages, often using general health, sexual and reproductive health and/or community development as an entry point. However, such programmes tended to be ad hoc, targeted at the general population and limited to awareness and information campaigns. Some distribution of leaflets and playing cards with HIV messages on them was carried out by IOM in collaboration with UNAIDS.

The team found that, on the whole, some Sri Lankan civil servants, including those from the National STI and AIDS Control Programme (NSACP) and National Dangerous Drugs Control Board (NDDCB), and NGO staff placed a strong emphasis on 'moral' values and indicated that the low HIV prevalence rate in Sri Lanka could be attributed to its culture. Many were not in favour of condom promotion or distribution, seeing it as inappropriate in the Sri Lankan context and linking it to 'illicit sex' and adultery. Abstinence and being faithful were the preferred methods of HIV prevention. As one key informant put it, 'Condoms encourage people to do the wrong thing the

¹ Sri Lanka Demographic and Health Survey 2000.

² This information was obtained from the interviews conducted with staff members of the NSACP.

right way'. Another key informant stated that Sri Lankan culture was unique in that Sri Lankans are not interested in sex and did not engage in promiscuous behaviour.

Vulnerabilities to contracting HIV during the tsunami - findings

The main objective of the study was to assess the ways in which the tsunami affected not only vulnerability to contracting HIV (through displacement, loss of livelihoods, changes in social norms and family structures, trauma, fatalism and disruption to health services), but also specific HIV risk behaviours such as unsafe sex, injecting drug use, SGBV and sex work. Given that HIV was not considered a priority in the tsunami response, it was difficult to find reliable field-level information on the impact of the tsunami on HIV vulnerability and risk behaviours. The following findings are based largely on information from key informant interviews and focus group discussions (FGDs).

Summary of findings:

In addition to pre-existing social and cultural factors such as low levels of knowledge about HIV, high levels of stigma and low levels of condom use the findings of the assessment suggest that displacement and loss of livelihoods may have resulted in increased vulnerability of affected populations to contracting HIV during the post-tsunami period. However, there is little data available on the ways in which HIV risk behaviours, via both sexual and non-sexual, were affected. Pre-existing low HIV prevalence, even among MARP, low levels of STIs, low levels of IDU and universal access to free health care all imply that levels of HIV risk prior to the tsunami were low. Furthermore, information gathered through KIs and FGDs identified several factors relating to the post-tsunami context which may have contributed to a reduction in levels of HIV risk in the immediate aftermath. Such factors include shock and trauma, which may have decreased sexual activity immediately following the tsunami; unprecedented levels of humanitarian aid (food, water, sanitation, shelter etc.) which may have helped to keep levels of transactional sex low; and the negative impact of the tsunami on tourism and the sex industry in the coastal areas, where many sex workers and beach boys are reported to have been killed. However, there is also evidence that, as aid flows declined and camp conditions deteriorated, SGBV, transactional sex and trafficking were taking place among affected populations, which may have increased HIV risk. There were also accounts, from sex workers, of sexual violence and of men turning to (unprotected) sex for comfort as a result of shock and grief.

Key findings on vulnerable groups:

- There were reports of SGBV following the tsunami and of women and girls engaging in transactional sex for survival. According to KIs and secondary sources, attention to the safety, privacy and sexual and reproductive health of women and girls was not adequately integrated into the management, coordination and infrastructure of camps. Conditions of close physical proximity, as well as lack of privacy for sexual relations between married couples can increase HIV risk by leading to the trend of seeking sex outside the couple (Oxfam and Swasti, 2007). IDPs living in camps stated that the lack of electricity posed a real threat to women's security at night. Women stated that, when they needed to use the toilet, they went in pairs in order to increase their safety.
- Bereaved, single men were reported to have been more vulnerable to alcohol and drug use, with this leading to violence and risky behaviour such as unsafe sex. However data on this was anecdotal.
- The vulnerability of children to sexual abuse was highlighted as an issue and there were reports of fatalism among young people who, following the tsunami, were more inclined to engage in risky behaviours with little concern for their future. Young people who did not necessarily engage in sex work before the tsunami were reportedly going to beaches and hotels in search of sex work in the weeks and months which followed.
- MSM affected by the tsunami were reportedly vulnerable to discrimination in camps, possibly leading to increased vulnerability to transactional sex due to lack of assistance. There were also reports of sexual exploitation of MSM by police.

- Information gathered from the FGD with sex workers suggests that the tsunami temporarily reduced levels of sex work. One respondent described how she was so traumatised she could not engage into any sex work for some time after the tsunami. Another described how, having lost her home, she stayed with friends and family, which made it difficult to continue engaging in sex work as her hosts did not know what she did for a living. Several respondents described how the tsunami and recent floods had made it more difficult and more expensive to travel to Colombo to engage in sex work. Some also complained that there were fewer clients after the tsunami and those that remained paid less. FSW reported increases in SGBV towards them from bereaved men following the tsunami.
- Given the low levels of IDU in Sri Lanka, no data was available on the impact of the tsunami on this group.
- Of the 957 registered PLHIV in Sri Lanka, very few were affected by the tsunami and of those that were, even fewer were aware of their HIV status at the time. Evidence from the FGD with PLHIV points to extremely high levels of stigma and discrimination against PLHIV which leads them to keep their status hidden from friends, family and the authorities. Nothing was done specifically to assist PLHIV in the aftermath of the tsunami. PLHIV's main concerns at the time were adequate nutrition, protection from malarial mosquitos (as malaria can significantly undermine the already weakened immune system of PLHIV) and appropriate livelihood support.

Key findings on impact on coping strategies/resilience of those affected by the tsunami:

- Evidence from key informant interviews with NGOs and UN agencies suggests that displacement and loss of livelihoods as a result of the tsunami led affected populations (mainly women and young people) to engage in increased levels of transactional sex for survival but that food distribution programmes - food for education, food for work - and cash transfer programmes helped to keep levels down. The MO-STD from Balapitya observed that in the first two or three months, people got enough aid, whereas later on when aid levels decreased, levels of transactional sex increased.
- According to one NGO, 'protection committees' and 'discipline committees' were formed within camp settings to minimise different forms of violence against women but it is not clear if these mechanisms were effective in achieving the stated goals. Family support, when available, seems to have been the most effective coping strategy.
- According to medical staff in the Southern districts, there was an increase after the tsunami in the number of people going to the Middle-East in search of work, but without more data, it is not possible to link this directly to the impact of the tsunami.

Key findings on impact on health and other basic services:

- On the whole the provision of general health services continued and remained accessible to the general population, despite the fact that the tsunami destroyed and/or damaged several primary, secondary and tertiary care institutions in the northern, eastern and the southern provinces and killed some health staff. The general health needs of the population were met by conducting mobile clinics and there were special mobile clinics to address maternal and child health.
- There were no special programmes on the prevention of STIs. Condoms, when they were promoted mainly through NGOs, although only one NGO interviewed actively distributed them.

Key findings on the response to HIV in emergencies:

- The government (central and district level), local NGOs, international NGOs and the private sector all played important roles in the response, although the government's immediate response was perceived, by some, to have been slow and overly centralised. Access to food, water, basic health care and shelter appears to have been adequate in the initial relief

phase, with a few exceptions; provision for basic needs took priority over addressing sexual health issues and preventing the spread of HIV. The situation in IDP camps is perceived to have deteriorated in the longer-term recovery phase.

- There appears to be little awareness amongst government agencies or NGOs of the need to consider HIV-related vulnerabilities in emergency responses, possibly due to the low HIV prevalence rate. The national strategic plan does not specifically refer to emergency situations. An Action Plan for Responding to HIV and AIDS in Emergencies in Sri Lanka, based on the IASC guidelines, had been drafted in collaboration with the NSACP and UN agencies including FAO, ILO, IOM, OCHA, UNDP, UNFPA, UNHCR, UNICEF, WB, WFP and WHO. However, an assessment of the implementation of the action plan, jointly conducted by UNAIDS and WFP in Batticaloa in June 2005 revealed that few of the agreed actions had been implemented. None of the UN staff interviewed during the current assessment knew about or mentioned the Action Plan.
- An interesting finding concerns the UNAIDS 'Keep the Promise' campaign for World AIDS day in 2006 which was originally intended as an appeal to governments, policy makers and regional health authorities globally to ensure that they meet the many targets that have been set in the fight against HIV and AIDS. Key informant interviews with civil servants and NGOs revealed that this message had been misinterpreted in the Sri Lankan context to mean 'Keep the promise to your husband/wife' i.e. be faithful. This is a prime example of the cultural barriers to HIV prevention in Sri Lanka and a lack of cultural insight on the part of international campaigns and slogans.

Recommendations

- Despite Sri Lanka's low HIV prevalence rate, the possibility that vulnerability to HIV may increase during and after an emergency needs to be better taken into account by policy makers, relief programme managers, operational decision makers and all those working in the response to sudden-onset natural disasters and other types of emergencies. The government, UN agencies and NGOs should work to ensure a multi-sectoral response to HIV and AIDS in emergencies – one which ensures that the special needs of PLHIV in emergency situations are addressed.
- HIV/AIDS and SGBV awareness-raising and prevention activities should be carried out among crisis affected-populations, along with promotion and free distribution of condoms and livelihood generating activities.
- UN agencies in Sri Lanka should work with the NSACP to revive and update the 'Action Plan for Responding to HIV and AIDS in Emergencies in Sri Lanka'. The Action Plan, which is based on the IASC guidelines for HIV/AIDS interventions in emergency settings, was drafted by UNAIDS in 2004 in collaboration with the NSACP and other UN agencies. It provides practical guidelines for government and UN organisations and NGOs in Sri Lanka responding to the special needs of HIV-infected and HIV-affected people in emergency situations.
- HIV-related stigma and discrimination, as well as discrimination against women, sex workers, homosexuals and drug users remain critical barriers to effectively addressing HIV in Sri Lanka, as well as being issues in their own right. In view of this, the government of Sri Lanka, relevant UN agencies and NGOs should prioritise activities to reduce or eliminate stigma and discrimination. Such activities should target individuals, families, communities, institutions, the media and government policies and practices.
- It could be useful and necessary to establish a system whereby, whilst maintaining respect and confidentiality, PLHIV could be contacted to ensure that any additional needs emerging as a result of the emergency (e.g. food requirements to enable ARVs) can be addressed. Lanka+ is a potential organisation through which registered PLHIV could be contacted.

- It is also important to improve collaboration between the Government Health Services (both preventive and curative) and NGOs addressing community health needs at district level. This will provide an opportunity for the state health services to benefit from the reach NGOs have to vulnerable populations and for NGOs to benefit from the health services provided through the state.
- Finally, many data are still lacking and further research is needed in a number of areas including HIV risk behaviour among the general population and MARPs in non-emergency settings, in order to establish baselines; the impacts of emergencies on HIV risk behaviour among the general population, MARPs and IDPs both in camps and those who do not enter camps but move to stay with friends, relatives or neighbours.

1.0 Introduction

The present report explores existing evidence on the ways in which the 2004 Asian tsunami affected vulnerabilities to contracting HIV, the coping strategies of PLHIV and others affected by the emergency and HIV-related programming and services in Sri Lanka. The report forms part of a broader ODI study on HIV in Emergencies, which is being carried out in collaboration with WFP and supported by UNAIDS. The overall study is split into 2 phases:

- Phase 1 involved a literature review with 3 inter-related aims: 1) to review existing literature on HIV and emergencies; 2) to develop a conceptual and operational framework for thinking about HIV in emergency situations; and 3) to identify gaps in the literature and areas for further exploration. This was completed in September 2007 (see Samuels and Proudlock, 2007).
- Phase 2 aims to work towards filling in the gaps in knowledge identified in Phase 1 through 5 country case studies which represent a range of different emergencies, HIV prevalence rates and socio-cultural contexts. Selected countries include: Haiti, Central African Republic (CAR), Kenya, Mozambique, and Sri Lanka.

Nearly two decades since reporting its first HIV infection, Sri Lanka remains one of the few countries in South-East Asia with a low-level HIV epidemic. HIV prevalence is estimated to be less than 0.1% (UNAIDS Sri Lanka website). In December 2004, Sri Lanka experienced a devastating tsunami, which had massive physical, economic and social impacts. It also suffers recurring natural disasters such as droughts, floods and occasional landslides against a backdrop of complex and protracted violent conflict in the North and East of the country. This context has presented particular humanitarian and HIV response challenges.

The rest of the report is divided into the following sections: section 2 describes the methodology used and the limitations facing the researchers; section 3 outlines the country context with regard to HIV epidemiology, humanitarian emergencies, livelihoods, health and culture; section 4 provides a summary of programmatic responses to both HIV and emergencies and; section 5 discusses the evidence of the impact of the tsunami on vulnerable groups, including PLHIV, as well as on health and other basic services. The final section draws out some conclusions and recommendations.

2.0 Methodology of assessment

The 14 day assessment (16th – 29th March 2008) covered Colombo and Galle districts³ and was carried out by two consultants; one international and one based in Sri Lanka. The study used qualitative methods such as key informant interviews (KIs) and focus group discussions (FGDs) to collect most of the data. KIs were carried out with government, UN and I/NGO staff. Focus group discussions (FGDs) were held with community groups affected by the tsunami including PLHIV, sex workers and people living in IDP camps. For ethical reasons, the identities of respondents from community groups have been withheld. The study also draws on secondary source material collected during the field work.

³ The team was unable to travel to the North and East due to escalating violence in these regions. As a consequence, and also due to lack of time, the study is limited to the Southern and Western tsunami-affected districts of Galle and Colombo.

A total of 26 KIs were carried out: 22 in Colombo and 4 in Galle. 3 FGDs were carried out: 1 with PLHIV affected by the tsunami, 1 with sex workers affected by the tsunami in Galle and floods in Ratnapura, and 1 with internally displaced people who are still living in camps three years on in Moratuwa.

The team faced a number of challenges, mainly with regard to a lack of data on issues of interest to the assessment:

- 1) **Lack of data:** The classification of Sri Lanka as a low level HIV epidemic has led to only a very few studies being conducted on HIV risk-related issues, let alone in emergency contexts. Very little secondary data exist on HIV risk behaviours, either among high risk groups or the general population. The few studies that do exist are not linked to emergency contexts. One study carried out by UNHCR and UNAIDS on HIV risk among conflict-affected IDPs was not available during the field work period but will become available soon and should contribute further to this topic. For these reasons, the study relies largely on evidence from key informant interviews and FGDs.
- 2) **Cultural sensitivities and taboos:** The issues that the assessment intended to explore are culturally highly sensitive. High levels of stigma against PLHIV coupled with taboos regarding open discussion on sexuality and sexual behaviour, made it difficult to access accurate information on the factors affecting HIV risk.
- 3) **HIV not a priority in emergency response:** Another challenge was that HIV was not considered by government or NGOs to be a priority issue in the response to the tsunami. Consequently, there are few examples of HIV-related initiatives that formed part of the tsunami response either in the emergency or recovery phase.
- 4) **Geographical limitations:** While the tsunami affected areas in the South, North and East, the team was unable to travel to the North and East due to escalating violence in these regions. As a consequence, and also due to lack of time, FGDs and KIs are limited to communities in the Southern and Western tsunami-affected districts of Galle and Colombo.
- 5) **Institutional constraints:** Lack of institutional memory within UN agencies was another difficulty which presented itself. The most common reason given by key UN informants for lack of data/knowledge about a particular programme or issue was that either they themselves or a relevant colleague had left their post. The fact that the tsunami occurred more than 3 years prior to the assessment may have contributed to this problem.

3.0 Country context

3.1 Epidemiology

Sri Lanka is considered a low prevalence country in the South Asian region with less than 0.1% of the general population infected with HIV. According to the National STD/AIDS Control Programme (NSACP), the HIV prevalence rate has remained less than 1% even amongst most-at-risk-populations (MARPs) such as female sex workers (FSW), men who have sex with men (MSM) and their sexual partners. As of December 2007, the number of people registered as HIV positive with the NSACP was 957. However, according to UN estimates, there are between 3000 to 5000 people living with HIV in Sri Lanka.

Sexual routes of transmission are the most common; 86% of reported HIV cases were transmitted through heterosexual contact and 11% through homosexual/bisexual contact (World Bank 2007). This is followed by mother-to-child transmission, 31 cases of which have been recorded to date. According to the persons interviewed transmission from blood transfusions is negligible since Sri Lanka has an effective blood screening programme where all blood donations are tested for HIV. Only three cases of transmission through blood transfusion have been recorded to date. Injecting drug use (IDU) is not considered common in Sri Lanka even though 4% of drug users supposedly do inject. Despite the low levels of IDU, the state recognises that if drug users switch to injecting, this could lead to rapid HIV transmission. According to Lanka+, a network for people living with HIV in Sri Lanka (also see Footnote number 11), there is only one recorded case of HIV transmission from injecting drug use.

The first case of HIV infection was reported in 1986 and there has been a steady increase in the number of reported cases even though the national estimates have been decreasing over the years due to improved data collection methods. There has also been an increase in HIV infections among women. According to the World Bank (2007) the proportion of women who are infected with HIV compared to men rose from 21% during the 1987-1991 period to 47% in the 2002-2005 period. Similarly, the number of young people (those below 30 years of age) becoming infected with HIV has increased over the years and according to the NSACP 35 persons between the ages of 15-24 were infected with HIV as at the end of 2004. The regional variations indicate that the highest number of people with HIV, who are registered with the NSACP, are resident in the Western province and the lowest number in the Uva province. Of the 25 districts, Colombo district has the highest number of registered PLHIV at 35.4% of the 957 registered with the NSACP and Mannar district has the lowest number of registered PLHIV at 0.1%. These variations are to be expected given that the Western province is the most populous and urbanised province in the country. According to the data from the NSACP, as of the end December 2007, 686 out of the 957 recorded HIV cases were from the 13 districts affected by the tsunami but these are the most recent figures and there is no known link between these figures and the emergency.

There are several factors which are likely to contribute to the low levels of HIV transmission and prevalence rates in Sri Lanka. These include high levels of education, relatively strong gender equality indicators, good access to health services including STI services (except in conflict – affected and under served areas), low levels of STIs even amongst persons engaging in unprotected sex with multiple partners, low levels of injecting drug use and the fact that Sri Lanka is an island state. Still, Sri Lanka also has risk factors which could potentially increase the rates of HIV transmission and thus result in a concentrated and possibly, subsequently a generalised epidemic. The ongoing ethnic conflict and large Internally Displaced Persons (IDP) community, internal and external migration for employment, increasing number of sex workers, large number of sexually active youth and the country's reputation for sex tourism are some factors which pose a threat to the low levels of HIV prevalence in the country. In addition, low levels of condom use in general as well as the limited availability of access to health and social services in underserved

areas (plantations, urban slums and conflict affected districts) are also factors which could contribute to increases in HIV transmission.

The recently concluded BSS, which was conducted among three-wheel drivers⁴, drug users, factory workers from Free Trade Zones (FTZs), beach boys, MSM and FSW, found a widespread belief in myths of how HIV can be transmitted, a poor understanding of how correct and consistent use of condoms could prevent transmission and stigmatising attitudes towards those who are HIV positive (BSS 2007). Low levels of condom use among all groups was another findings from the BSS and the report highlights the low levels of condom use especially among FSWs working in casinos as a cause for concern. FTZ employees and three wheeler drivers, who are frequently cited as most-at-risk groups, were not considered to be at high risk of contracting HIV. This survey also revealed that even though awareness about HIV was common, accurate knowledge of HIV was low among all groups. For example, while most had heard of HIV and knew that it was sexually transmitted, over 50% of the respondents incorrectly identified HIV as being transmitted by mosquito bites, over a third of respondents did not know that condoms provided protection from HIV and a majority felt that someone with HIV could not look healthy (BSS, 2007). Similar findings were also revealed in a UNICEF study conducted amongst adolescents in Sri Lanka in 2004.

Currently, there is no data available on HIV infection rates according to occupation or vulnerable groups. According to the NSACP, persons who are infected with HIV come from a range of different occupations and socio-economic strata. An MDG country report in 2005 stated that 48% of reported HIV cases were among international migrant (women) workers. However, since women migrant workers have to undergo compulsory HIV screening prior to departure it is argued that they are highly over represented in HIV testing data. Furthermore, given the lack of information on how these women contracted the virus – whether locally or internationally – what is fuelling the epidemic remains unclear. According to a key informant from WHO, given that there is very little difference between the prevalence of HIV among the general public and that of so-called MARPs, prevention efforts for Sri Lanka should target both.

⁴ Three-wheel drivers are drivers of three-wheeled taxis. They are generally considered to be a MARP because of their close association with the commercial sex trade. Three-wheeled taxis are frequently used to transport sex workers and their clients, and they are used as venues for sex, with the drivers functioning as pimps (BSS, 2007:10). However, the recent BSS found that their risk of contracting HIV was not as high as is generally perceived.

3.2 History of emergency

The tsunami that hit Sri Lanka and the region on December 26, 2004 had a massive human, physical, economic and social impact and was the largest and most destructive natural disaster in the history of the country (ADB, JBIC and WB 2005). It caused over 30,000 fatalities, displaced over half a million people and ruined the livelihoods of over 200,000 people (Frerks and Klem 2005). Fishing communities living close to the shore in simple houses and shelters bore the brunt of the impact.

The Federation of Chambers of Commerce and Industry of Sri Lanka (FCCISL) estimates the economic costs of the tsunami to be US\$1 billion although many of these assets were concentrated in the private sector (FCCISL 2005). According to government estimates, more than 130,000 houses were damaged of which approximately 99,000 were completely destroyed. Coastal infrastructure including roads, railways, communication systems, power supplies, water supply and health systems were also severely damaged. Fisheries and the tourism sector shared the largest output losses (ADB, JBIC and WB 2005). However, the influx of international humanitarian aid workers in the immediate aftermath of the tsunami may have contributed to some extent to reducing the negative impact on the tourist industry.

It is important to note that the tsunami and its aftermath created an 'emergency within an emergency' as it hit coastal areas that had already suffered over 25 years of civil war between the Sinhalese state and the Liberation Tigers of Tamil Eelam (LTTE), a separatist insurgency claiming to represent the Tamil minority. Prior to the tsunami, more than 350,000 people had already been forced to leave their homes in the north and east of the country, and many children were already missing out on school (Save the Children 2006), despite the fact that a cease fire had been in place for two and a half years. The war-affected regions were among the worst affected by the tsunami in terms of human loss and damage to infrastructure, which was already less robust than in other parts of the country. On Jan 16th 2008, the Sri Lankan government abrogated the Ceasefire Agreement (CFA) with the LTTE. Today, the conflict in the North East of Sri Lanka continues as fiercely as before.

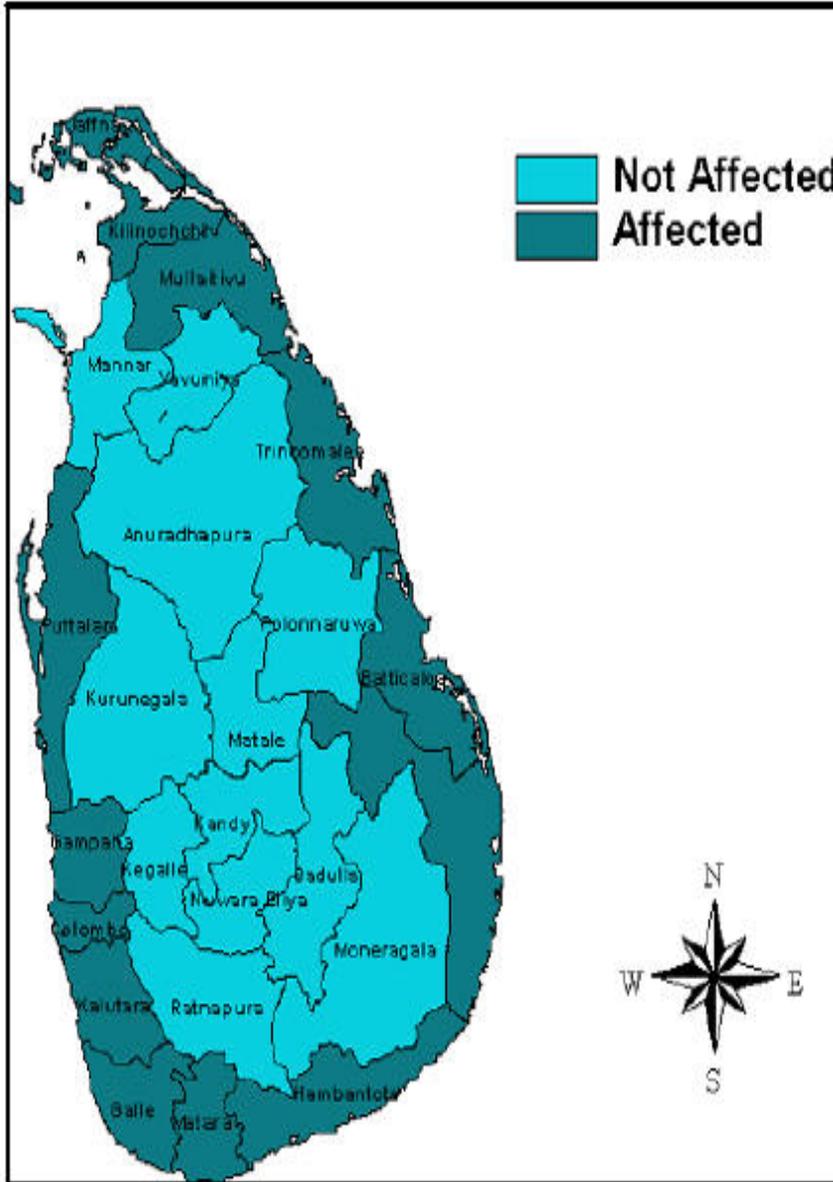
The magnitude and the geographic extent of the disaster were such that it affected people from a range of socio-economic, ethnic and religious backgrounds. More women and children died since most men were away from their homes and in certain instances cultural practices prevented women from seeking safety.⁵ Many of the deaths have been attributed to the lack of knowledge about tsunamis amongst the local community members who did not know how to react to such a phenomenon.

Large numbers of people were displaced as a result of the tsunami and forced to live in IDP camps and then move to temporary shelter prior to being resettled or relocated. The provision of food, shelter, water and sanitation, health services and other facilities for people living in camps was carried out by civil society, non-governmental organisations and international humanitarian agencies in collaboration with the government of Sri Lanka. Despite the prevailing concerns at that time Sri Lanka did not experience any public health epidemics subsequent to the tsunami. However, according to anecdotal information there were instances of gender based violence, transactional sex and increase in alcohol use in camp settings especially during the recovery phase. More than three years after the tsunami, there are still some families living in camps or temporary shelter who seem to have limited livelihood options.⁶

⁵ According to anecdotal evidence some women refused to leave their homes since they were 'inappropriately' dressed (they had been in their nightdresses and housecoats) when the tsunami hit them and other women did not want to leave the house without being accompanied by another adult since it was against their cultural expectations.

⁶ This information was obtained during the key informant interviews and the focus group discussions held with persons who were affected by the tsunami – some of whom are still living in camps/temporary shelter.

Figure 1: Tsunami-affected districts



Source: UN Standing Committee on Nutrition. Nutrition in Crisis Situations Vol. 5 Feb 2005

3.3 Livelihood contexts of the country/area and people

Despite experiencing a civil conflict of more than 25 years, Sri Lanka's economy has been steadily growing; over the past few years, the economic growth rate has been between 5 to 5.5% and even in 2004 when Sri Lanka was affected by severe drought and the tsunami, the country was able to achieve an economic growth rate of 5.2% (NCED 2005). In 2007, Sri Lanka's per capita income exceeded US\$ 1000.00, a rate higher than most of its neighbouring countries (UNFPA 2007). Its per capita Gross Domestic Product (GDP) and Gross National Product for 2007 were US\$ 1,617.00 and US\$ 1,599.00 respectively – again reflecting better economic conditions than most other South Asian countries (Central Bank 2007). In 2007 Sri Lanka ranked 99 out of 177 countries on Human Development Index (HDI), with an index of 0.743 (UNDP 2007a). Still, the conflict has slowed economic development and progress especially in the Northern and Eastern provinces and poverty remains a concern for Sri Lanka with more than 5.6% living below the poverty line of US\$ 1.00 per day and more than 41% living below the poverty line of US\$ 2.00 per day. (UNDP 2007b)

A majority of Sri Lanka's population (approximately 85%) live in rural areas. They also account for more than 90% of the population who are considered poor (NCED 2005). Several districts, especially those in the Northern and Eastern provinces and a few in the Southern and Sabaragamuwa provinces are considered least developed with less access to basic health, education, water and sanitation and social services in relation to the rest of the country. Urbanisation has been increasing over the years and the western province remains the most populous in the country, but still a large number of people travel daily from more rural districts to Colombo for employment purposes. Internal migration from rural to urban is becoming increasingly common given that certain districts, and especially the district of Colombo, are more industrialised and offer greater employment opportunities than the rest of the country.

Sri Lanka used to have a strong agriculture based economy but it has now changed to one which is dominated by the services sector (ibid). In 2004, the services sector contributed most to the country's GDP, followed by the industrial and agricultural sectors. While the agricultural sector is no longer the primary contributor to the GDP, it still does account for approximately 20% of a national output and provides employment for over one third of the workforce (ibid). In line with the above mentioned changes, the composition of exports has also changed over the years. From 1990 to 2007, there has been a decline in agricultural exports of more than 17% and an increase in industrial exports of more than 26%, with the apparel industry dominating the export sector.

Agriculture is the main source of livelihood in rural areas. However, in the tsunami-affected coastal areas, fisheries are an important source of employment and livelihood. In the southern province, especially in areas such as Seenigama and Hikkaduwa, coral mining was also a means of livelihood for the local population. According to the tsunami Evaluation Coalition, approximately 3% of the labour force (200,000 people) lost their jobs because of the tsunami with half of them being from the fisheries and the remainder from the tourism and informal sectors. They also report a reduction in the usage of agricultural land and fishing waters subsequent to the tsunami and a shift in employment patterns from fishing to casual labour or work in the NGO sector (2006). Some of the persons we spoke with during the field visits, especially those living in camps, also indicated a change in their means of livelihood. It is important to note, that for them, these changes were brought about through lack of choice and limited opportunities rather than being a deliberate shift to alternative forms of employment. Many of those who were fisherman prior to the tsunami mentioned that they no longer could go fishing since all their equipment (boat, motor, fishing nets, ice boxes) was destroyed in the tsunami and they had not received any livelihood support to continue fishing from humanitarian agencies. Some of them had received bicycles from humanitarian agencies and so they had resorted to using these to cycle to neighboring communities to sell fruits and vegetables for their livelihood. Others, who had received carpentry tools through humanitarian agencies, were now working as assistants to full-time carpenters.

3.4 Health environment prior to the emergency

Sri Lanka has health indicators which are comparable to and better than some middle income countries. The life expectancy for women is 75.9 years and 69.9 years for men. The maternal mortality ratio is 58 per 100,000 live births and 96% of all births are monitored by trained attendants. Infant and child mortality rates are 12 and 14 respectively per 1000 live births (UNDP 2007b). Nearly 99% of children are fully immunised against tuberculosis and measles by the age of one year. Improved sanitation and access to clean water is available to a majority of Sri Lankans at 91% and 79% respectively. However, despite all these positive indicators, 22% of the population are undernourished and 29% of children under five are under weight for age. The prevalence of HIV, as mentioned before, is low. In 2003, 47% of the new episodes of STIs reported were amongst men and women in the age group of 20-39 years thus indicating an increase in the prevalence/reporting of STIs in this age group (Ministry of Health 2004).

Universal free health care, both preventive and curative, and including the provision of prescribed drugs, is available to all Sri Lankans, although access to and the quality of services are more limited in the districts of the Northern and Eastern provinces. Total expenditure on health (both public and private expenditure) constitutes approximately 4.3% of the GDP (UNDP 2007a). The public health sector expenditure on health is approximately half of this amount or 2% of the GDP. So, with the exception of the underserved districts, access to healthcare is relatively good and more than 60% of the country's population depends on the public healthcare system (Ministry of Health 2001). In recent times, there has been a surge in the use of private hospitals due to overcrowding, long waits and queues at public hospitals. However, since most of the population cannot afford the high private hospital charges, they continue to rely on public hospitals for services, many of which have insufficient resources, infrastructure and staff (CPA 2007).

The government's preventive healthcare system is structured so that there is one Public Health Midwife (PHM) - also known as Family Health Worker (FHW) - for every 3000 to 4000 persons and one Medical Officer of Health for every 60,000 to 80,000 persons. They, together with the Public Health Nurses and the Public Health Inspector (PHI) and PHM are responsible for promoting health and wellbeing at community level. Conducting awareness programmes on various health issues, providing pre and post natal support to mothers and addressing the health, nutrition and wellbeing of children up to the age of 5 years are some areas which fall under the purview of preventive health services. In addition, the Public Health Inspectors are also responsible for ensuring that public facilities maintain minimum health and hygiene standards. The preventive health staff, works together with the curative sector staff based at clinics, base hospitals and/or tertiary care hospitals at district/provincial level.⁷ Medical Officers specialising in STIs, Mental Health and/or Maternal and Child Health work in both the preventive and curative streams to provide services to the community and the patients

National Health Policy Context

A range of policies to address the health needs of the population have been formulated by the government of Sri Lanka. The National Health Policy formulated in 1996 provides a general framework for the delivery of public health programmes and services and includes STIs and HIV/AIDS as areas requiring focussed attention (Centre for Reproductive Rights 2004). The Population and Reproductive Health Policy of 1998 also indicates that the prevention of STIs and HIV/AIDS is priority concern for Sri Lanka. The government, in its effort to prevent the spread of HIV incorporated the prevention and control of the infection to its STI control programme in 1985

⁷ These three offer different levels of health care and support to the community. Clinics are generally single purpose service points which provide a particular service such as child health or maternal health. They can be located at the field or in a hospital. There are also several polyclinics which cover a broader scope and provide a range of services such as reproductive health. Base hospitals will include the major specialities of medicine, surgery, obstetrics and gynaecology and paediatrics and provide services in all these aspects. Some base hospitals also have specialised STI, eye and ENT services. Tertiary hospitals are larger, often have teaching facilities, and include the above mentioned specialities as well as their sub-specialities. They also serve a larger population.

and renamed the programme as the National STD/AIDS Control Programme (NSACP) under the Ministry of Health (DHS 2000).

At present there is no comprehensive national policy on STI and HIV/AIDS even though a draft policy is available and in the process of being finalised.⁸ The government has, however, developed several strategic plans for the prevention and control of STI and HIV/AIDS and the most recent one covers the period between 2007 and 2011. The stated aim of the current National Strategic Plan (NSP) is to maintain low HIV prevalence amongst the most-at-risk-population (MARP) and the general population and to increase the quality of life of those infected with HIV (MoH 2007). The provision of VCT and access to ART was included in the previous NSP (2002-2006) but is further emphasised in the present NSP, which calls for greater involvement of NGOs in efforts to prevent the spread of HIV.

VCT and ART

Access to VCT is available at district level clinics (there are 30 STD clinics in different parts of Sri Lanka) and at the National STD/AIDS Control Programme (NSACP). Several NGOs also provide voluntary counselling but have to refer clients to government clinics or private sector hospitals for testing. The initial testing for the virus (the Elisa test) can be carried out at the district level or in private sector hospitals but the confirmatory test (Western Blot) can be carried out only at the NSACP thereby making it possible for the government to register all persons who are confirmed as being HIV positive.⁹ The government ART programme commenced in December 2004 and treatment is made available only through the NSACP in Colombo. Only persons with a CD4 count of 200 or below are given ART.¹⁰ There are 111 patients¹¹ receiving ART through the NSACP and the treatment is made available on a monthly basis after checking for the CD4 count. There are no NGOs which provide ART to PLHIV but it is not known if any (or how many) PLHIV receive treatment through private practice. Even though travelling to Colombo is likely to result in difficulties for persons living in distant districts and especially in conflict affected areas we were informed by various informants (including some PLHIV) that patients prefer to travel to Colombo since this enables them to obtain their medication without having to reveal their status to their community/family.

ART and medication for opportunistic infections are provided for free to all patients by the government. World Bank funding is used to provide free ARVs which cost approximately US \$250 per month per patient. The state meets the cost of opportunistic infections through its own budget. There is no established Home Based Care (HBC) programme available in Sri Lanka. A few NGOs support PLHIV by attending to their immediate needs but these efforts are not streamlined or coordinated. Given the low prevalence rate of HIV in Sri Lanka, HIV-related orphans and vulnerable children (OVC) are few. As mentioned elsewhere in this report, there are only 31 recorded cases of HIV transmission from mother-to-child but a special programme on PMTCT training has now been introduced by the state health services.

3.5 Cultural context prior to the emergency

The Sri Lankan cultural context precludes open discussion of any issue related to sexuality and/or sexual behaviour outside of marriage. People, especially women, are expected to remain virgin until marriage and extra marital sex, even though it takes place, is rarely acknowledged. However, an island wide survey on adolescence, conducted by UNICEF revealed that young people are sexually active and do not practice effective contraception (2004). According to this survey the average age at first sexual intercourse is 15.3 and 14.4 years for school going boys and girls respectively. Similar trends were found amongst out-of-school youth. Of the total population, even

⁸ This information was obtained from the interviews conducted with staff members of the NSACP.

⁹ This information was obtained from the interview conducted with the Director of the NSACP.

¹⁰ Interview with Dr. Neelamani Punchihewa of the NHAPP.

¹¹ Dr. Ariyaratna, of the NSACP, indicated that this figure fluctuates regularly since the number of patients on ART changes according to the frequency of new cases and those who die/pass away.

though only 6% admitted to having had heterosexual intercourse, nearly one fifth of the sample mentioned they had friends their age who were sexually active. Furthermore, the national average of teenage births is 8.6% of total births and as high as 16% in more remote districts.

Marriage is the norm rather than the exception although the average age at marriage has been steadily increasing and is 24 and 28 for women and men respectively. The legal age at marriage is 18 years except for when minors can be given in marriage with parental consent or for those who are governed by Muslim law (Centre for Reproductive Rights 2004). However early marriage, is not uncommon in rural settings, in conflict affected areas, and amongst certain ethnic communities. According to UNDP, early marriages are fuelled by poverty and in some cases, are attempts to avoid recruitment of young people by armed groups (South Asians for Human Rights, 2007). The importance of chastity, responsibility, appropriate marriage and having children is promoted at both micro and macro levels and especially apply to women. Apart from these values being promoted in families, programmes on sexual and reproductive health conducted by NGOs also follow similar approaches. Further, family life education/life skills education, is also included in school curriculum; this includes components on: self-discipline; complying with elders and community leaders; obeying the law; non violent communication; negotiating skills; fulfilling one's responsibilities; protecting one's rights, collective responsibilities and actions; and respecting one's culture. Awareness programmes on HIV/AIDS, more often than not, are also conducted to promote abstinence till marriage and then being faithful to one faithful partner. Condoms are promoted and distributed by NGOs only amongst the so-called MARP. The two district level MO-STIs informed us that they distribute condoms only to sex workers, beach boys and married couples.

Compared with other countries in the region, Sri Lanka's gender disparities with regard to literacy, infant mortality, access to health care and enrolment primary, secondary and tertiary education are considered minimal (UNDP 2005). However, women still face inequality and discrimination both at the micro and the macro levels. Sexual harassment in public places or in places of employment and domestic violence continue to be serious concerns even though both are punishable by law. The rise in early marriages, especially in conflict affected areas, is likely to increase women's vulnerabilities and decrease their negotiating skills with regard to relationship dynamics. Fear of further harassment and stigma prevent women from reporting most forms of harassment and violence even though several Police stations have Women's Desks specifically for this purpose. At a macro level women may face discrimination in the employment sector and the low level of female representation in the parliamentary system (at just 4%) can be taken as an indication of macro level inequalities Sri Lankan women still face.

Sex work is illegal and punishable by law. According to IOM officials and sex workers interviewed, the possession of condoms is considered synonymous with sex work and women can be arrested for having condoms on them.

Homosexuality is also illegal and while at one level, cultural taboos prevent men and women from revealing their sexual orientation, at another level homosexual behaviour is accepted as a common practice amongst adolescent and young adults but is seen as a passing phase. In a study conducted among male university students, 50% of respondents are reported to have had their first sexual encounter with another man (Silva *et al* 1997). Furthermore, the phenomenon of beach boys, young men who work in coastal areas and offer sex (to both men and women) for some form of payment, is common in Sri Lanka. Same sex behaviour among women is less heard of and/or tolerated by the community and represents an area for further research.

There are no known local beliefs on how HIV can be cured using traditional and/or Ayurvedic practices. However, belief in certain myths on how HIV can be transmitted or how/what a person who is HIV positive should look like are still prevalent: for example, beliefs that a healthy looking person cannot be HIV positive, that HIV can be transmitted through mosquito bites or through sharing cutlery and crockery are some of the commonly held misconceptions. Stigma and discrimination against PLHIV are high – not just among the general population but even among

those working in the health sector.¹² According to the BSS (2007), awareness on HIV/AIDS varies, with some groups having a good knowledge on the subject and others having heard of HIV/AIDS but unaware of methods of transmission and prevention.

4.0 Programmatic response

4.1 What was the emergency response?

According to an EU report on the tsunami response, the initial emergency response to the tsunami was spontaneous, uncoordinated but largely successful (EU, 2005). Rescue and life saving activities were undertaken almost instantaneously. Medical aid was given within hours, bodies buried and aid mobilised within a day (Frerks and Klem, 2005). Access to food, water, basic health care and shelter appears to have been adequate in the initial relief phase, with a few exceptions, although the situation in IDP camps is perceived to have deteriorated in the longer-term recovery phase. Providing for basic needs took priority over addressing sexual health issues and preventing the spread of HIV.

Sri Lankan Civil Society:

Immediately after the disaster struck, survivors themselves, their friends and relatives, local authorities and NGOs jump-started relief operations to provide lifesaving services to survivors (Fritz Institute, 2005; TEC 2007). Many community groups and NGOs provided food, health supplies and services, water, and other basic necessities to thousands of families throughout the country. Sarvodaya, one of Sri Lanka's largest national NGOs, was one of the first to deliver aid to the tsunami-affected people in many parts of the country, while the Tamil Rehabilitation Organisation (TRO) provided emergency assistance especially in the North and East (Joint ADB, JBIC and WB report, 2005). SEWA Lanka, the Salvation Army and the Sri Lanka Red Cross (SLRC) were among the many local NGOs instrumental in providing emergency relief and rehabilitation including emergency shelter, transportation and distributing food and non-food emergency relief items, clearing debris and providing psycho-social support to families. Over the following year, emergency relief shifted to longer term recovery, broadening into areas such as transitional housing, community health and development, livelihood support, including cash transfers and income generation programmes.

Government response:

“On December 27, Sri Lankan President Kumaratunga addressed the nation and promised full support to the tsunami victims and enacted several emergency response mechanisms to expedite relief activities. The day after the disaster, the Government released LKR 93 million from the National Treasury to facilitate relief operations in ten of the affected districts. In addition to this, a Centre for National Operations (CNO) was eventually formed under the President's Secretariat to oversee and monitor emergency programs and liaise with relevant line ministries, NGOs, the private sector, and other organisations contributing to the relief and recovery phases. Three new task forces comprising representatives of the public and private sectors were also formed under the President's Secretariat: the Task Force for Rescue and Relief, the Task Force to Rebuild the Nation, and the Task Force for Logistics and Law and Order. At the district level, Disaster Management Authorities were appointed to coordinate local relief efforts.” (Joint ADB, JBIC and WB report, 2005)

The above extract is taken from a Joint Asian Development Bank, Japan Bank for International Cooperation and World Bank report, commissioned by the Government of Sri Lanka soon after the disaster struck. The report describes how, as of January 18, the government distributed more than

¹² Information obtained during the FGDs and IDIs

2,300 tents, 20,000 metric tons of food, clothing, and other necessities to tsunami victims and opened hundreds of temporary shelters. It also dispatched the military to assist with the search and rescue phase and to help distribute relief items.

However, according to some, the government of Sri Lanka's immediate response was slow and overly centralised, and needs assessments and consultations with affected communities were inadequate (Harris 2006; TEC 2007; EU, 2005; Frerks and Klem 2005). According to an EU report, it took the government a week to set up a coordinating body (2005). There are also reports of aid becoming subject to patronage and clientelism (EU, 2005). Evidence obtained through KIs and FGDs during the assessment also indicate that this was the case. Several respondents at both government and community level observed that areas and individuals with better links to government officials received more aid.

International Community:

International relief aid was mobilised within a very short time period, and on an unprecedented scale (TEC Evaluation on LRRD 2007). By January 6, just 10 days after the tsunami hit, contributions in cash and kind of around \$22 million had been pledged by bilateral donors for post-tsunami relief programs, channelled mainly through national and international NGOs (Joint ADB, JBIC and WB report, 2005).

Over 170 international governmental and non-governmental organisations registered with the government of Sri Lanka offering assistance, in addition to the countless local level initiatives (Frerks and Klem 2005). The United Nations Office of Coordination and Humanitarian Assistance (OCHA) immediately deployed the United Nations Development and Assessment Coordination (UNDAC) Team to the country, to provide technical assistance for the management and coordination of the disaster response. The United Nations Development Programme (UNDP) also provided assistance to the Government to coordinate relief efforts. Other specialised UN agencies, such as the World Health Organisation (WHO), United Nations Children's Fund (UNICEF), the International Organisation for Migration (IOM), the World Food Programme (WFP), and the United Nations Population Fund (UNFPA) provided emergency assistance.

The response of international humanitarian agencies has been described as a 'second tsunami' which led to an oversupply of aid in some areas, particularly in the East (Harris, S. 2006) While international relief undoubtedly played a crucial and necessary role, the rapid proliferation of I/NGOs in Sri Lanka and an over abundance of aid is thought to have had some considerable negative side effects such as interagency competition, lack of co-ordination and the creation of a 'culture of dependency' (Frerks and Klem 2005; Harris, S. 2006). An issue that was raised repeatedly during the KIs is that of UN agencies and INGOs weakening national and local level emergency response capacities by 'poaching' government and local NGO staff.

Private sector:

Private giving from the general public and corporations - ranging from international sports conglomerates such as the International Cricket Council to global firms including Daihatsu Motor Company, Dow Chemical, Nestle Corporation, Microsoft, Shanghai Banking Corporation (HSBC), Vodafone, Coca Cola, Shell Corporation, Exxon, and News Corporation, broke all records (Joint ADB, JBIC and WB report, 2005; TEC Synthesis Report, 2007)). According to the TEC report, over 80 percent of private funding went to 12 agencies and consortia.

4.2 How was HIV addressed in the emergency response?

This assessment found that there did not appear to be a systematic emergency response to address sexual health among populations affected by the tsunami. Very little was done to prevent the potential spread of HIV in the emergency phase. Provision of food, water, sanitation, basic health care and shelter overshadowed concerns about sexual health in IDP camps and villages. Sri

Lanka's relatively low HIV prevalence rate was the main reason given for this. HIV prevention was seen as an unnecessary burden on already over stretched field staff and a waste of resources.

Discussions with the previous Country Representative for UNAIDS revealed that an Action Plan for Responding to HIV and AIDS in Emergency settings for Sri Lanka had been drafted in collaboration with the NSACP and UN agencies including FAO, ILO, IOM, OCHA, UNDP, UNFPA, UNHCR, UNICEF, WB, WFP and WHO. However, an assessment of the implementation of the action plan, jointly conducted by UNAIDS and WFP in Batticaloa in June 2005 revealed that few of the agreed actions had been implemented. Some of the findings included:

- HIV and AIDS awareness programmes were not being carried out in all camps;
- leaflets and posters on protection and awareness were not being distributed through all channels (WFP food distribution; NGOs working in camps);
- medical personnel, police and NGOs were not adequately integrating HIV and AIDS into their existing programmes;
- levels of HIV/AIDS knowledge and awareness among affected populations was low; water and sanitation issues were being adequately addressed in camps;
- medical supplies, including condoms, were also adequate but condoms were provided only as a form of contraception and not linked to STDs or HIV/AIDS;
- the Medical Officer for Sexually Transmitted Diseases (MO-STD) has not been involved in any awareness raising activities in camps;
- blood supplies were adequate and all donations were screened.

None of the UN staff interviewed during the current assessment knew about or mentioned the action plan.

On the whole, national STD and HIV clinics and services continued to operate during the post-tsunami period, although some hospitals and STI clinics were severely damaged, including one visited by the assessment team in Galle District. The Government MO-STD in Balapitya stated that he had been involved in a few HIV awareness programmes in tsunami-affected areas and camps in the district, but these were ad hoc and NGO driven. The MO-STD in Galle stated that she was not involved in HIV awareness in response to the tsunami and that her work focused on general health provision.

Findings from key informant interviews with government and I/NGO staff, as well as people living in camps, suggest that two to three months after the tsunami, some INGOs and NGOs such as the SLRC, IOM, the Salvation Army, ActionAid and the Family Planning Association (FPA) began to incorporate HIV awareness and prevention into their health programmes in IDP camps and villages, often using general health, sexual and reproductive health and/or community development as the entry point. However, such programmes tended to be ad hoc, targeted at the general population and limited to awareness and information campaigns. Some distribution of leaflets and playing cards with HIV messages on them was carried out by IOM in collaboration with UNAIDS.

The majority of I/NGOs interviewed stated that they did not actively distribute condoms as this was deemed culturally inappropriate by both government authorities and communities. An exception to this was one Public Health Inspector (PHI) from Galle district who apparently recruited volunteers from within communities to distribute condoms. According to him, the demand for condoms was high but communities were unwilling to approach government health staff directly. Reasons for this could include low levels of knowledge about condoms and the stigmatising belief that condoms are linked to multiple sex partners and sex work.

The team found that, on the whole, some Sri Lankan civil servants, including those from the National STI and AIDS Control Programme (NSACP) and National Dangerous Drugs Control Board (NDDCB), and NGO staff placed a strong emphasis on 'moral' values and indicated that the low HIV prevalence rate in Sri Lanka could be attributed to its culture. Many were not in favour of

condom promotion or distribution, seeing it as inappropriate in the Sri Lankan context and linking it to 'illicit sex' and adultery. Abstinence and being faithful were the preferred methods of HIV prevention. As one key informant put it, 'Condoms encourage people to do the wrong thing the right way'. Another key informant stated that Sri Lankan culture was unique in that Sri Lankan people are not interested in sex and did not engage in promiscuous behaviour. They admitted that sex work did go on but this was mainly with foreign tourists who come from 'outside'.

An interesting finding concerns the UNAIDS 'Keep the Promise' campaign for World AIDS day in 2006. The slogan was originally an appeal to governments, policy makers and regional health authorities globally to ensure that they meet the many targets that have been set in the fight against HIV and AIDS, and in particular the promise of universal access to HIV treatment, care, support and prevention services by 2010. Key informant interviews with civil servants and NGOs revealed that this message had been misinterpreted in the Sri Lankan context to mean 'Keep the promise to your husband/wife' i.e. be faithful. This is a prime example of the cultural barriers to HIV prevention in Sri Lanka and a lack of cultural insight on the part of international campaigns and slogans.

5.0 The effects of the emergency

5.1 Vulnerability to contracting HIV

The main objective of the study was to assess the ways in which the tsunami affected not only general or indirect vulnerability to contracting HIV (through displacement, loss of livelihoods, changes in social norms and family structures, trauma, fatalism and disruption to health services), but also specific HIV risk behaviours such as unsafe sex, injecting drug use, SGBV and sex work. Given that HIV was not considered a priority in the tsunami response, the researchers found very little field-level information on the impact of the tsunami on HIV vulnerability and risk behaviours. Thus, the following sections are based largely on information collected through KIs and FGDs. They attempt to answer the question: *who has become more vulnerable to HIV as a result of the tsunami and why?*

Displaced populations:

Women:

The safety of women and girls in the aftermath of the tsunami emerged as a serious issue. According to an EU report, there were numerous reports of rape of women and girls following the tsunami both within and outside unsegregated shelters without family protection. Attention to the safety, privacy, sexual and reproductive health of women and girls was not adequately integrated into the management, coordination and infrastructure of camps (EU, 2005). The CATAW report 'After the Wave: Moving On' states that from the immediate aftermath of the tsunami, women were subjected to incidents of rape or forced marital sex, forced miscarriages or abortions and domestic violence (2007). They go on to report that sexual and gender based violence (SGBV) was experienced by women from different age and ethnic groups, that they were blamed for their experiences of SGBV and that many of the perpetrators were known to the women thus making it difficult to report their experiences.

In nearly all the interviews and the FGDs conducted, the researchers were informed that sexual violence against women was a problem in the immediate aftermath of the tsunami. Though instances of rape, sexual violence and/or harassment were reported to have taken place, informants indicated that few, if any, had been officially reported due to fear of further harassment and stigmatisation. A PHI from Galle district informed us that a significant amount of sexual activity took place in the camps he was working in but was unsure if these activities were consensual or forced. During the FGDs with people living in camps, participants stated that lack of electricity poses a real threat to women's security at night. Women stated that, when they need to use the toilet, they go in pairs in order to increase their safety. One woman said "*This is the only camp in this area which never had electricity provided, so when it gets dark we cannot go about at all because it's not safe. Even when we want to go to the toilet, we have to ask some one to come with us*". A recent survey carried out by Oxfam and Swasti on the impact of the Tsunami on HIV vulnerability on 30 Indian coastal communities identified shelter design as a key factor leading to increased vulnerability. Close physical proximity, as well as lack of privacy for sexual relations between married couples (leading to the trend of seeking sex outside the couple) were both mentioned as having a high impact on vulnerability increase (Oxfam and Swasti, 2007).

According to staff members of the NGOs interviewed, increased sexual behaviours were common in all areas affected by the tsunami – be it forced or consensual sex. An informant at the Salvation Army, spoke to us about the phenomenon of 'tsunami babies' and indicated that this could be taken as evidence of increase in sexual activity soon after the tsunami; and it also points to the fact that people did not use protection during sex. However, given that there is no recorded increase in childbirth after the tsunami it is important to read this information with caution.

While women in general were made vulnerable as a result of the tsunami, widows, women who were separated from their husbands and young women have been noted as facing higher levels of to SGBV compared to others (ibid). However, the lack of hard data on levels of SGVB makes it impossible to draw any conclusions as to whether this increased HIV risk. For example, there are no data on the extent to which rape occurred during the post-tsunami period among affected populations. According to our interviews, much of the sexual and physical harassment/abuse took place in camps and we were not able to obtain any information on, whether women who moved in with relatives or friends had to face similar experiences.

Men:

For a number of reasons, ranging from lesser ability to swim or climb trees to being trapped in homes or looking after children, the tsunami killed more women than men (Ariyabandu, M. 2003; TEC Evaluation, 2007; EU, 2005). Small scale estimates suggest that as many as three-quarters of tsunami casualties may have been women (Oxfam, 2005 in EU, 2005). Thus, many of those left behind are bereaved single men. The problems and vulnerabilities of bereaved single men differ from those of women. They are less to do with physical safety, and more to do with emotional needs and prevention of alcohol and drug abuse, violence and unprotected sex. While some NGO programmes have addressed the practical needs of men and their children with regard to housework and childcare, for instance, targeted support for men who lost their wives appears to have been neglected (SouthAsiaDisasters.net, 2005).

According to key informants, there was an increase in levels of alcohol consumption amongst men who were displaced, after the tsunami although again, no research had been carried out on this and no baseline data was available. With increasing alcohol and drug use, it is possible that levels of SGBV and risky sexual practices increased. An interview with the team leader of a recent joint UNAIDS/UNHCR HIV risk assessment among conflict affected populations (report forthcoming) stated that this was also the case in the conflict affected areas. Some sex workers reported an increase in SGBV towards them soon after the tsunami and refusal by men to wear condoms (see section on FSW below). The increased vulnerabilities which men may have faced in the immediate aftermath and during the recovery phase of the tsunami were not raised as key concerns in any of the interviews or FGDs conducted during the assessment.

Children and young people:

Many boys and girls were made vulnerable as a result of the tsunami by either losing one or both parents or by the mere fact that they were placed in a setting which did not offer them the same levels of protection that were available prior to the tsunami. Some key informants stated that girl children were vulnerable to sexual exploitation but again they were of the opinion that none of these incidents would have been reported to the police. The MO-STI in Balapitiya also alluded to the possibility of child trafficking subsequent to the tsunami but did not have any data to back his premise.

The MO-STI in Galle mentioned that abuse of boys and young men took place during the post-tsunami and attributed this to the lack of protection parents offer to boys compared to girls. She indicated that the increased number of unknown persons who were working and providing humanitarian aid in the camp settings made boys equally vulnerable to abuse. She related that two male children had been sexually abused and were subsequently tested and treated for STIs. According to her, one of them had also started abusing alcohol and drugs thus increasing the likelihood of HIV risk behaviours. She said, "in our culture we pay a lot of attention to protecting the girl child and maintaining her chastity and boy children are rarely thought of in the same way. But they also have to face great risks and can be sexually abused which our parents very rarely think about".

There were also reports of fatalism among young people immediately after the tsunami. A PHI-STD from Galle district, who was involved in the provision of health services to 8 IDP camps stated

that young people were in shock following the tsunami and began to engage in risky sexual behaviour with no thought or care for their futures. According to him, “Soon after the tsunami, young ones didn’t know what the future held for them and so they just went around behaving in ways which they normally would not do, engaging in promiscuous behaviours, without a care in the world”.

The consultants also heard reports of young girls ‘mixing’ with military forces protecting the camps although it was not made clear whether these girls were engaging in sex. The 10pm lights off policy in the camps apparently afforded some protection, although groups of young men were said to have ‘roamed’ around looking for young women.

MSM:

The category ‘MSM’ refers to sexual behaviour rather than identity and is therefore extremely broad, capturing a wide range of people with different sexual identities and practices. Some MSM in Sri Lanka identify as homosexual but marry women due to social and cultural pressure and stigma. As one informant pointed out, “there are two types of men in Sri Lanka: those that are married, and those that are about to be married”. Others consider themselves to be heterosexual or bi-sexual and engage in sex with men, either for pleasure or for material benefit (also see section on Beach Boys below).

The criminalisation of homosexuality in Sri Lanka, and the lack of social acceptance of, and safe spaces for, MSM undoubtedly contributes to unsafe sexual behaviour and may increase the likelihood of men having multiple partners since monogamous relationships between men cannot be formalised (COJ 2005). A KAP survey conducted by Companions on a Journey - a Colombo-based NGO, which provides HIV-related services and safe spaces to gay-identifying men and MSM, as well as campaigning for decriminalisation of homosexuality - in June 2007 revealed high rates of unprotected sex among the homosexually active community. Even though the findings from this survey cannot be extrapolated and applied at a national level, the wide range of sexual practices engaged in by the participants of this survey, the finding that many of them have or have had sex with women and the low use of condoms in their various sexual encounters have implications for HIV transmission in Sri Lanka. Furthermore, a recent BSS survey carried out among 302 MSM revealed that only 25.9% reported always using a condom during sex with regular male partners and 46.5% reported always using condoms with casual male partners. Almost a quarter of the sample (23.0%) had had sexual intercourse with a woman in the previous 12 months.

Anecdotal evidence suggests that discrimination against MSM keeps them away from STI treatment and HIV prevention, testing and counselling. NGOs working with MSM stated that they are reluctant to work with the government as it actively discriminates against MSM and might attempt to undermine their programmes.

Due, partly, to low coverage of NGOs and/or government programmes targeting MSM, very few data were available on MSM in relation to the tsunami.¹³ Discussions with Companions on a Journey revealed that several members of their network had been directly affected by the tsunami but it was not possible to assess whether or not risk behaviours among MSM had increased as a direct result of the disaster.

One male sex worker, who had been internally displaced by the tsunami, stated that levels of sex work among MSM had decreased in the immediate aftermath of the tsunami, mainly because curfews in IDP camps and temporary shelters prevented sex workers from going out after 10pm. He also stated that sexual exploitation of MSM was occurring in camps and transitional shelters by the local police and armed forces imposing the curfews. According to him, members of the local

¹³ There are only 4 NGOs providing information, services and promoting the rights of MSM in Sri Lanka. These are Companions on a Journey, Women’s support group, Equal Ground and Community Strength Development Fund.

police and military would have sex with MSM operating as sex workers and then refuse to pay them. He was not aware of any condoms or HIV prevention programmes in the camps.

Discrimination against MSM in terms of aid provision was also highlighted as an important issue. As unmarried men without children, MSM were not considered a priority for food aid, cash transfers, shelter or any other kinds of assistance. Aware of this problem, Companions on a Journey had used limited funds from foreign supporters to provide temporary shelters for around 6 or 7 members of their MSM network who had been directly affected by the tsunami but they admitted that, given their limited capacity, they could not assist everyone.

No information on HIV risk among MSM affected by the tsunami who were not in camps or transitional shelters was collected.

Beach boys:

One group considered to be most at risk of HIV infection in Sri Lanka is that of so-called 'Beach Boys'. Beach boys are predominantly young men who work near or on the beaches, typically tourist beaches, and who offer sexual services to tourists in exchange for some form of payment. These young men may also work as tourist guides and may not all identify as 'beach boys'. Beach boys may also be working in restaurants, hotels, guest houses and boating-related tourism (BSS 2007).

Condom use among beach boys with both regular and non-regular partners has been found to be low: out of 553 beach boys interviewed during the recent BSS survey, only 4.8% reported always using a condom with regular female partners and 21.6% reported always using a condom with regular male partners; 47.2% reported always using a condom with casual female partners and 45.9% with casual male partners (BSS 2007).

According to the Coordinator of the National HIV and AIDS Prevention Programme (NHAPP), a survey of sexual behaviour among beach boys and FSW had been planned for Jan 2005 (a few weeks after the tsunami hit) but when the research team arrived at the coastal areas, very few beach boys or FSW were found to be operating there. There are several possible explanations for this. Firstly, a high number of beach boys working on or close to beaches were killed by the tsunami. The MO-STD in Balapitya stated that a high number of his patients, who operated as sex workers on or near beaches, were killed in the tsunami. Secondly, the tsunami hit the coastal areas and had a negative impact on tourism. Many of the hotels and restaurants in which beach boys usually operate were damaged or closed following the tsunami, which meant that they could not work as usual. This points to a possible reduction in some HIV risk among beach boys following the tsunami, although more evidence is needed to confirm this.

Female Sex Workers:

Sri Lankan sex workers work at a range of venues: there are street/beach workers, those who work in brothels or from home, and workers in massage parlours, casinos, karaoke bars and hotels (BSS 2007). A FGD with 25 street-based FSW in Colombo revealed that the majority were from the South but travelled to Colombo to find work. For some respondents, sex work was their main source of livelihood. Others also engaged in petty trade such as selling incense sticks, food packets or poultry farming. Some were married and had children. All stated that poverty drove them to sex work and that they had no alternative means of income. Some were married to gamblers or drug users. Some had been directly affected by the tsunami and lost their homes and family members.

Information gathered from the FGD suggests that the tsunami temporarily reduced levels of sex work. One respondent described how she was so traumatised she could not engage in any sex work for some time after the tsunami. Another described how, having lost her home, she stayed with friends and family, which made it difficult to continue engaging in sex work as her hosts did not know what she did for a living. Several respondents described how the tsunami and recent floods

had made it more difficult and more expensive to travel to Colombo to engage in sex work. Some also complained that there were fewer clients after the tsunami and those that remained paid less.

None of the FSW interviewed entered into IDP camps following the tsunami, although some joked that they should have done as then they would have received houses, food and other types of aid. No sexual encounters with foreign aid workers were reported. The group stated that their clients were Sri Lankan and based in Colombo.

Several respondents reported an increase in sexual violence by clients towards sex workers after the tsunami. When questioned about this, respondents described how men who had lost their wives took their anguish and frustrations out on them. According to one woman the men were “angry that their wives, who were considered ‘good’ women had died in the tsunami and we were still alive and so they took out their anger on us”. Respondents also reported that some men turned to sex (most likely unprotected, although they did not state this) for comfort as a result of shock and grief. Sexual abuse of children was also raised as an issue for similar reasons. Respondents had heard of the children of other FSW being abused, although this was not necessarily related to the tsunami. One respondent stated that she was afraid to leave her daughter in the village as she did not trust her own male family members not to abuse the child but it was not clear whether this fear had increased as a consequence of the tsunami.

The respondents stated that they knew about HIV and that it could be passed on through oral, anal and vaginal sex. They also knew about condoms and stated that there were two types, regular and flavoured ones for oral sex, although none of them had seen or used the latter. They reported difficulty negotiating condom use with clients in general and suggested that this was most difficult for street- and beach-based FSW who were considered more vulnerable and less protected than those working in brothels or hotels. It is not clear whether ability to negotiate condom use decreased during the tsunami, but the fact that sex workers reported an increase in sexual violence by clients towards them and refusal by men to wear condoms suggests that it may have decreased. FSW stated that they could be arrested for carrying condoms and that sexual abuse and rape by police officers does occur but goes unreported.

Injecting Drug Users:

Sri Lanka has a high number of heroin users but few of them currently inject drugs (see epidemiology section 3.1). Given the low prevalence of IDU and the lack of HIV prevention programmes targeting them, it was not possible to collect any information on IDUs in relation to the tsunami.

According to the Director of Sri Lanka’s National Dangerous Drugs Control Board, one of the reasons for the low levels of injecting drug use in Sri Lanka is the lack of availability of liquid heroine. However, anecdotal evidence indicates this lack of availability has led some users to mix heroine with blood in order to inject it.

A key informant from the NDDCB informed us that there is no IDU taking place in prisons in Sri Lanka, although some prisoners have injected prior to being incarcerated. The MO-STD in Balapitya, who had carried out some HIV prevention programmes in prisons, stated that it is likely that government surveys carried out on drug use in prisons underestimate the levels of IDU given that the questions are presented in a language that drug users are unlikely to understand. Further research on IDUs and HIV risk is required.

5.2 Coping strategies/resilience of people affected by the tsunami

The SLRC stated that the number of women and girls resorting to transactional sex for survival did increase immediately after the tsunami. A former member of WFP staff also stated that transactional sex was taking place in camps in the post-tsunami period but that food distribution

programmes - food for education, food for work - and cash transfer programmes helped to keep levels down. The MO-STD from Balapitya observed that in the first two or three months, people got enough aid, whereas later on when aid levels decreased, levels of transactional sex increased. While the statement from the MO-STD appears to contradict evidence from the SLRC that transactional sex was happening in the emergency phase, this could reflect differences in different geographical areas. Nevertheless, according to our key informant interviews with NGOs and UN agencies, displacement and loss of livelihoods as a result of the tsunami may have led affected populations (mainly women) to engage in transactional sex for survival.

The team also heard reports, from NGOs which provided emergency relief in camps that young people who did not necessarily engage in sex work before the tsunami were going to beaches and hotels in search of sex work in the weeks and months which followed. Given the desperate circumstances, it may be assumed that those engaging in transactional sex would be vulnerable to engaging in unsafe sex and therefore at increased risk of contracting HIV.

According to one NGO, 'protection committees' and 'discipline committees' were formed within camp settings to minimise different forms of violence against women but it is not clear if these mechanisms were effective in achieving the stated goals. Family support, when available, seems to have been the most effective coping mechanism.

Trafficking was highlighted as an issue affecting tsunami survivors who had lost their means of livelihood. According to one member of medical staff from Galle district, there had been an increase in the number of people going to the Middle-East in search of work, but without data, it is not possible to link this directly to the impact of the tsunami.

5.3 The impact of the tsunami on PLHIV

There are only 957 recorded PLHIV in Sri Lanka and few were directly affected by the tsunami. At the time of tsunami, Sri Lanka's ART programme had just begun and, according to the NSACP, only two people who were on ART were affected. The NSACP stated that it had been possible to trace them and continue their treatment without any disruption despite the nature and the severity of the emergency.

According to Lanka+, Sri Lanka's only network for HIV positive people¹⁴, 15 of their current members were directly affected. Some had their houses washed away and lost family members. Some sought refuge in camps and shelters, others stayed with friends and family. Not all of the 15 affected knew their HIV status at the time of the tsunami and only 6 of those affected are currently on ARVs and 2 were on ARV at the time of the tsunami.

The assessment team spoke to 6 members of Lanka+ who had been directly affected by the tsunami. Of those, only two stated that they had been aware of their HIV status at the time of the tsunami; neither had received any special assistance nor revealed their HIV status to friends or family.

On the basis of discussions with PLHIV, it is clear that nothing was done specifically to support PLHIV in the aftermath of the tsunami. High levels of stigma and discrimination led most PLHIV to hide their status despite the fact that they had special needs. When asked what their HIV-related needs were during the post-tsunami period, participants listed adequate nutrition; ARVs; protection from malarial mosquitos (as malaria can further undermine PLHIVs' immune system); appropriate livelihood support; and the means to travel to Colombo to receive treatment.

¹⁴ Lanka+ carries out home and hospital visits, counselling, condom distribution and provides medicine and other medical equipment to PLHIV such as hearing aids. They also carry out awareness and prevention programmes and engage with the media regarding HIV. It receives its core funding from the World Bank.

According to all PLHIV interviewed, they strongly feared, and continue to fear, discrimination from family and the wider community. All respondents felt that PLHIV suffer more in disasters in Sri Lanka because they are scared of the discrimination they would face should their status be revealed. A female respondent had experienced discrimination by government hospital staff when giving birth; her mattress and clothes had been burned and her baby neglected. A married couple stated that schools had refused to enrol their HIV+ children. Another respondent had lost his job in Korea when his company tested him for HIV without his consent and immediately deported him back to Sri Lanka. One woman who claimed that she had contracted HIV through a blood transfusion commented that she would rather have died than received the infected pint of blood. A male respondent described his constant fear that he might infect his family, even though he realised that it was unlikely to happen. He felt that his HIV+ status hindered his ability to fulfil the traditional role of Sri Lankan man: to 'protect' his family.

Given that very few PLHIV affected by the tsunami were aware of their status at the time, and that those that were aware of their status hid it from the rest of the community, it was/is extremely difficult to reach any conclusions about the impact of the tsunami on PLHIVs existing vulnerability. Clearly, stigma and discrimination is a major barrier preventing PLHIV from accessing the services and assistance they require. A possible solution suggested by PLHIV themselves would be for aid providers to contact them in a crisis via Lanka+. In that way, they said, they would not need to reveal their status to anyone. Clearly, the implications of this for confidentiality would need to be considered. Respondents also recommended that awareness and stigma reduction campaigns should be carried out with government medical staff.

Coping strategies/Resilience of PLHIV

As mentioned above, the consultants only spoke with two PLHIV who were aware of their HIV status at the time of the tsunami; as, neither had divulged their status to their family or community; their coping strategies do not necessarily reflect their HIV status. They both lost their livelihoods – one the boat he used to go fishing and the other a small shop which he used to run with his brother – and their means of employment changed after the tsunami.

The person who lost his boat was given a new fishing boat by an international NGO but without the necessary equipment to run the boat. Since he did not have adequate resources to purchase the additional equipment and so was unable to put the boat to sea he has been renting his new boat to other fisherman and is earning an income from it. He no longer goes fishing but does piece work when the opportunity arises. The other man who lost his livelihood as a result of the tsunami was not able to go back to being a shop owner since his brother decided to move elsewhere after the tsunami and he did not get any funding to re-open the shop on his own. He has, since the tsunami, been employed at Lanka+ and lives with his mother and sister who do not know his HIV status.

The PLHIV who took part in the FGD relied largely on family support networks in the aftermath of tsunami. Some stated that they had no network to rely on and simply struggled alone. One couple had briefly sought shelter in a temple but left after a few weeks. Their decision to leave was due to unpleasant and over-crowded camp conditions but not because of their HIV status. Lanka+ was described as the greatest source of hope and support.

Food shortage was not considered to have been a problem. Those on ARVs stated that they had had enough food in order to continue to adhere to treatment, despite receiving no special food aid.

5.4 On service provision

Impact on health services

The tsunami destroyed and/or damaged several primary, secondary and tertiary care institutions in the northern, eastern and the southern provinces thus affecting, to some extent, the provision of quality health services by the public sector. The tsunami also affected healthcare personnel: some were killed in the tsunami while others lost their family members and/or property thus affecting their ability to provide services. The Provincial Director of Health Services (PDHS) for the Southern Province informed us that organisations like the SLRC and other international organisations supported the public health sector in meeting the immediate health needs of the tsunami. According to him, the main focus of the health services in the immediate aftermath of the tsunami was the appropriate disposal of dead bodies and increased efforts to prevent the spread of communicable diseases or the possibility of any epidemic. At the same time, the public health sector had also conducted programmes to educate the public on the possible emergence of new diseases.

The emotional needs of those who were affected by the tsunami and lost family members and/or their belongings were also given priority in all districts. Psychosocial support programmes, mainly in the form of counselling, were interventions provided by most organisations. The PDHS informed us that a community level mental health programme was launched in the Hambantota district with the support of the WHO and World Vision. The other general health needs of the population were met by conducting mobile clinics and there were special mobile clinics to address maternal and child health conducted by the district level health authorities. He also stated that there were no special programmes on the prevention of STIs, a statement which was supported by the Mo-STI for Galle who said that while she provided general health services she did not conduct any programmes of STI or HIV.

Several NGOs conducted HIV/AIDS awareness programmes following the tsunami but only few promoted condom use and an even fewer actually distributed condoms. However, of the NGOs that were interviewed for this case study only FPA admitted to distributing condoms in camp settings.

Condoms, when introduced in camp settings, were distributed predominantly through NGOs. However, very few of the NGOs that were interviewed for this case study admitted to distributing condoms. While some NGOs did conduct HIV/AIDS awareness programmes following the tsunami, few promoted condom use and an even fewer actually distributed condoms. In fact, of the NGOs that were interviewed for this case study, only the Family Planning Association (FPA) admitted to distributing condoms in camp settings. A PHI in Galle district, however, mentioned that he distributed condoms by recruiting health volunteers from within the camp settings and that there was a great demand for condoms.

It is unclear how accessible condoms were in different camp settings but it can be safely assumed that they were not easy to obtain. We were informed in nearly all our interviews that distributing condoms would have been inappropriate given that people were grieving and that there was no demand for them from the community. The only exception to this was the information we obtained from the above mentioned PHI and even he mentioned that he did not know why there was such a high demand for condoms – whether it was for their own use or for selling and making a quick profit. During our FGD with the persons living in camps, we were informed that several organisations conducted HIV prevention programmes. When they were questioned about the distribution of condoms all of them said that condoms were not distributed and it would not have been appropriate to do so.

On the whole, the provision of general health services, even though it was affected by the tsunami, was continued without necessarily being inaccessible to the population. According to the PDHS the public health sector partnered with the WHO, Red Cross, UNICEF, UNFPA and UNOPS to ensure the provision of health services. The Assistant Director of HIV at the SLRC mentioned that they were one of the first organisations to visit the tsunami affected districts and provide general health services through their mobile clinics. In terms of sexual health though, even the SLRC did not provide specialised or clinical services but conducted awareness programmes on the prevention of HIV. Other international humanitarian agencies specialising in the field of health, established themselves after the tsunami especially in the eastern province and supported the public health sector in the provision of health services. According to the previous Country Director of UNAIDS, however, universal precautions were not adhered to in the eastern provinces of Sri Lanka after the tsunami.

The NSACP, which is the only place where ART can be accessed, was not directly affected by the tsunami. Besides, the government ART programme began only in December 2004 and so the numbers of people on ART at the time of the tsunami were small. According to the NSACP only two people who were on ART were affected by the tsunami and it had been possible to continue their treatment without any disruption. There was no HBC programme in place at the time and no information was available on PMTCT during the time of the tsunami. As mentioned above, Sri Lanka has an effective blood screening programme and this process was not affected by the emergency. None of the three HIV positive cases which have been attributed to blood transfusion were in any way related to the tsunami.

Impact on other basic services (education, sanitation, nutrition etc.)

As mentioned above, food shortage was not a problem. The provision of food, especially in the immediate aftermath of the tsunami, was in abundance and it is only after three months or so after the event that food supplies, especially by private philanthropic actors, dwindled out. However, the WFP with the support of the government of Sri Lanka continued the provision of food rations to persons living in camp settings for several months after the tsunami. Water and clothes were provided in camps. Sanitation was highlighted as a problem. According to two respondents who had stayed in the shelter, there had been only one toilet for 400 people.

The tsunami destroyed many schools which were on the coastal belt which made it impossible for schools to reopen after the Christmas vacation according to plan. In addition, the schools which were not affected by the tsunami were used as transitional camps to house those who were displaced by the tsunami. So, for these two reasons access to education in affected areas was made difficult as a result of the tsunami. There were also reports of parents and children fearing a second tsunami and therefore not wanting their children to go back to schools which were located close to the sea. All these posed challenges in 'normalising' the situation for children who needed some form of structure in their lives to ensure wellbeing. The transitional shelters were moved and damaged schools were rebuilt subsequently but there was a delay in reopening schools after the tsunami.

Finally, hygiene and sanitation was a problem especially in the camps in the immediate aftermath of the tsunami. The tsunami waves had polluted most of the fresh water wells in the coastal belt which made it impossible to use these wells for drinking water. However, water for drinking and washing were subsequently supplied by humanitarian agencies. During our interviews, we were informed that there were limited numbers of toilets in most camps thus affecting the sanitary conditions of these settings. Despite these conditions, it is important to note that there was no outbreak of diarrhoea or any other water borne diseases in any of the tsunami camps. Further, the lack of privacy around the bathing areas and the distance to where the toilets were located were cited as causing discomfort for women living in the camps.

6.0 Conclusions/recommendations

Much remains to be done in determining risk factors for the spread of HIV in emergency settings in Sri Lanka, as well as the impact of emergencies such as the tsunami and ongoing conflict on the coping strategies of PLHIV and other emergency-affected populations and HIV-related programming and services in Sri Lanka. A lack of base line data on HIV risk behaviour among the general population, possibly due to low HIV prevalence rates and low prioritisation of HIV as a health issue, is one of the main factors preventing meaningful analysis of impact of emergencies on HIV. Sri Lanka is also a prime example of a country whose social and cultural barriers (including the illegality of homosexuality) limit access to accurate evidence about HIV-related behaviour, both before and after and emergency; if such information were available it might assist in informing humanitarian responses.

6.1 Evidence of the impact of the tsunami on HIV risk, PLHIV and HIV-services

In addition to pre-existing social and cultural factors such as low levels of knowledge about HIV, high levels of stigma and low levels of condom use the findings of the assessment suggest that displacement and loss of livelihoods may have resulted in increased vulnerability of affected populations to contracting HIV during the post-tsunami period. However, there is little data available on the ways in which HIV risk behaviours, via both sexual and non-sexual, were affected. Pre-existing low HIV prevalence, even among MARP, low levels of STIs, low levels of IDU and universal access to free health care all imply that levels of HIV risk prior to the tsunami were low. Furthermore, information gathered through KIs and FGDs identified several factors relating to the post-tsunami context which may have contributed to a reduction in levels of HIV risk in the immediate aftermath. Such factors include shock and trauma, which may have decreased sexual activity immediately following the tsunami; unprecedented levels of humanitarian aid (food, water, sanitation, shelter) which may have helped to keep levels of transactional sex low; and the negative impact of the tsunami on tourism and the sex industry in the coastal areas, where many sex workers and beach boys are reported to have been killed. However, there is also evidence that, as aid flows declined and camp conditions deteriorated, SGBV, transactional sex and trafficking were taking place among affected populations, which may have increased HIV risk. There were also accounts, from sex workers, of sexual violence and of men turning to (unprotected) sex for comfort as a result of shock and grief.

Key findings on vulnerable groups:

- There were reports of SGBV following the tsunami and of women and girls engaging in transactional sex for survival. According to KIs and secondary sources, attention to the safety, privacy and sexual and reproductive health of women and girls was not adequately integrated into the management, coordination and infrastructure of camps. Conditions of close physical proximity, as well as lack of privacy for sexual relations between married couples can increase HIV risk by leading to the trend of seeking sex outside the couple (Oxfam and Swasti, 2007). IDPs living in camps stated that the lack of electricity posed a real threat to women's security at night. Women stated that, when they needed to use the toilet, they went in pairs in order to increase their safety.
- Bereaved, single men were reported to have been more vulnerable to alcohol and drug use, with this leading to violence and risky behaviour such as unsafe sex. However data on this was anecdotal.
- The vulnerability of children to sexual abuse was highlighted as an issue and there were reports of fatalism among young people who, following the tsunami, were more inclined to engage in risky behaviours with little concern for their future. Young people who did not necessarily engage in sex work before the tsunami were reportedly going to beaches and hotels in search of sex work in the weeks and months which followed.

- MSM affected by the tsunami were reportedly vulnerable to discrimination in camps, possibly leading to increased vulnerability to transactional sex due to lack of assistance. There were also reports of sexual exploitation of MSM by police.
- Information gathered from the FGD with sex workers suggests that the tsunami temporarily reduced levels of sex work. One respondent described how she was so traumatised she could not engage into any sex work for some time after the tsunami. Another described how, having lost her home, she stayed with friends and family, which made it difficult to continue engaging in sex work as her hosts did not know what she did for a living. Several respondents described how the tsunami and recent floods had made it more difficult and more expensive to travel to Colombo to engage in sex work. Some also complained that there were fewer clients after the tsunami and those that remained paid less. FSW reported increases in SGBV towards them from bereaved men following the tsunami.
- Given the low levels of IDU in Sri Lanka, no data was available on the impact of the tsunami on this group.
- Of the 957 registered PLHIV in Sri Lanka, very few were affected by the tsunami and of those that were, even fewer were aware of their HIV status at the time. Evidence from FGDs with PLHIV points to extremely high levels of stigma and discrimination against PLHIV which leads them to keep their status hidden from friends, family and the authorities. Nothing was done specifically to assist PLHIV in the aftermath of the tsunami. PLHIV's main concerns at the time were adequate nutrition, protection from malarial mosquitos (as malaria can significantly undermine the already weakened immune system of PLHIV) and appropriate livelihood support.

Key findings on impact on coping strategies/resilience of those affected by the tsunami:

- Evidence from key informant interviews with NGOs and UN agencies suggests that displacement and loss of livelihoods as a result of the tsunami led affected populations (mainly women and young people) to engage in increased levels of transactional sex for survival but that food distribution programmes - food for education, food for work - and cash transfer programmes helped to keep levels down. The MO-STD from Balapitya observed that in the first two or three months, people got enough aid, whereas later on when aid levels decreased, levels of transactional sex increased.
- According to one NGO, 'protection committees' and 'discipline committees' were formed within camp settings to minimise different forms of violence against women but it is not clear if these mechanisms were effective in achieving the stated goals. Family support, when available, seems to have been the most effective coping strategy.
- According to medical staff in the Southern districts, there was an increase after the tsunami in the number of people going to the Middle-East in search of work, but without more data, it is not possible to link this directly to the impact of the tsunami.

Key findings on impact on health and other basic services:

- On the whole the provision of general health services continued and remained accessible to the general population, despite the fact that the tsunami destroyed and/or damaged several primary, secondary and tertiary care institutions in the northern, eastern and the southern provinces and killed some health staff. The general health needs of the population were met by conducting mobile clinics and there were special mobile clinics to address maternal and child health.
- There were no special programmes on the prevention of STIs. Condoms, when they were promoted mainly through NGOs, although only one NGO interviewed actively distributed them.

Key findings on the response to HIV in emergencies:

- The government (central and district level), local NGOs, international NGOs and the private sector all played important roles in the response, although the government's immediate response was perceived, by some, to have been slow and overly centralised. Access to food, water, basic health care and shelter appears to have been adequate in the initial relief phase, with a few exceptions; provision for basic needs took priority over addressing sexual health issues and preventing the spread of HIV. The situation in IDP camps is perceived to have deteriorated in the longer-term recovery phase.
- There appears to be little awareness amongst government agencies or NGOs of the need to consider HIV-related vulnerabilities in emergency responses, possibly due to the low HIV prevalence rate. The national strategic plan does not specifically refer to emergency situations. An Action Plan for Responding to HIV and AIDS in Emergencies in Sri Lanka, based on the IASC guidelines, had been drafted in collaboration with the NSACP and UN agencies including FAO, ILO, IOM, OCHA, UNDP, UNFPA, UNHCR, UNICEF, WB, WFP and WHO. However, an assessment of the implementation of the action plan, jointly conducted by UNAIDS and WFP in Batticaloa in June 2005 revealed that few of the agreed actions had been implemented. None of the UN staff interviewed during the current assessment knew about or mentioned the Action Plan.
- An interesting finding concerns the UNAIDS 'Keep the Promise' campaign for World AIDS day in 2006 which was originally intended as an appeal to governments, policy makers and regional health authorities globally to ensure that they meet the many targets that have been set in the fight against HIV and AIDS. Key informant interviews with civil servants and NGOs revealed that this message had been misinterpreted in the Sri Lankan context to mean 'Keep the promise to your husband/wife' i.e. be faithful. This is a prime example of the cultural barriers to HIV prevention in Sri Lanka and a lack of cultural insight on the part of international campaigns and slogans.

6.2 Specific recommendations that have emerged from 6.1

- Despite Sri Lanka's low HIV prevalence rate, the possibility that vulnerability to HIV may increase during and after an emergency needs to be better taken into account by policy makers, relief programme managers, operational decision makers and all those working in the response to sudden-onset natural disasters and other types of emergencies. The government, UN agencies and NGOs should work to ensure a multi-sectoral response to HIV and AIDS in emergencies – one which ensures that the special needs of PLHIV in emergency situations are addressed.
- HIV/AIDS and SGBV awareness-raising and prevention activities should be carried out among crisis affected-populations, along with promotion and free distribution of condoms and livelihood generating activities.
- UN agencies in Sri Lanka should work with the NSACP to revive and update the 'Action Plan for Responding to HIV and AIDS in Emergencies in Sri Lanka'. The Action Plan, which is based on the IASC guidelines for HIV/AIDS interventions in emergency settings, was drafted by UNAIDS in 2004 in collaboration with the NSACP and other UN agencies. It provides practical guidelines for government and UN organisations and NGOs in Sri Lanka responding to the special needs of HIV-infected and HIV-affected people in emergency situations.
- HIV-related stigma and discrimination, as well as discrimination against women, sex workers, homosexuals and drug users remain critical barriers to effectively addressing HIV in Sri Lanka, as well as being issues in their own right. In view of this, the government of Sri Lanka, relevant UN agencies and NGOs should prioritise activities to reduce or eliminate

stigma and discrimination. Such activities should target individuals, families, communities, institutions, the media and government policies and practices.

- It could be useful and necessary to establish a system whereby, whilst maintaining respect and confidentiality, PLHIV could be contacted to ensure that any additional needs emerging as a result of the emergency (e.g. food requirements to enable ARVs) can be addressed. Lanka+ is a potential organisation through which registered PLHIV could be contacted.
- It is also important to improve collaboration between the Government Health Services (both preventive and curative) and NGOs addressing community health needs at district level. This will provide an opportunity for the state health services to benefit from the reach NGOs have to vulnerable populations and for NGOs to benefit from the health services provided through the state.
- Finally, many data are still lacking and further research is needed in a number of areas including HIV risk behaviour among the general population and MARPs in non-emergency settings, in order to establish baselines; the impacts of emergencies on HIV risk behaviour among the general population, MARPs and IDPs both in camps and those who do not enter camps but move to stay with friends, relatives or neighbours.

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Annex A: Key Informants Interviewed for the Study

Organisation	Name	Designation
Companions on a Journey	Mr. Sherman De Rose	Executive Director
	Mr. Sagara Paliyawardane	Project Manager
UNAIDS	Mr. David Bridger	Country Director
Sarodaya	Ms. Wimala Ranathunga	Executive Assistant
NSACP	Dr. Nimal Edirisinghe	Director
	Dr. K. Ariyaratna	Consultant
	Dr. Sriyakanthi Beneragama	Consultant Epidemiologist
Family Planning Association	Mr. Lasantha Gunerathna	Field Director
Salvation Army (Colombo)	Major Noel Lapagnya	Community Services Secretary
WHO	Dr. Harishchandra Yakandawala	Programme Officer/ HIV and Adolescents focal point at UNICEF during the tsunami
Lanka Plus	Ms. T. W. Princey Mangalika	President
WFP	Ms. Ana-lena Rosanen	Programme Officer
CSDF	Mr. Laksman Hewage	Executive Director
	Ms. Kanthi Abeykoon	Project Coordinator
	Mr. Sudath Priyantha	Field Coordinator
UNFPA	Ms. Malathi Weerasooriya	Assitant Representative
	Dr. Chandani Galwaduge	Programme Officer/HIV Focal Point
UNDP	Mr. Madhumita Sarkar	Gender Specialist
World Bank	Ms. Janet Leno	Country Director of UNAIDS during the tsunami
Equal Ground	Ms. Nigel De Silva	Project Manager
IOM	Dr. Marion Staunton	Psychosocial Training Coordinator/ HIV Focal Point
NDDCB	Mr. D. P. Mendis	Chairman
Sri Lanka Red Cross	Mr. A. Premathilake	Deputy Director
WHO	Ms. Visakha Tilekarathna	Programme Officer/HIV focal point at WFP during the tsunami
Ministry of Health	Dr. Sarath Nihal	MO-STI Balapitiya
Ministry of Health	Name withheld	PHI – Galle District
Ministry of Health	Dr. Manel Devasiri	MO-STI Galle
Ministry of Health	Dr. J. B. Senerath	PDHS – Southern Province
Salvation Army (Hikkaduwa)	Mr. Mark Jenson Edwards	Community Capacity Development Coordinator
	Mr. Sisira Samarage	HIV/AIDS Project Officer
NHAPP	Dr. Nilamani Punchihewa	Coordinator – Surveillance
Sri Lanka Army	Major General Dr. D. Perera	Consultant
UNHCR	Ms. Kerri Boland	Protection Officer

Annex B: List of Focus Group Discussions

Location	Date	Group	Number of Participants
Lanka Plus Office	19.03.2008	PLHIV	6
CSDF Office	20.03.2008	Sex workers	25
IDP Camp - Moratuwa	26.03.2008	Persons displaced by the tsunami	8