National Programme on Elimination of Mother to Child Transmission of HIV and Syphilis in Sri Lanka

Guidelines for Management of Pregnant Women with HIV Infection 2024

National STD/AIDS Control Programme

Ministry of Health

Sri Lanka

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Published by

National STD/AIDS Control Programme

Ministry of Health

Colombo, Sri Lanka.

1st Edition 2008

2nd Edition 2011

3rd Edition 2016

4th Edition 2024

The guidelines for management of pregnant women with HIV infection - 2024 was prepared to assist policymakers to optimize PMTCT interventions and healthcare workers to provide optimal services to pregnant women with HIV

Contents

Abbreviations and acronyms

Abacavir	ABC
Antenatal clinic	ANC
Antiretroviral	ARV
Antiretroviral therapy	ART
Acquired Immune deficiency syndrome	AIDS
Atazanavir	ATV
Atazanavir/cobicistat	ATV/c
Atazanavir/ritonavir	ATV/r *
Bictegravir	BIC
Cabotegravir	CAB
Caesarean Section	CS
Combined hormonal contraception	CHC
Copper intrauterine device	Cu- IUD
Darunavir/cobicistat (DRV/c	DRV/c
Darunavir/ritonavir (DRV/r)	DRV/r
Depot medroxyprogesterone acetate	DMPA
Dolutegravir	DTG
Doravirine	DOR
DRV darunavir	DRV
Early infant diagnosis	EID
Efavirenz	EFV
Elvitegravir	EVG
Elvitegravir/ cobicistat	EVG/c
Emtricitabine	FTC
Enfuvirtide	ENF
Enhanced postnatal prophylaxis	ePNP
Enzyme Linked Immunosorbent Assay	ELISA
Etonogestrel implant	ENG-IMP
Etravirine	ETR
External cephalic version (ECV)	ECV
Fixed dose combinations	FDCs
Global validation advisory committee	GVAC
Global AIDS Monitoring	GAM
Health-care worker	HCW
HIV drug resistance	HIVDR
Human immunodeficiency virus	HIV
Integrase strand transfer inhibitors	INSTIs
Lamivudine	3TC
Levonorgestrel-releasing intrauterine system	LNG-IUD
Long-acting injectable cabotegravir	CAB-LA
Lopinavir/ritonavir	LPV
Lopinavir/ritonavir (LPV/r)	LPV/r
Lower segment caesarean section	LSCS
Maraviroc	MVC
Maternal and child health	MCH
Medical officer	MO

Ministry of Health	MOH
Mother and child health	MCH
Mother to child transmission	MTCT
Mother-to-child transmission	MTCT
Multidisciplinary team	MDT
National Reference Laboratory	NRL
Nucleic acid amplification test	NAT
Nevirapine	NVP
Non-nucleoside reverse transcriptase inhibitors	NNRTIs
Nucleic acid testing	NAT
Nucleoside reverse transcriptase inhibitors	NRTI
Point-of-care	POC
Polymerase chain reaction	PCR
Post Exposure Prophylaxis	PEP
Pre-Exposure Prophylaxis	PrEP
Pre-labour Caesarean Section	PLCS
Prevention of mother-to-child transmission	PMTCT
Progestogen-only pill	POP
Public health midwife	PHM
Raltegravir	RAL
Rapid diagnostics test	RDT
Regional validation committee	RVC
Rilpivirine	RPV
Sexually Transmitted Infections	STI
Spontaneous Rupture of Membranes	SROM
Tenofovir alafenamide	TAF
Tenofovir disoproxil fumarate	TDF
Viral load	VL
World Health Organization	WHO
Zidovudine	AZT

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Annexures

1. Validation of Elimination of mother to child transmission (EMTCT) of HIV and syphilis programme

Sri Lanka has been declared as a country that eliminated MTCT of HIV and syphilis by the WHO, Geneva in 2019. The overall goal for EMTCT of HIV and syphilis is to ensure the prevention of MTCT of HIV and syphilis to a level that it is no longer a public health problem. Sri Lanka had to achieve the following impact and process indicators to achieve the elimination status.

Table 1 : Indicators and targets for validation of EMTCT of the HIV programme

Impact indicators
A case rate of HIV positive infants ≤50 per 100 000 live births
Process indicators
Population-level ANC1 coverage (at least one visit) of ≥95% Coverage of HIV testing of pregnant women of ≥95% Treatment coverage of HIV positive pregnant women of ≥95% Treatment coverage of infants exposed to HIV of ≥95%

The EMTCT programme is closely monitored by WHO and will be revalidated once every three years. It is important to maintain satisfactory process and impact indicators and to sustain the success of the programme throughout.

Sero-prevalence of HIV among antenatal population has remained at <0.01% for the last two decades in Sri Lanka.

The probability of mother to child transmission of HIV can be eliminated with appropriate management. If there is no intervention, the risk of transmission of HIV from an untreated mother to child is between 15-45 % depending on the stage of the infection, HIV RNA level and infant feeding practices.

1.1 Maintenance of eliminated status of MTCT of HIV

Following validation of the EMTCT programme, it is important to maintain the impact and process indicators each year to certify the country as successfully maintaining the services for EMTCT of HIV.

Countries that fail to maintain the required EMTCT impact and process indicators or maintain human, sexual and reproductive rights for women, can lose validation status.

Maintenance of validation reports are expected to be submitted by countries every 3 years after initial validation. These reports will be submitted through the regional validation committee (RVC) and reviewed by the GVAC and the global secretariat to verify maintenance of validation.

To sustain elimination, a country requires comprehensive surveillance and monitoring systems (including among vulnerable and key populations at risk of acquiring HIV and STIs). Such strong systems are needed to provide accurate data on intervention coverage, and quickly detect changes in disease transmission trends. For MTCT of HIV and syphilis, these systems provide ongoing monitoring of the prevalence of disease in pregnant women and the coverage and effectiveness of treatment.

The global secretariat will maintain a list of countries that have achieved validation and maintain validation criteria and standards over time. A country may lose its validation status if coverage of services falls or if impact indicators such as case rate or MTCT rate exceed the global validation targets.

To maintain validation status, data should be reported through global reporting mechanisms such as the UNAIDS Global AIDS Monitoring (GAM) system. Indicators that are not captured in the GAM should be reported directly to the WHO country office.

At the time of assessment of maintenance of validation, countries will be required to prepare a report that should include data tables on validation targets (process and impact indicators for the previous 3 years). For countries like Sri Lanka, with small populations and small numbers of HIV-positive and/or syphilis-positive pregnant women per year, 4 years of pooled data can be used to assess maintenance of validation. Human rights, gender equality and civil society engagement must be reassessed and included in the report at this time to ensure that there are no violations or changes in laws pertaining to this component of validation since the last validation review. Maintenance reports should include updates on any programmatic data, laboratory and human rights recommendations provided by the GVAC at the time of validation. Maintenance reports should be submitted to the RVS, which will review the report and, if the validation criteria are still being met, will submit the report to the RVC (if applicable) and the GVAC for final revalidation.

2. HIV testing in pregnant women

HIV testing services should be offered to all pregnant women during the first visit with the antenatal care package before 12 weeks of gestation.

- Pregnant women should be informed about these tests, with testing being voluntary after providing adequate information on MTCT of HIV and prevention methods.
- If a woman declines testing, her decision should be respected, and she should be assured that it will not affect her access to ANC services.
- For pregnant women at high risk for HIV or STIs, a second HIV test should be offered at 28 weeks of gestation either through the nearest STD clinic or via RDT.

- All pregnant women should receive opt-out HIV testing as early as possible during each pregnancy.
- Dual HIV and syphilis rapid diagnostic tests can be offered as the first test in antenatal care to increase testing and treatment coverage.
- Repeat HIV testing in the third trimester is recommended for pregnant women with negative initial HIV tests who are at increased risk of acquiring HIV.
- Repeat HIV testing is recommended for pregnant women with a sexually transmitted infection, with signs and symptoms of acute HIV infection, or with ongoing exposure to HIV.
- Expedited HIV testing should be performed during labor or after delivery for people with undocumented HIV status and for those who tested negative early in pregnancy but are at increased risk of HIV infection and were not retested in the third trimester.

Figure 1: Referral flow system of a HIV positive pregnant woman from the ANC clinic to the STD clinic

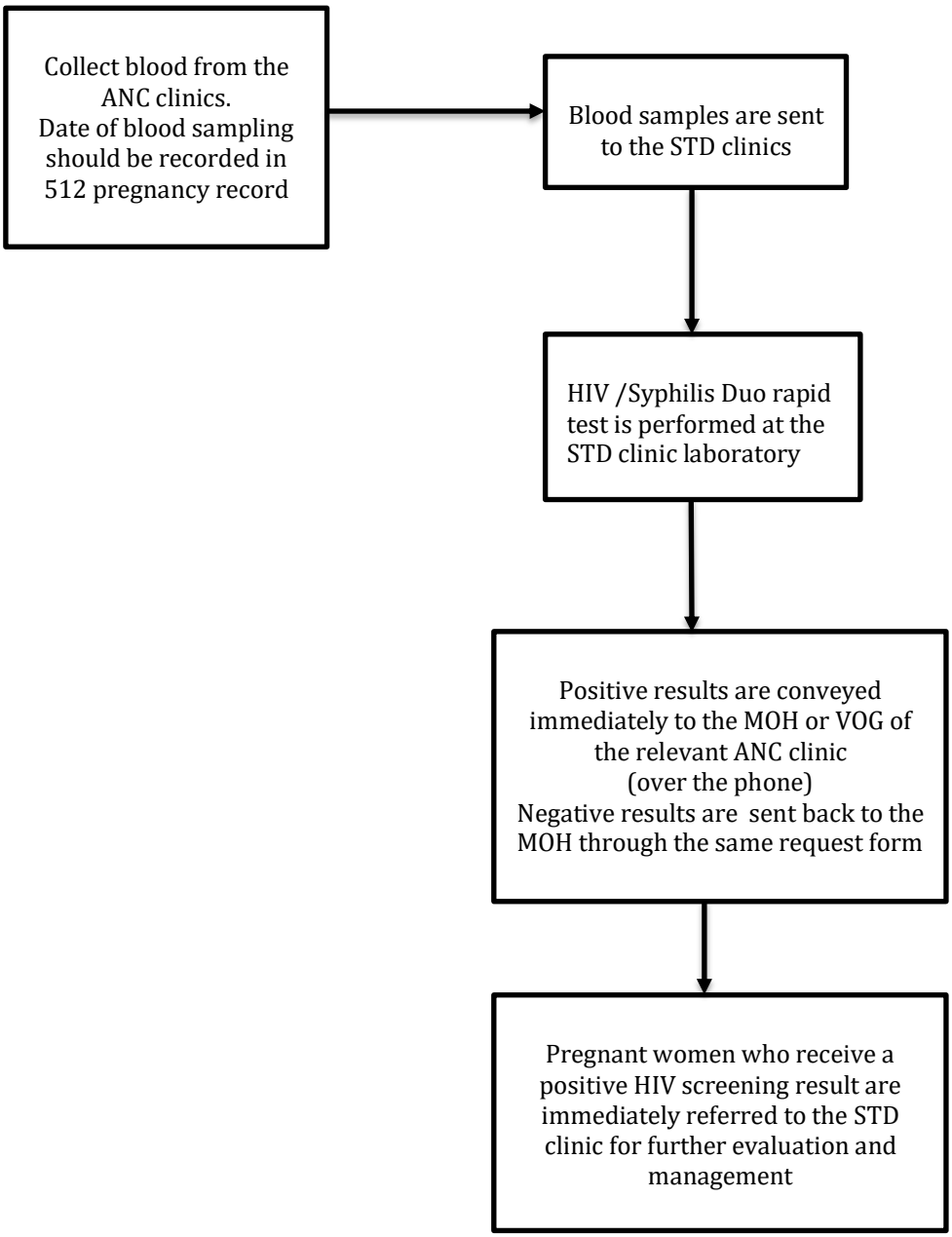
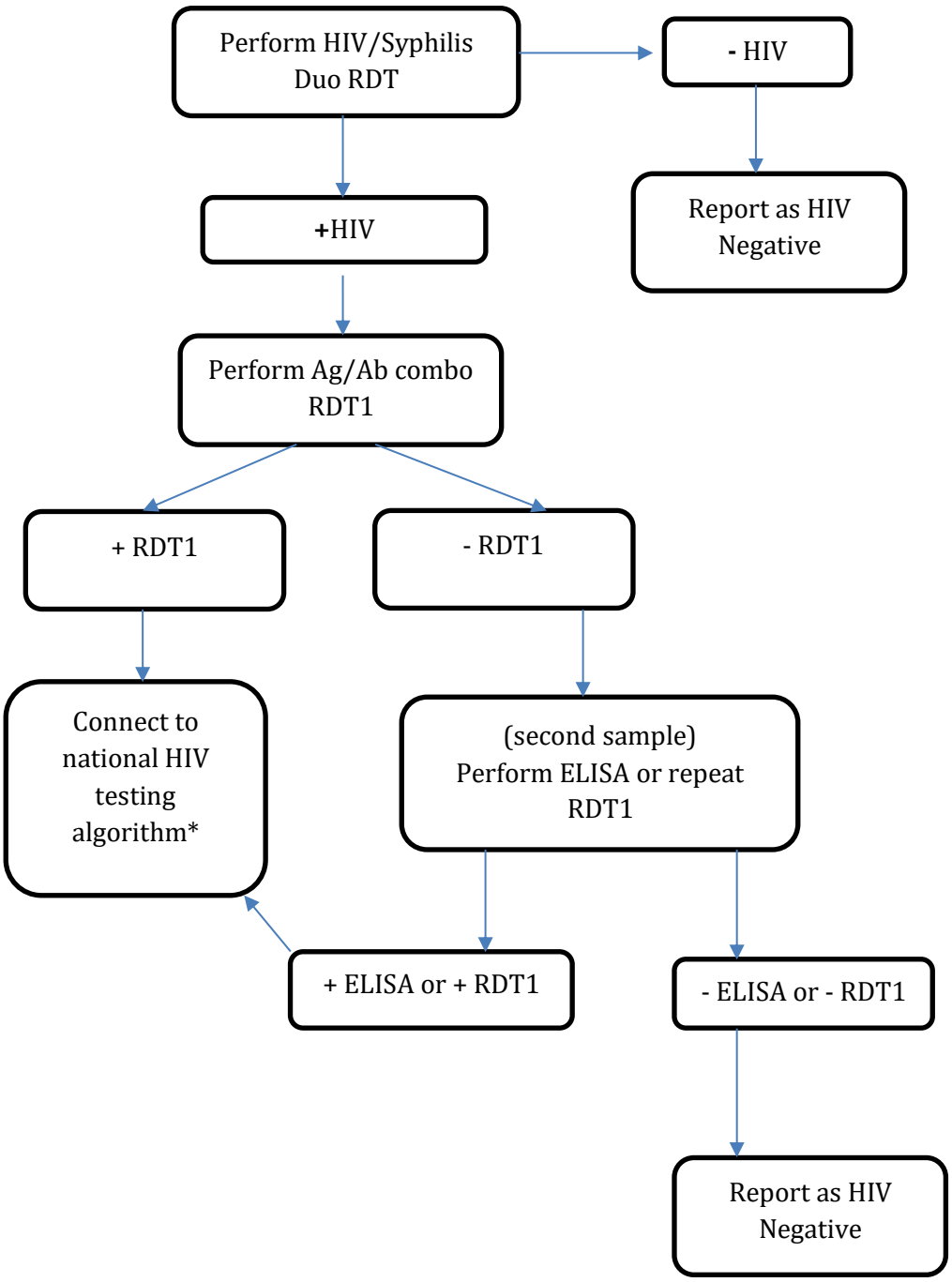


Figure 2 : HIV Testing algorithm for pregnant women



*Any discrepancy of a test results; sample should be immediately sent to the NRL for molecular or viral load testing

3. Fertility desires among women with HIV

- Improvements in life expectancy and quality of life for women living with HIV, along with enhanced access to EMTCT services, have increasingly led HIV positive women to contemplate the possibility of pregnancy.
- Pre-conception counselling need to be offered to all HIV positive women planning to have children. Counselling should include the importance of treatment adherence and virologic suppression to eliminate the risk of MTCT of HIV. ARV therapy should be discussed with every woman taking their concerns and preferences into account and management should be based on the standard treatment guidelines.
- All women planning on pregnancy should start folic acid supplementation before pregnancy and continue up to 12 weeks of gestation.

3.1 Fertility options for PLHIV

Increasingly, parenting is regarded as a realistic option for couples where one or both partners are infected with HIV and the demand for reproductive care is rising. HIV-positive men and women and their partners planning to have children should receive pre-conception counselling on all their conception options, including HIV transmission risks associated with each case, so that they can make an informed choice. All discussions should be documented clearly in clinical notes.

For sero-concordant or discordant couples who want to conceive, expert consultation is recommended so that approaches can be tailored to specific needs, which may vary from couple to couple.

The physician does need to ensure that the uninfected partner has a full understanding of the possibility of becoming infected through unprotected intercourse. More importantly, the need for ART adherence and regular attendance for STI screening in the couple and viral load checks in the infected partner should be stressed.

For couples in which one or both partners are HIV-infected, optimal health should be attained before attempting conception.

- Infected partner/couple should be receiving combination antiretroviral therapy and demonstrate sustained viral suppression (two undetectable viral load over the

period of six months) of plasma viral load below the limits of detection (at present <34 copies/ml).

- Both partners should be screened for genital tract infections. Treatment of such infections is important because genital tract inflammation is associated with genital tract shedding of HIV.
- Should undergo fertility screen where necessary.

3.1.1 Sero-discordant Couples

Before conception is attempted, the HIV-infected partner should be receiving ART and demonstrate sustained suppression of plasma viral load below the limits of detection. The possible fertility options are as follows.

1. **Antiretroviral Therapy (ART) for the HIV-Positive Partner**:
   Ensuring the HIV-positive partner is on effective ART and has an undetectable viral load reduces the risk of sexual transmission to effectively zero. This approach is known as "U=U" (Undetectable = Untransmittable). Once the viral load is suppressed, natural conception through timed intercourse becomes safer.
2. **Pre-Exposure Prophylaxis (PrEP) for the HIV-Negative Partner**:
   The HIV-negative female partner can take PrEP to further reduce the risk of acquiring HIV during conception attempts. PrEP is most effective when taken consistently as prescribed.
3. **Timed Intercourse with ART and PrEP**:
   This involves natural conception through intercourse timed around ovulation, combined with ART for the HIV-positive partner and PrEP for the HIV-negative partner.
4. **Sperm Washing**:
   Sperm washing is a process where sperm is separated from the seminal fluid, which may contain HIV. The washed sperm can then be used for intrauterine insemination (IUI) or in vitro fertilization (IVF). This method significantly reduces the risk of HIV transmission.
5. **In Vitro Fertilization (IVF)**:
   IVF using sperm washing is a common method where the washed sperm is used to fertilize the female partner's ovum in a laboratory, followed by the transfer of the embryo to the uterus. This option is particularly useful for couples with fertility challenges.
6. **Donor Sperm**:
   If the couple prefers to avoid the risk of transmission altogether, donor sperm from an HIV-negative donor can be used for insemination or IVF.

4. Pre-Exposure Prophylaxis

In sero-discordant couples where the HIV-positive partner is on antiretroviral therapy and has achieved sustained viral suppression, condomless sexual intercourse enables conception without the risk of HIV transmission to the HIV-negative partner. As an added precaution, they have the option to choose PrEP for HIV prevention, even if the HIV-positive partner has achieved viral suppression.

The preferred PrEP option for HIV prevention in people who have receptive vaginal sex during pregnancy and breastfeeding is tenofovir disoproxil fumarate with emtricitabine or lamivudine (TDF+FTC/3TC). People who become pregnant while using TDF/FTC or TDF/3TC as PrEP, can continue PrEP throughout pregnancy and breastfeeding. Risk for HIV acquisition should be reassessed, and couple should be counselled regarding the benefits and risks of PrEP use in pregnancy and breast feeding.

Providers should counsel patients about the importance of adherence to oral PrEP to prevent HIV acquisition. Event driven or non-daily PrEP is not recommended for protection against vaginal exposure to HIV.

5. Management of pregnant women with HIV

5.1 When to start ART in pregnant and breastfeeding women?

All pregnant and breastfeeding women living with HIV should initiate and continue lifelong ART, regardless of WHO clinical stage or CD4 count. Pregnant women newly diagnosed with HIV should start ART as early as possible, while those already on ART with sustained viral suppression should maintain their current regimen.

Providing ART to all pregnant and breast-feeding women living with HIV serves three synergistic purposes.

1. Improving mothers' health
2. Preventing mother to child transmission of HIV
3. Preventing transmission of HIV from mother to sexual partner/partners

Following a confirmed HIV diagnosis and clinical assessment, rapid ART initiation should be offered to all individuals, ideally within seven days. Those with advanced HIV disease should be prioritized. Same-day ART initiation should be available for individuals ready to start treatment immediately.

5.2 What ART regimens to initiate (Refer Guide to Anti-retroviral treatment 2024)

5.2.1 Recommendations for the Use of Antiretroviral Drugs During Pregnancy

When selecting an ARV regimen for pregnancy, factors to consider include adverse effects, drug interactions, pharmacokinetics, regimen convenience, pregnancy safety data, virologic efficacy, and comorbidities. The selection of ARV regimen for pregnancy, is a shared and individualized decision taken with consideration of available data for drug use in pregnant people as well as durability, tolerability and simplicity of medication regimen to ensure treatment adherence

5.2.2 ARV regimens

There are five categories of drug recommendations in pregnancy as Preferred, Alternative, Insufficient data to recommend, not recommended except in special circumstances and not recommended.

Out of them the preferred first line regimen for the treatment of pregnant people with HIV who have never received ARV drugs consist of the integrase strand transfer inhibitor (INSTI) dolutegravir (DTG) plus a dual-nucleoside reverse transcriptase inhibitor (NRTIs) combination.

5.2.3 Preferred regimens

Table 2 : First line ART regimens

First line ART	Preferred first –line regimens	Alternative first –line regimens*
Pregnant and breast-feeding women	TDF + FTC/3TC + DTG TAF + FTC + DTG	ABC[1] + 3TC +DTG/DRV/r[2]/EFV[3]/ATV/r AZT + 3TC + DTG/DRV/r /EFV/ATV/r TDF + FTC + DRV/r[2] / EFV[3] / RPV[4] TAF + FTC + DRV/r[2] / EFV[3] /RPV[4]

[1]ABC - Presence of HLA-B 5701 gene indicates higher risk for hypersensitivity. Viral load should be <100,000 copies/ml and without chronic hepatitis B virus (HBV) coinfection

[2]DRV Twice daily dose is recommended in pregnancy.

[3]If the preferred ART regimen is unavailable or contraindicated, alternatives for pregnant and breastfeeding women include substituting TAF/ABC for TDF or using EFV or DRV/r instead of INSTI. The efficacy of low-dose EFV (400 mg) in pregnancy has not been studied

[4]RPV can be used if VL< 100 000 c/ml and CD_4 >200 cells/mm^3.

Note:

- *TAF or boosted PIs (DRV/r, ATV/r, LPV/r) can be used in special circumstances.*
- *INSTI Bictegravir (BIC) classified as an alternative ARV drug for use in pregnancy.*
- *Other INSTI Elvitegravir (EVG) or Cabotegravir (CAB) are not recommended in pregnancy due to limited data during pregnancy.*

If an ARV regimen is stopped during pregnancy, all drugs should be discontinued together, and a complete regimen restarted promptly. Pregnant women with HIV who have defaulted on ART should resume treatment immediately, adjusting the regimen later if resistance test results require it

In addition to ART, they should receive comprehensive pregnancy care, including nutritional support, infant feeding counseling, and family planning guidance. Monitoring for pregnancy-induced hypertension and pre-eclampsia, particularly in women on ART before conception, is essential.

5.2.4 Women with HIV conceiving while on ART

It is recommended that women conceiving on an effective ART regimen should be continued. The ART regimens should not be changed just due to non-inclusion of preferred or alternative regimens or drugs, because the changing could lead to increase in viral load, decline in immune status, progression of disease and increased risk of mother to child transmission of HIV infection. However, ART regimen should be changed if it contains medications which are not recommended to use in pregnancy.

It is recommended to continue suppressive regimen with frequent viral load monitoring when she is on an ART regimen with insufficient data about using in pregnancy.

Oral two drug regimens are not recommended for use in pregnancy. How ever if patient got pregnant while maintaining successful viral suppression, oral two drug regimen may be continued with more frequent (every 1-2 months) viral load monitoring.

5.2.5 Late-presenting woman not on treatment

INSTIs have an important role to play in late pregnancy as DTG and RAL can suppress viral load rapidly. A decrease of approximately 2 $\log_{10}$ copies/ml occurs by two-week therapy with DTG and RAL. DTG preferred and RAL (Raltegravir) is alternative as RAL requires twice daily dosing and has a lower barrier to development of drug resistance than DTG.

6. Monitoring of pregnant women receiving ART

- Clinical and laboratory evaluation is as for non-pregnant women receiving ART.
- Haematological and biochemistry parameters should be monitored as appropriate to the ART regimen used.
- Regular viral load monitoring is needed in pregnancy.
- All pregnant women, regardless of when they start ART, may require more intense monitoring of viral suppression, including conducting viral load testing at 34–36 weeks of gestation (or at the latest at delivery) to identify women who may be at risk of treatment failure and/or may deliver infants at higher risk of perinatal transmission.
- In addition, a viral load test is recommended for all breastfeeding women three months after delivery and every six months thereafter to detect viraemic episodes during the postnatal period.
- When lack of suppression is identified, a thoughtful evaluation of potential contributing factors is needed, including barriers to adherence, drug resistance, drug–drug and drug–food interactions, pharmacokinetics changes in pregnancy that affect drug levels, and combinations of these factors.
- In women who commence ART in pregnancy, HIV viral load should be performed four weeks after commencing ART and at 36 weeks.
- In women commencing ART in pregnancy, liver function tests should be performed at initiation of ART and then at each antenatal visit.
- If a woman who has initiated ART during pregnancy has not achieved a plasma viral load of < 50 HIV RNA copies/ml at 36 weeks, following interventions are recommended:

➢ Review treatment adherence and concurrent use of other medication
➢ Perform resistance testing if appropriate
➢ Optimize to the best regimen
➢ Consider intensification

7. Obstetric management

7.1 Antenatal management

- Pregnant women with HIV should receive comprehensive care from a multidisciplinary team, including an obstetrician, venereologist, paediatrician, anaesthetist, theatre nurse, MOH, microbiologist/virologist, and infection control nurse. Effective coordination, confidentiality, and shared responsibility are crucial in their management.
- Healthcare providers must ensure that antenatal, labor, delivery, and postpartum care are delivered in a supportive environment, with institution heads and consultants working to prevent stigma and discrimination. Ensure privacy and confidentiality during consultations and reassure the woman that her HIV status will be kept confidential.
- Explain to the woman who the information will be shared with.
- Explain to the woman that she will have to follow routine antenatal clinic visits and give her confidence by discussing the management plan with her.
- Foetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.
- Invasive prenatal diagnostic testing should not be performed until after the HIV status of the mother is known and should ideally be deferred until HIV viral load has been adequately suppressed.
- Plan and discuss the mode of delivery with the pregnant woman during antenatal care. Give her clear instructions on when to get admitted for delivery and whom should be contacted.
- External cephalic version (ECV) can be performed in women with HIV who are virally suppressed.
- Health care workers should practice universal infection control measures for all deliveries irrespective of the infection status of pregnant women.
- Amniocentesis may be performed on virally suppressed pregnant women with HIV after thorough counseling on risks, benefits, and alternatives, if they are on ART with an undetectable viral load.
- Coordinated multidisciplinary team management involving MCH staff, infection control, venereologists, obstetricians, pediatricians, and other relevant services is crucial for delivering quality care.

- During pregnancy, pregnant woman needs to be counselled on mode of delivery, family planning and contraceptive options, infant feeding, infant ARV prophylaxis, and timing of infant diagnostic testing.
- Fetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.
- Invasive prenatal testing should be delayed until the woman's viral load is suppressed to <50 copies/mL. If invasive testing can't wait for viral suppression, ART with DTG should be initiated, and a single dose of nevirapine administered 2–4 hours before the procedure.

7.2. Mode of delivery

- For women with a plasma viral load of <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, planned vaginal delivery can be supported.
- For women with a plasma viral load of ≥ 50 HIV RNA copies/mL at 36 weeks, pre-labour Caesarean Section (PLCS) is recommended.
- In women for whom a vaginal delivery has been planned and labour has commenced, obstetric management should follow the same guidelines as for the HIV-negative population, except for managing the duration of ruptured membranes.
- Traditionally amniotomy, fetal scalp electrodes and blood sampling, instrumental delivery and episiotomy have been avoided in HIV infection because of theoretical transmission risks.

Points for consideration

- All known HIV infected pregnant women should have an individualized, regularly updated, plan of care which summarizes mutually agreed obstetric/HIV management including the drug regimen and recommended mode of delivery.
- Properly applied universal infection control measures protect staff from blood borne infections. Routine use of these precautions is essential to minimize occupational risk.
- Ward staff must maintain confidentiality regarding a pregnant woman’s HIV status and provide nonjudgmental, stigma-free care. Information should be shared only on a "need to know" basis

7.3. Multiple pregnancies

Multiple pregnancies should be managed according to obstetric need of the woman and as per HIV-negative protocols.

8. Antenatal care at the primary health care ANC clinic

- When a pregnant woman is diagnosed as having HIV infection, the venereologist of the STD clinic will communicate with the MOH regarding the steps need to be taken.
- MOH and staff play a key role in caring for pregnant women with HIV. Effective coordination, confidential communication, and shared responsibility are essential for proper management.
- Ensure privacy and confidentiality during consultations and reassure the woman that her HIV status will be kept confidential.
- Explain to the pregnant woman who the information will be shared with.
- Explain to her that she will have to follow routine antenatal clinic visits.
- The pregnant woman should be reassured and should be referred immediately to the STD clinic for further management.
- Health care providers should ensure that pregnant women with HIV are provided antenatal care, labour and delivery care and post-partum services in a user-friendly environment.
- The MOH and the staff should take all measures to maintain confidentiality and prevent stigma and discrimination.
- Check whether she has been seen by a VOG as delivery care needs to be arranged in a unit with specialist services.

9. Management of HIV positive pregnant women in the STD clinic

There are two possibilities.

- A pregnant woman may be identified as having HIV infection during routine antenatal screening and referred to the STD clinic by the MOH or VOG for further management.
- A woman already diagnosed as living with HIV and under care services from STD clinic can become pregnant.

➢ All pregnant women with HIV should have an individualized, regularly updated plan of care which summarizes mutually agreed obstetric and HIV management plan.

➢ Check whether the woman has already attended for antenatal care and encourage regular attendance at antenatal visits.

➢ Ask about the health of other children and encourage checking HIV status of partner and children.

9.1 Counselling

The following areas need to be covered in counseling.

- ART and adherence to treatment
- Partner disclosure/screening
- HIV testing of other children
- Mode of delivery
- Choice of infant feeding
- Condom use to prevent acquiring other STIs, entry of other strains of HIV and onward transmission to a negative partner
- Postpartum family planning

Pregnant women should be counselled on delivery options, lifelong HIV therapy, family planning, contraceptives, infant feeding, ARV prophylaxis for the infant, and timing of infant diagnostic testing.

10. Management of delivery of pregnant mother with HIV

10.1 Plan for delivery

Plan and discuss the mode of delivery with the pregnant woman (and her partner if possible) during the antenatal care.

Give her instructions on when to get admitted to the hospital for delivery and whom she should contact.

Explain the possibility of preterm labour and what to do in case of an emergency.

When admitted for delivery

- Check the expected date of delivery
- Confirm normal growth of the foetus
- Check which ART regimen have been prescribed and whether drugs have been taken as prescribed
- Check for recent viral load results
- ***Women with incomplete viral suppression (>50 copies/mL) at the time of delivery preferably should receive IV zidovudine (if available) while continuing oral ARV regimen.***
- ***In situations where IV administration is not possible/not available, oral administration of zidovudine using a 600-mg loading dose and 400 mg every 3 hours can be considered.***
- ***Check for availability of antiretroviral treatment for infant prophylaxis***.
- Check for infant feeding method and emphasize on adherence and support if she has decided on breast feeding.
- Provide lactation suppression therapy if mother has decided on formula feeding.
- Arrange parents to collect formula milk from the NGO. The peripheral STD clinics receive formula milk from the EMTCT unit, which obtains it in bulk from the NGO.
- Check for availability of safe delivery kits and post exposure prophylaxis therapy in the health care institution which is identified for delivery.
- Confirm that a post-partum family planning method is arranged before being discharged from the hospital.

10.2 Planned normal vaginal delivery

- If HIV viral load is < 50 copies/mL at 36 weeks, the risk of MTCT of HIV is less in the absence of other obstetric contraindications.
- Minimize vaginal examinations to reduce the risks of infection to the mother. Maintain aseptic techniques throughout labour.
- ART should be continued according to the ART plan.
- Amniotomy, fetal scalp electrodes and fetal blood sampling, instrumental delivery and episiotomy need to be avoided in pregnant women with HIV infection because of theoretical transmission risks.
- Artificial rupture of membranes increases the risk of infection of the placental membranes.
- Avoid prolonged labor by monitoring labour carefully and intervening appropriately (i.e., augmentation of labour through oxytocin or delivery by caesarean section).
- The head should be well engaged.
- Check whether the cervix is effaced and dilated and await spontaneous onset of labour.
- In women for whom a vaginal delivery has been recommended and labour has commenced, obstetric management should follow the same principles as for the uninfected population.

10.3. Planned caesarean section

- Explain to the pregnant woman about the reason for the caesarean section and obtain informed consent.
- Notify the Hospital Director, consultant anesthetist, neonatologist, paediatrician, infection control unit, head of the intensive care unit, sister in charge of the theatre, antenatal ward, postnatal ward and PBU where necessary, **while taking every precaution to maintain confidentiality.**
- Inform the consultant venereologist of the STD clinic.
- Provide premedication and prepare as usual for surgery.
- Regional analgesia is not contraindicated in delivery care of pregnant women with HIV.
- Continue ARV regimen as recommended. Oral medications can be continued preoperatively with sips of water.

10.4 Management of pre-labour spontaneous rupture of membranes

In all cases of term pre-labour spontaneous rupture of membranes (SROM), delivery should be expedited.

Table 3 : Recommendations following SROM

Scenario	Recommendations
1.	If maternal HIV viral load is < 50 RNA copies/mL immediate induction of labour is recommended, preferably under antibiotic cover.
2.	If maternal HIV viral load is ≥ 50 RNA copies/mL plasma, immediate caesarean section is recommended.
3.	If maternal HIV viral load is not available, immediate caesarean section is recommended

It has been observed that the risk of HIV transmission was twice as high among women with ruptured membranes for more than 4 hours before delivery compared with those with shorter duration of membrane rupture.

There is no evidence that steroids for foetal lung maturation (with associated 24-hour delay in induction) are of overall benefit at 34–37 weeks' gestation in women with ruptured membranes, thus delay for the optimization of fetal lung maturity is not recommended. For this reason, and to minimize the risk of developing chorioamnionitis, delivery is recommended from 34 weeks' gestation in women with ruptured membranes who are not in labour.

10.5 Management of women who present in labor without documentation of HIV status or women who have not received antepartum antiretroviral drugs

Women presenting in labour / ROM / requiring delivery without a documented HIV result must be recommended to have a Rapid HIV Test. A reactive/positive result must be acted upon immediately with initiation of the interventions to PMTCT without waiting for further/formal serological confirmation. Pregnant women with positive rapid HIV screening should be presumed to be infected until HIV confirmatory testing clarifies their infection status

An untreated woman presenting in labour at term should be given a **stat dose of nevirapine 200 mg and commence on fixed-dose zidovudine + lamivudine and raltegravir/dolutegravir** as the preferred additional agent (because it also rapidly crosses the placenta). Intravenous zidovudine can be administered for the duration of labour and delivery.

A single dose of nevirapine should be given immediately to the pregnant woman as this rapidly crosses the placenta and within 2 hours achieves and maintains effective concentrations in the neonate for up to 10 days .If delivery is not imminent, a caesarean section should be considered. If delivery occurs less than 2 hours post maternal nevirapine, the neonate should also be dosed with nevirapine immediately. After partus, refer mother to the STD Clinic for clinical and immunological assessment.

Table 4 : Recommendations for Intrapartum intravenous zidovudine infusion

Intrapartum intravenous zidovudine infusion is recommended in the following circumstances	
1.	For women with a viral load >1000 HIV RNA copies/mL plasma who present in labour or with SROM or who are admitted for PLCS
2.	For untreated women presenting in labour or SROM
3.	SROM in whom the current viral load is not known.
4.	Can be considered for women with viral load >50 HIV RNA copies/mL who present in labour or with SROM or who are admitted for CS

11. Post-partum Management

11.1 Immediate management

- Avoid suctioning the infant's mouth and pharynx, which may cause trauma to the mucous membranes thus promoting mother to child transmission of HIV.
- Clean the eyes of the baby with saline at delivery of the head.
- Clamp the cord as soon as possible to minimize the risk of maternal-fetal micro-transfusions.
- Cover the umbilical cord with a swab when cutting to prevent spurting blood.
- Towel dry the baby.
- Clean the baby's skin thoroughly before any infusions or injections.

Minimize the risk of postpartum haemorrhage by:

- Actively managing the third stage of labor
- Using controlled cord traction
- Performing uterine massage
- Repair any genital tears
- Carefully removing all products of conception
- Physical assessment in the postpartum period should follow routine guidelines. Examine women within 24 hours following delivery.
- Be aware of signs of infection following delivery. HIV positive women are also vulnerable to infection following delivery and retained blood and placental tissues. Postpartum uterine infection is a common and potentially life-threatening condition, and early detection and effective treatment are important measures to prevent complications.
- Manage infected tears or episiotomy.

11.2 Additional measures

- Advice women to come back to the same institution if LSCS wound infection is observed.
- When they are discharged from the healthcare facility, women should be advised to return to the clinic or inform the PHM if they notice symptoms such as fever, lower abdominal pain, burning with urination, foul smelling discharge, abnormal bleeding, cough, shortness of breath, calf pain (increasing on walking), diarrhoea and unusual/abnormal behaviour.

- Give information to the mother on care of the perineum and breasts. Women living with HIV require special care to reduce breast engorgement, mitigate pain and avoid mastitis.
- Women who choose to breast feed should be counselled to avoid breast engorgement which could lead to mastitis, since inflammation is associated with increased risk of HIV transmission. She should be advised to seek immediate medical care if breast engorgement is associated with fever and pain.
- Instruct her about the safe disposal of lochia and blood-stained sanitary wear or other potential infectious materials.
- If family planning has not been discussed before delivery it should be done during the early postpartum period.

11.3 Antiretroviral therapy

All women are recommended to continue ART postpartum.

11.4 Support services

During the postpartum period pregnant woman may face serious challenges to ART adherence and retention in HIV care due to new responsibilities. Continued supportive services need to be offered during this critical period.

11.5 Mental health assessment and support

Women should have their mental health needs assessed postpartum and those identified as having mental health issues should be referred to appropriate services.

12. Neonatal management

Risk assessment at delivery is essential for identifying high- and low-risk infants, ensuring proper prophylaxis and accurate diagnosis.

Table 5 : Criteria for risk assessment at the time of delivery and to identify infants at high and low risk:

Criteria for infants at high risk	Criteria for infants at low risk
Infants born to mothers with HIV who • Did not receive prenatal care. • Received no antepartum ARVs or only intrapartum ARV drugs. • Initiated ART late in pregnancy (during the late second or third trimester). • Diagnosis of acute HIV infection during pregnancy or in labor. • Had detectable HIV viral loads (> 50 copies/mL) close to the time of delivery, including those who received ART but did not achieve sustained viral suppression.	**Infants born to mothers with HIV who** • Receiving ART since first trimester or early second trimester . and • Has achieved and maintained viral suppression. (Defined as <50 copies/mL) and • Has reported good adherence and adherence concerns have not been identified.

12.1 Antiretroviral Management of Newborns with Perinatal HIV Exposure or HIV Infection

All newborns perinatally exposed to HIV should receive appropriate antiretroviral (ARV) drugs as soon as possible, preferably within 6 hours, after delivery to reduce the risk of perinatal transmission of HIV. A newborn's ARV regimen should be determined based on maternal and infant factors that influence the risk of perinatal transmission of HIV.

- Newborns at low risk of perinatal HIV acquisition, 4 to 6 weeks zidovudine (ZDV) or Nevirapine (NVP) is recommended.
- Newborns at high risk of perinatal acquisition of HIV should receive presumptive HIV therapy with 3-drug regimens administered from birth for 2 to 6 weeks
- All premature infants <37 weeks gestation who are not at high risk of perinatal acquisition of HIV should receive ZDV or NVP for 4 to 6 weeks **.**
- Infants of women who have primary or acute HIV infection during breast feeding period should be managed like infants at high risk of perinatal transmission with presumptive HIV therapy.
- The use of ARV drugs other than ZDV, lamivudine (3TC), and NVP cannot be recommended for any indication in premature newborns (<37 weeks gestational age) because of the lack of dosing and safety data.
- If an individual presents with unknown HIV status and has a positive HIV test during labor or shortly after delivery, the infant should begin presumptive HIV therapy **.** If supplemental maternal testing is negative, the infant's ARV regimen should be discontinued **.**

Table 6 : Infant post-exposure prophylaxis (PEP)

Scenario	ART	Duration
Low risk Pregnant women and non-breast-fed infants	NVP (twice daily) or AZT (twice daily)	4 - 6 weeks
High risk Pregnant women and non-breast-fed infants	AZT (twice daily) +3TC (twice daily + NVP (once daily) or AZT (twice daily) +3TC (twice daily + RAL (twice daily)	4 - 6 weeks if the duration of the 3-drug regimen is shorter than 6 weeks, ZDV / NVP should be continued alone, to complete a total of 6 weeks of prophylaxis.
Breastfed infants*	AZT (twice daily) and 3TC(twice daily and NVP (once daily)	12 weeks or until the mother's viral load is <50 cp/mL.

* Mothers with acute or primary HIV infection during breastfeeding , **breastfeeding should be immediately discontinued**

Factors such as prolonged rupture of membranes, preterm delivery and low birth weight are no longer associated with increased risk of transmission when mothers are with satisfactory viral suppression. The critical determinant of transmission is maternal viral load. Three-drug infant therapy is recommended for all circumstances other than where maternal viral load at 36 weeks' gestation/delivery is < 50 HIV RNA copies/mL.

Initiating ART as treatment in an infant less than 2 weeks of age, a regimen of AZT + 3TC + NVP should be started and NVP be substituted with LPV/r at the earliest opportunity, preferably at 2 weeks of age. In settings where LPV/r syrup is unavailable, NVP should be continued until 3 months of age, with close clinical monitoring for children at high risk of NNRTI resistance due to prolonged NVP-based postnatal prophylaxis or documented NNRTI failure in the mother. Where it is available, raltegravir could also be considered as an option in special circumstances.

13. HIV diagnosis in infants and children

- Virologic assays (HIV RNA or HIV DNA nucleic acid tests [NATs]) that directly detect HIV must be used to diagnose HIV in infants and children aged <18 months with perinatal and postnatal HIV exposure. HIV antibody and HIV antigen/antibody tests should not be used .
- Plasma HIV RNA or cell-associated HIV DNA NATs are generally equally recommended.
- Plasma HIV RNA or DNA NAT results can be influenced by maternal ART or infant ARV prophylaxis or presumptive HIV therapy.
- All HIV exposed infants should undergo nucleic acid testing (NAT) at birth to identify HIV infection , then at 8 weeks of age (at least 2 weeks after cessation of PEP) or at the earliest opportunity thereafter and at 4-6 months.
- Age-appropriate HIV testing also is recommended for infants and children with signs and/or symptoms of HIV.
- For children older than 24 months, and for those aged 18 to ≤ 24 months with non-perinatal HIV exposure, HIV antibody (or HIV antigen/antibody) tests are recommended for diagnostic testing.
- In infants with an initial positive virological test result, Antiretroviral therapy (Not PEP) should be started without delay and at the same time a second blood sample is collected to confirm the initial positive virological test result.
- Confirmation of HIV infection among infants less than 18 months should be based on two positive virologic tests from separate blood samples.
- **Do not delay ART for confirmatory test results.** Immediate initiation of ART saves lives and should not be delayed while waiting for the results of the confirmatory test.
  .

13.1 Timing of assessments

Table 7 : Infant diagnosis among exclusively non-breastfed infants

Virological assays (HIV RNA and HIV DNA nucleic acid tests) for HIV infection should be performed on the following occasions
• At Birth (During the first 48 hours) • At 8 weeks (or at least 2 weeks after cessation of infant prophylaxis • At 4-6 months (or at least 8 weeks after cessation of infant prophylaxis • Infants who are at high risk of perinatal HIV infection additional virological test at 2-3 weeks of age.
Antibody testing
• HIV antibody testing for seroreversion should be checked at age 9 and 18 months. • Although an HIV antibody test may be negative before this time, engagement in care with follow-up of the infant should continue until at least 18 months of age.

- ❖ HIV antibody testing for sero-reversion should be performed at age 9 and 18 months to exclude HIV infection. (If HIV antibody test is negative, the test should be repeated immediately with a separate blood sample to confirm HIV negative status).
- ❖ **Children with perinatal HIV exposure aged 18-24 months may have residual maternal HIV antibodies. In such a case, confirmation should be based on nucleic acid** test.

13.1.2 Definitive exclusion of HIV infection in non-breastfed infants

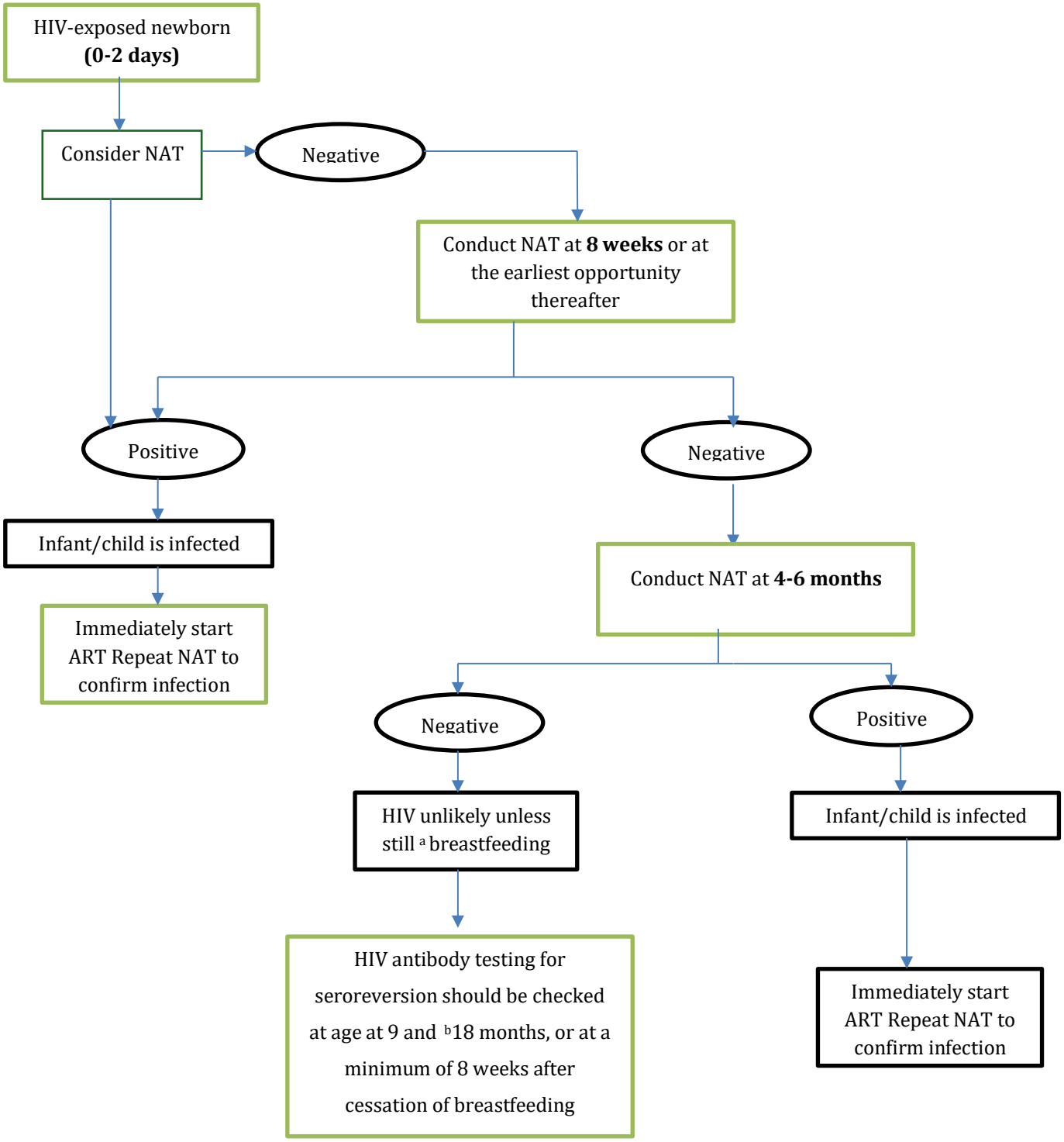
- Is based on 2 or more negative virological tests, with one obtained at age ≥1 month and one at age ≥4 months, or 2 negative HIV antibody tests from separate specimens obtained at age ≥6 months
- Some experts confirm the absence of HIV infection at 12 to 18 months of age in children with prior negative virological tests by performing an antibody test to document loss of maternal HIV antibodies.

- Health care providers should routinely inquire about abstinence of breastfeeding and emphasise HIV-infected mothers/caregivers on safer feeding options.

Table 8 : Infant diagnosis among breastfed infants

Virological assays for HIV infection should be performed on the following occasions
• At birth (During the first 48 hours) • At 2 weeks of age. • Virologic diagnostic testing should be performed every 3 months during breastfeeding • After cessation of breastfeeding, irrespective of when breastfeeding ends, virologic diagnostic testing should be performed at 4 to 6 weeks, 3 months, and 6 months after cessation.
Antibody testing
. • HIV antibody testing for seroreversion should be checked at age 9 and 18 months, or at a minimum of 8 weeks after cessation of breastfeeding, if this is later. • Engagement in care should continue until this time.

Figure 3: Early Infant diagnosis algorithm



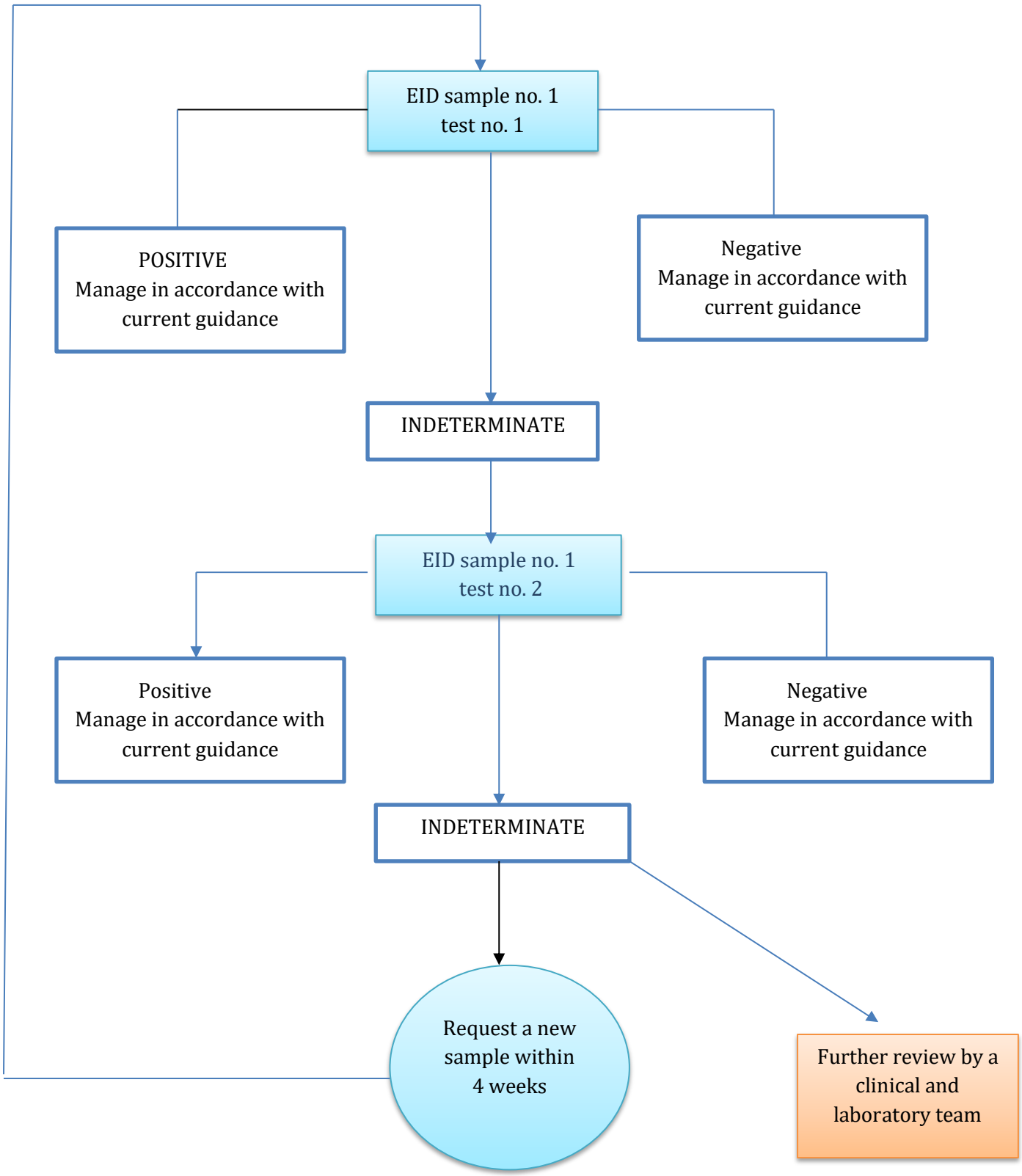
[a] Virologic diagnostic testing should be performed every 3 months during breastfeeding

[b] Children with perinatal HIV exposure aged 18-24 months may have residual maternal HIV antibodies. In such a case, confirmation should be based on nucleic acid test.

13.2 Managing indeterminate HIV test results in infants' diagnosis

Declining mother-to-child transmission rates globally have led to concerns about false-positive and indeterminate tests. People with indeterminate results need immediate repeat testing and should be managed according to the standard operating procedures. People with repeated indeterminate results need a multidisciplinary team of health care providers to support retention, tracking and status resolution. ART programmes need to give priority to confirmatory testing of all positive test results using a new sample. Clinical monitoring and further testing based on the national infant testing schedule need to be done until a definitive HIV status is established.

Figure 4: Managing indeterminate test results: standard operating procedure



14. Antiretroviral drug dosing recommendations for newborns

All newborns who were exposed perinatally to HIV should receive postpartum antiretroviral (ARV) drugs to reduce the risk of perinatal transmission of HIV .

Newborn ARV regimens should be started as soon as possible after birth, ideally within 6 hours, with doses appropriate for the infant's gestational age.

A newborn's ARV regimen should be determined based on maternal and infant factors that influence the risk of perinatal transmission of HIV

Table 9 : ART dosage for infants

<table>
<tr><th>Drug</th><th>Drug Doses by Gestational Age at Birth</th><th>Common side effects</th></tr>
<tr><td rowspan="2">ZDV</td><td>Weight-Band Dosing for Newborns Aged ≥35 Weeks Gestation from Birth to 4 Weeks
<table>
<tr><th>Weight Band</th><th>Volume of ZDV 10 mg/mL Oral Syrup Twice Daily</th></tr>
<tr><td>2 to < 3kg</td><td>1 mL</td></tr>
<tr><td>3 to <4 kg</td><td>1.5 mL</td></tr>
<tr><td>4 to < 5 kg</td><td>2 mL</td></tr>
</table></td><td>Anaemia, neutropenia</td></tr>
<tr><td>≥30 to <35 Weeks' Gestation at Birth
Birth to Age 2 Weeks
• ZDV 2 mg/kg per dose orally twice daily
Age 2 Weeks to 6 to 8 Weeks
• ZDV 3 mg/kg per dose orally twice daily
Age >6 to 8 Weeks
• ZDV 12 mg/kg per dose orally twice daily; make this dose increase only for infants with confirmed HIV infection.</td><td></td></tr>
</table>

	<30 Weeks' Gestation at Birth *Birth to Age 4 Weeks* • ZDV 2 mg/kg per dose orally twice daily *Age 4 to 8 to 10 Weeks* • ZDV 3 mg/kg per dose orally twice daily *Age >8 to 10 Weeks* • ZDV 12 mg/kg per dose orally twice daily; only make this dose increase for infants with confirmed HIV infection.	
3TC	**≥32 Weeks' Gestation at Birth** *Birth to Age 4 Weeks* • 3TC 2 mg/kg per dose orally twice daily *Age >4 Weeks* • 3TC 4 mg/kg per dose orally twice daily	Anaemia, neutropenia (much less common than with AZT)
NVP	**≥37 Weeks' Gestation at Birth** *Birth to Age 4 Weeks* • NVP 6 mg/kg per dose orally twice daily *Age >4 Weeks* • NVP 200 mg/m^2 BSA per dose orally twice daily; only makes this dose increase for infants with confirmed HIV infection.	Rash and liver dysfunction – rare in neonates **Stop NVP after 2/52, in view of long half-life**, continue other PEP agents for full 4/52
	≥34 to <37 Weeks' Gestation at Birth *Birth to Age 1 Week* • NVP 4 mg/kg per dose orally twice daily	

	Age 1 to 4 Weeks • NVP 6 mg/kg per dose orally twice daily *Age >4 Weeks* • NVP 200 mg/m^2 BSA per dose orally twice daily; only makes this dose increase for infants with confirmed HIV infection.	
	≥32 to <34 Weeks' Gestation at Birth *Birth to Age 2 Weeks* • NVP 2 mg/kg per dose orally twice daily *Age 2 to 4 Weeks* • NVP 4 mg/kg per dose orally twice daily *Age 4 to 6 Weeks* • NVP 6 mg/kg per dose orally twice daily *Age >6 Weeks* • NVP 200 mg/m^2 BSA per dose orally twice daily; only make this dose increase for infants with confirmed HIV infection.	

15. Co-trimoxazole prophylaxis

Pneumocystis pneumonia (PCP) prophylaxis , cotrimoxazole, should be initiated from age 4 weeks in:

- All HIV-infected infants.
- Infants with an initial positive HIV DNA/RNA test result (and continued until HIV infection has been excluded).

Age Category	Dose (Sulfamethoxazole/ trimethoprim)
Infants below 6 months or < 5 kg	100 mg /20 mg
Children 6 months–5 years or 5-15 kg	200 mg/40 mg
Children 6–14 years old or 15–30 kg	400 mg/80 mg
over 14 years or >30 kg	800 mg/160 mg

Note : Cotrimoxazole suspension contains 200 mg/40 mg per 5 ml of syrup. Single strength tablets contain 400 mg/80 mg, double strength tablet twice that. It is possible to divide the tablets for children and infants.

16. Infant feeding

Infant feeding intentions need to be discussed early in pregnancy so that appropriate information and support can be provided.
Factors that increase the risk of HIV transmission via breast milk when women are not on ART include:

- Detectable HIV viral load.
- Advanced maternal HIV disease.
- Longer duration of breastfeeding.
- Breast and nipple infection/inflammation.
- Infant mouth or gut infection/inflammation.
- Mixed feeding, in particular solid food given to infants less than 2 months of age

The safest option for infants born to women with HIV is formula feeding, as it eliminates post-birth HIV exposure risk Women who choose to breastfeed should be advised of the small on-going risk of HIV transmission. They should be supported in their decision, if they maintain the following criteria.

- A fully suppressed HIV viral load (for as long a period as possible, but certainly during the last trimester of pregnancy).
- A good adherence history.
- Strong engagement with the perinatal MDT
- Prepared to attend for monthly clinic review and blood HIV viral load tests for themselves and their infant during and for 2 months after stopping breastfeeding

Women not breastfeeding their infants, should be offered cabergoline to suppress lactation.
Formula milk is provided with the support of the NGO, National AIDS Foundation

17. Contraception for women living with HIV

Family planning is a cornerstone of maternal and child health and a vital component of global health initiatives. The integration of family planning and HIV services is essential for achieving the Sustainable Development Goals, particularly in reducing maternal mortality, unplanned pregnancies, and new pediatric HIV infections. By ensuring universal access to comprehensive sexual and reproductive health services, including family planning, for all individuals living with or affected by HIV, we can significantly improve health outcomes and promote social and economic well-being.

- Contraceptive needs should be discussed with all women during antenatal period.
- Using condoms alongside another method of contraception is recommended for dual protection against both pregnancy and the transmission of HIV.
- The choice of contraception will depend on individual health, potential drug interactions, and personal preferences.
- Ovulation usually resumes at 6 weeks of postpartum but may occur earlier in non-breastfeeding women. A plan for contraception postnatally should have been discussed in advance of delivery and revisited in the early postpartum period and at the 4- to 6-week follow-up.
- Women should be advised that it is possible to conceive before the first postnatal menses and therefore to use condoms, if necessary, until the postnatal review.
- They have options for oral contraceptive pills, injectables (e.g., Medroxy Progesterone Acetate), implants (e.g., Jadelle), intrauterine devices (IUDs), and female sterilization.
- Some antiretroviral medications may interact with hormonal contraceptives potentially reducing their effectiveness. Drug interactions between ART and hormonal contraceptives should be checked with the WHO Medical Eligibility Criteria .

Table 10: Contraceptive methods

Non-hormonal methods	• **Male condom** • **Female condom** • **Intrauterine device (IUD)** • **Female sterilization**
Hormonal methods	• **Intrauterine system (IUS)** • **Injection -** Depo Medroxy Progesterone Acetate is the most common version, and it should be taken every twelve weeks. • **Combined pill -** Contains the hormones oestrogen and progestogen. • **Implant -** Small flexible rods that are inserted under the skin, and releases progestogen for up to three years or five years depending on the brand.

Table 11: Drug Interactions Between HIV Antiretroviral Therapy (ART) and Contraception

(Contraceptive methods: CHC, combined hormonal contraception**; Cu-IUD**, copper intrauterine device**; DMPA,** progestogen-only injectable: depot medroxyprogesterone acetate**; ENG-IMP,** etonogestrel implant; **LNG-IUD,** levonorgestrel-releasing intrauterine system; **POP,** progestogen-only pill**)**

ART Class	CHC	POP	ENG-IMP	DMPA	LNG-IUD	Cu-IUD
Nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs) Abacavir (ABC) Emtricitabine (FTC) Lamivudine (3TC) Tenofovir disoproxil fumarate (TDF) Tenofovir alafenamide (TAF) Zidovudine (AZT)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					
Non-nucleoside reverse transcriptase inhibitors (NNRTIs) Efavirenz (EFV)	X			✓	✓	✓
	Contraceptive effectiveness could be reduced. Use not advised. Recommend an No need for extra precautions. alternative effective method					
Etravirine (ETR) Nevirapine (NVP	?			✓	✓	✓
	Potential weak interaction but not expected to affect contraceptive effectiveness. To err on the side of caution, recommend an alternative effective method or advise additional condoms use					
Doravirine (DOR) Rilpivirine (RPV	✓	✓	✓	✓	✓	✓
Rilpivirine (RPV)	✓	✓	✓	✓	✓	✓

ART Class	CHC	POP	ENG-IMP	DMPA	LNG-IUD	Cu-IUD
Boosted protease inhibitors Atazanavir/ritonavir (ATV/r) Darunavir/ritonavir (DRV/r) Lopinavir/ritonavir (LPV/r) Atazanavir/cobicistat (ATV/c)* Darunavir/cobicistat (DRV/c	?	?	?	✓	✓	✓
	• Interaction that could increase progestogen exposure but not expected to affect contraceptive effectiveness. • In case of PIs boosted with cobicistat, recommend an alternative effective method or use with caution due to increased ethinylestradiol exposure	• Potential weak interaction that could increase progestogen exposure but not expected to affect contraceptive effectiveness. No need for extra precautions				
Integrase strand transfer inhibitors (INSTIs) Raltegravir (RAL) Dolutegravir (DTG) Bictegravir (BIC) Cabotegravir CAB)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					
Boosted INSTIs **Elvitegravir/ cobicistat (EVG/c)**	?	✓	✓	✓	✓	✓
	Potential interaction causing decreased ethinylestradiol exposure. Should not be given with a low dose (ie, 20μg ethinylestradiol) combined oral contraceptive	No expected effect on contraceptive effectiveness. No need for extra precautions.				

ART Class	CHC	POP	ENG-IMP	DMPA	LNG-IUD	Cu-IUD
CCR5 antagonists Maraviroc (MVC)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					
Fusion inhibitors Enfuvirtide (ENF)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					
CCR5 antagonists Maraviroc (MVC)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					
Fusion inhibitors Enfuvirtide (ENF)	✓	✓	✓	✓	✓	✓
	No expected effect on contraceptive effectiveness. No need for extra precautions.					

Table 12: ART and emergency contraception (EC)

ART Class	LNG-EC	UPA-EC	Cu-IUD
Nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs) Abacavir (ABC) Emtricitabine (FTC) Lamivudine (3TC) Tenofovir disoproxil fumarate (TDF) Tenofovir alafenamide (TAF) Zidovudine (AZT)	✓	✓	✓
	No effect on EC effectiveness.		
Non-nucleoside reverse transcriptase inhibitors (NNRTIs) Efavirenz (EFV)	?	?	
	The effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. If Cu-IUD not appropriate or not acceptable, offer double dose LNG-EC.	The effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. Double dose UPA-EC is not recommended. The effectiveness of UPAEC compared to double dose LNG-EC is not known	The effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. Double dose UPA-EC is not recommended. The effectiveness of UPAEC compared to double dose LNG-EC is not known
Etravirine (ETR) Nevirapine (NVP	?	?	?
	Effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. If Cu-IUD not appropriate or not acceptable, offer double dose LNG-EC	Effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. Double dose UPA-EC is not recommended. The effectiveness of UPAEC compared to double dose LNG-EC is not known	Effectiveness of EC could be reduced. Offer a Cu-IUD if appropriate. Double dose UPA-EC is not recommended. The effectiveness of UPAEC compared to double dose LNG-EC is not known
Doravirine (DOR) Rilpivirine (RPV	✓	✓	✓
	No effect on EC effectiveness.		

ART Class	LNG-EC	UPA-EC	Cu-IUD
Boosted protease inhibitors Atazanavir/ritonavir (ATV/r) Darunavir/ritonavir (DRV/r) Lopinavir/ritonavir (LPV/r) Atazanavir/cobicistat (ATV/c)* Darunavir/cobicistat (DRV/c	✓	✓	✓
	No effect on EC effectiveness.		
Integrase strand transfer inhibitors (INSTIs) Raltegravir (RAL) Dolutegravir (DTG) Bictegravir (BIC) Cabotegravir CAB)	✓	✓	✓
	No effect on EC effectiveness.		
Boosted INSTIs Elvitegravir/ cobicistat (EVG/c)	✓	✓	✓
	No effect on EC effectiveness.		
CCR5 antagonists Maraviroc (MVC)			
	No effect on EC effectiveness.		
Fusion inhibitors Enfuvirtide (ENF)	✓	✓	✓
	No effect on EC effectiveness.		
CCR5 antagonists Maraviroc (MVC)			
	✓	✓	✓
	No effect on EC effectiveness.		

19. Immunization

Infants born to HIV-positive mothers should follow the routine national primary immunization.

Table 13: Immunization Schedule

Age	Standard schedule	Infant with HIV	Remarks
0-4 weeks	BCG	HIV infected infants should not receive BCG vaccine. BCG should be avoided till HIV is excluded in HIV exposed infants	
On completion of			
2 months	OPV & Pentavalent (DPT-Hep B-Hib) (1st dose)	Inactivated Polio vaccine + Pentavalent (DPT-Hep B-Hib) (1st dose)	When Inactivated Polio vaccine is not available giving OPV can be considered when the child is not severely immune suppressed
4 months	OPV & Pentavalent (DPT-Hep B-Hib) (2nd dose)	Inactivated Polio vaccine + Pentavalent (DPT-Hep B-Hib) (2nd dose)	
6 months	OPV & Pentavalent (DPT -Hep B-Hib) (3rd dose)	Inactivated Polio vaccine + Pentavalent (DPT-Hep B-Hib) (3rd dose)	
9th month	MMR	MMR	MMR- should be postponed in severe immune deficiency
12th month	Live JE	Inactivated JE vaccine, Hep A 1st dose (2nd dose in 6-12 months)	If using live attenuated should not be given to severely immune compromised children Hep A- patients with severe immunosuppression may have a suboptimal response
13-15 months		Varicella -2 doses 3 months apart	Patients who are severely

			immunosuppressed should not receive the vaccine.
18th month	OPV & DTP (4th dose)	Inactivated Polio vaccine +DTP	
Age	Standard schedule	Infant with HIV	Remarks
3rd year	MMR 2nd dose	MMR 2nd dose	
5 years	OPV+DT	Inactivated polio+DT	
12 years	aTd	aTd	
12-13 years (females, males)		HPV (Gardasil) 2 doses (0, 6 months)	

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17. Antiviral management new borns with perinatal HIV exposure or HIV infection updated January 31st, 2023.

21. Annexures

Annexure 1 : General circular letter No. 01-51/2016 - English

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சுவசிரிபாய
SUWASIRIPAYA

මගේ අංකය)
எனது இல)
My No.) DDG/(PHS-1)/NSACP/2011

ඔබේ අංකය)
உமது இல)
Your No. :)

දිනය)
திகதி)
Date) 2016.09. 30

සෞඛ්‍ය, පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார,போசணைமற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition& Indigenous Medicine

General Circular No : 01 - 51 /2016

All Provincial / Regional Directors of Health services,
All Directors of Teaching Hospitals,
All Heads of Specialized Campaigns,
All Heads of Health Institutions

Programme for Ending AIDS by 2025 in Sri Lanka

Sri Lanka is currently planning to work towards ending AIDS by 2025. The decision to treat all persons living with HIV (PLHIV) with antiretroviral treatment was taken by the Ministry of Health after a series of consultations based on the WHO recommendations. To facilitate this process the Ministry of Health procured ARV drugs using government funds from 2016. With appropriate services majority of PLHIV on antiretroviral treatment will achieve undetectable viral loads within months after starting ART minimizing further transmission risks. With use of ART the quality of life and life expectancy has increased among PLHIV. Most PLHIV who adhere to treatment will be asymptomatic and live for many years eliminating the risk of developing AIDS. They will be able to contribute to the betterment of the country, society and their families.

02. The diagnosis of HIV affects a person physically, psychologically and socially. Care and support provided by the health care workers without stigma or discrimination will help them to adjust to living with HIV. Early identification through testing is important to provide comprehensive care services to all PLHIV. Services for PLHIV including antiretroviral treatment (ART) are available at STD clinics and Infectious Diseases Hospital (IDH).

03. It is necessary to take measures to facilitate comprehensive care services for PLHIV as per the guidelines given below.

i. Provider initiated HIV testing should be offered to patients based on symptoms, signs or risky behaviours. Hospital clinic/ward has to arrange collection of 3cc of blood in a vacutainer tube and transport to the local STD clinic for HIV testing.

ii. STD clinics have to carry out HIV screening tests on the blood samples received from wards and issue reports. The information on HIV positive reports need to be informed immediately to the relevant medical officer or consultant while taking measures to strictly maintain the confidentiality.

ii. Antenatal clinic services (MOH clinics and Hospital ANC clinics) have to arrange collection of 5cc of blood in a vacutainer tube and transport to the STD clinic for Syphilis and HIV testing. The method of sample transport need to be locally adopted, after discussions with RDHS, MOMCH, MO/STD and MOHs.

iii. Review syphilis and HIV test results at subsequent visits. Syphilis and HIV test reports need to be entered in the antenatal record appropriately.

iv. STD clinics have to carry out Syphilis and HIV screening tests on the blood samples receivedfrom ANC clinics and send reports to the relevant officers.

v. The information on reactive VDRL reports and HIV positive reports need to be informed to the MO, MOH or VOG and measures should be taken to strictly maintain the confidentiality of the information.

vi. All the pregnant women with positive screening test need to be referred to STD clinic for further management.

vii. If a pregnant woman was not tested during pregnancy, syphilis and HIV screening should be offered at the time of delivery before being discharged from the ward.

viii. All pregnant women with Syphilis or HIV should be provided appropriate services including institutional care, without stigma or discrimination.

ix. EMTCT of syphilis and HIV programme need to be reviewed at the district level every six months with the participation of staff of the STD clinic, MOHs, MOMCH, VOG and RDHS.

x. Women reporting abortions, still births, adverse pregnancy outcomes may need to undergo VDRL and HIV tests if not done in early pregnancy.

(B) Private sector

i. All pregnant mothers are to be screened before 12 weeks of gestation for Syphilis and HIV (preferably at the first visit).

ii. Syphilis and HIV tests need to be done from recognized laboratories maintaining quality standards.

iii. Syphilis and HIV test details need to be entered in the antenatal record appropriately.

iv. Women with positive syphilis or HIV test results should be managed according to the national guidelines by referring to venereologist/ STD clinic.

v. All pregnant women with Syphilis or HIV should be provided appropriate services including institutional care, without stigma or discrimination.

vi. Data on pregnant women with syphilis or HIV should be informed to the NSACP in relevant formats.

5. National HIV policy of Sri Lanka states that "The government of Sri Lanka accepts the right of those living with HIV/AIDS to have access to treatment without stigma and discrimination. Persons living with HIV/AIDS requiring antiretroviral treatment and management of opportunistic infections will be provided by the state sector in line with the national guidelines and prevailing National Health policy." (3.8 page 22)

6. Further, the judgement given on SC.FR.No.77/2016 on 14.03.2016 states "The court also wishes to place on record that the state should ensure that the human rights of the people living with HIV/AIDS are promoted, protected and respected and measures to be taken to eliminate discrimination against them."(Page 4)

7. I reiterate the policy of the Government of Sri Lanka, is to provide a comprehensive antenatal care package to pregnant women for a successful pregnancy outcome and it includes providing services for syphilis and HIV testing for all. Your cooperation is earnestly requested.

Dr. P. G. Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine
"Suwasiripaya",
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Colombo 10.

Dr. P.G.Mahipala
Director General of Health Services

Cc
1. Director, Private Health sector, MOH.
2. President, Sri Lanka College of Obstetricians.
3. President, Independent Medical Practitioners Association.
4. President, Ceylon College of General Practitioners.
5. President, Sri Lanka Medical Association.

Annexure 2 : General circular letter No. 01-51/2016 - Tamil

Annexure 1.3 General Circular in Tamil

எனது இல:.....

சுகாதார சேவைகள் பணிப்பாளர் நாயகம் அலுவலகம்

சுவசிரிபாய,

சுகாதார அமைச்சு,

கொழும்பு ,

07.11.2013

அனைத்து மாகான சுகாதார சேவைகள் பணிப்பாளர்கள்,

அனைத்து பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்கள்,

அனைத்து போதனா, பொது, மாவட்ட வைத்தியசாலைகளின் பணிப்பாளர்கள்,

இலங்கையில் தாயிலிருந்து குழந்தைக்கு பரவும் மேக நோய் (CONGENITAL SYPHILIS) மற்றும் எச்.ஐ.வி. தொற்றுதலை (MOTHER TO CHILD TRANSMISSION OF HIV) இல்லாதொழிக்கும் செயல் முறைத்திட்டம். (EMTCT OF SYPHYLIS AND HIV)

தாயிலிருந்து குழந்தைக்கு பரவும் பிறப்பியல் மேக நோய் மற்றும் எச்.ஐ.வி. தொற்றுதல் முதலியனவற்றை இலங்கையிலிருந்து இல்லாதொழிக்க முடியுமென இனங்காணப்பட்டுள்ளது.

இந்த இல்லாதொழிக்கும் நிலையை அடையவதற்கு, உரிய செயலூக்கமுடைய, முழு நாடளவிலான, பொதுத் தழுவுகொண்ட செயல்த்திட்ட நடைமுறை அவசியமாகும். இலங்கையில் தாயிலிருந்து குழந்தைக்கு பரவும் மேக நோய்க்கான திரையிடல் பரிசோதனையானது, கிட்டத்தட்ட முழு நாடளவிலானதாக சாதிக்க முடிந்துள்ளது(98%).

கர்ப்பிணித் தாய்மார்களுக்கான எச்.ஐ.வி. திரையிடல் பரிசோதனையை, ஏற்கனவே உள்ள மேக நோய்க்கான திரையிடல் பரிசோதனையுடன் சேர்த்து நடைமுறைப்படுத்த சுகாதார அமைச்சினால், தொடரான ஆலோசனைக் கூட்டங்களின் பின்னர் தீர்மானிக்கப்பட்டுள்ளது.

இதனால், தாயிலிருந்து குழந்தைக்கு பரவும் மேக நோய் (CONGENITAL SYPHILIS) மற்றும் எச்.ஐ.வி. தொற்றுதலை (MOTHER TO CHILD TRANSMISSION OF HIV) இல்லாதொழிக்கும் செயல் முறைத்திட்டத்துக்கு, சுகாதார அமைச்சானது, பிராந்திய சுகாதார சேவை அதிகாரிகளின் முழுப் பொறுப்பையும் ஒத்துழைப்பையும் நாடுகின்றது.

பின்வரும் வழிகாட்டல் முறைகளின் மூலம் கர்ப்பிணித் தாய்மார்களுக்கான மேக நோய்க்கானதும், மற்றும் எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனைகளை உங்கள் மாவட்டங்களிலுள்ள சுகாதார ஸ்தாபனங்களினூடாக மேற்கொண்டு இச்செயல்முறைக்கு வலிமை சேர்க்குமாறு வேண்டப்படுகிறீர்கள்.

- எல்லா கர்ப்பிணித் தாய்மார்களுக்கான மேக நோய்க்கான, மற்றும் எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனைகளை 12 கிழமை கர்ப்பகாலத்தில் அல்லது முதலாவது கிளினிக் வருகையின்போது செய்யப்படல் வேண்டும்.
- பிரசவமுன்கால கிளினிக்குகளில் - சுகாதார சேவை பணிமனை அதிகாரிகள், வைத்தியசாலை பிரசவமுன்கால கிளினிக்குகள் (ANTENATAL CLINICS - MOH OFFICE; HOSPITAL ANCS) கர்ப்பிணித் தாய்மார்களுக்கான மேக நோய்க்கானதும், மற்றும் எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனைகளை செய்வதற்கு **5 மி.லீ**. குருதியை ஒரு பரிசோதனைக் குழாயிலிட்டு (VACUTAINER TUBE), அருகிலுள்ள பாலுறவு சிகிச்சை நிலையங்களுக்கு உரிய முறையை கையாண்டு அனுப்பப்படல் வேண்டும். இதற்கு பிராந்திய சுகாதார சேவைகள் பணிப்பாளர் (RDHS), தாய்-சேய் சுகாதார அதிகாரி (MOMCH), பாலுறவு

நோய் கிளினிக் மருத்துவ அதிகாரி (MO-STDs) மற்றும் சுகாதார சேவை பணிமனை அதிகாரி(MOHs) போன்றோருடன் கலந்தாலோசித்து சிறந்ததொரு அனுப்பும் முறை கடைப்பிடிக்கப்படல் வேண்டும்.

- பாலுறவு நோய் சிகிச்சை நிலையங்கள், இந்த கர்ப்பிணித் தாய்மார்களுக்கான மேக நோய் மற்றும் எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனைகளை உரிய முறையில் செய்து, சம்பந்தப்பட்ட சுகாதார உத்தியோகத்தர்களுக்கு அனுப்பப்படல் வேண்டும்.
- மேக நோய்க்கான திரையிடல் பரிசோதனை முடிவு நேர்மறையாகவிருப்பின்(VDRL REACTIVE) மற்றும் எச்.ஐ.வி. தொற்றுதலுக்கான முடிவு நேர்மறையாகவிருப்பின் (HIV SCREENING POSITIVE) அவற்றை இரகசியமாகவும் பாதுகாப்பானதாகவும் உரிய சுகாதார சேவை பணிமனை அதிகாரி(MOH) / விசேட மகப்பேற்று மருத்துவ அதிகாரி (VOG) க்கு அனுப்பப்படல் வேண்டும்.
- எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனை முடிவு நேர்மறையாகவுள்ள எல்லா கர்ப்பினித் தாய்மார்களையும் (ALL HIV SCREENING POSITIVE PREGNANTS) அருகிலுள்ள பாலுறவு நோய் சிகிச்சை நிலையங்களுக்கு மேலதிக பரிசோதனை மற்றும் சிகிச்சைக்காக அனுப்பப்பப்படல் வேண்டும்.
- எல்லா நேர்மறையாகவுள்ள மேக நோய்க்கான / எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனை முடிவுகள் உள்ள கர்ப்பிணித் தாய்மார்களுக்கு எதுவித கலங்கங்களையும் ஏற்படுத்தாமலும், பாகுபாடு காட்டாமலும் உரிய சுகாதார சேவைகளை உரிய நேரத்தில் வைத்தியசாலைகளில்/ சுகாதார நிறுவனங்களில் வழங்கபடல் வேண்டும்.
- தாயிலிருந்து குழந்தைக்கு பரவும் மேக நோய் மற்றும் எச்.ஐ.வி. தொற்றுதலை இல்லாதொழிக்கும் இந்த செயல் முறைத்திட்டமானது (EMTCT OF SYPHYLIS AND HIV) ஒவ்வொரு 6 மாத காலத்திற்கு ஒரு தடவை, ஒவ்வொரு மாவட்ட ரீதியாக அனைத்து சுகாதார அதிகாரிகள் முன்னிலையில் ஒன்றுகூடி கலந்துரையாடப்படல் வேண்டும். இதன்போது பிராந்திய சுகாதார சேவைகள் பணிப்பாளர் (RDHS), தாய்-சேய் சுகாதார அதிகாரி (MOMCH), பாலுறவு நோய் கிளினிக் மருத்துவ அதிகாரி (MO-STDs), சுகாதார சேவை பணிமனை அதிகாரி(MOHs) மற்றும் விசேட மகப்பேற்று மருத்துவ அதிகாரி (VOG) போன்றோர் கட்டாயமாக பங்குபற்ற வேண்டும்.

இலங்கை அரசாங்கம் கர்ப்பிணித் தாய்மார்களுக்காக சிறந்ததொரு பிரசவமுன்கால பொதியை கொடுத்து, இதன்மூலம் சிறந்த பிரசவகால முடிவைப் பெறும் முகமாக, மேக நோய்க்கான / எச்.ஐ.வி. தொற்றுதலுக்கான திரையிடல் பரிசோதனைகளை செய்து; இலங்கைவாழ் சகல மக்களுக்கும் மிகச்சிறந்த சேவையை பெற்றுக் கொடுக்கும் நோக்கத்துடன் இந்த சுற்றரிக்கையை கொள்கையாக பிரகடனப்படுத்துகின்றது.

இதற்காக நான் உங்களின் இன்றியமையாத பூரண ஒத்துழைப்புகள் மற்றும் சேவைகளை மிக மனப்பூர்வமாக கேட்டுக் கொள்கின்றேன்.

சுகாதார சேவைகள் பணிப்பாளர் நாயகம்
சுகாதார அமைச்சு

பிரதிகள்:- 1. பணிப்பாளர் நாயகம், சுகாதார சேவைகள்.
2. பிரதிநிதி, உலக சுகாதார அமைப்பு
3. பிரதி பணிப்பாளர் நாயகம்- பொது சுகாதார சேவைகள் 1,2
4. பிரதி பணிப்பாளர் நாயகம்- ஆய்வுகூட சேவைகள்
5. பணிப்பாளர், தேசிய பாலுறவு நோய், எய்ட்ஸ் தடுப்பு வேலைத்திட்டம்
6. பணிப்பாளர், குடும்ப சுகாதார பிரிவு
7. பணிப்பாளர், தனியார்துறை சுகாதார அபிவிருத்தி

Annexure 3 : General circular letter No. 01-51/2016- Sinhala

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SUWASIRIPAYA

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எனது இல)
My No.)

ඔබේ අංකය)
உமது இல)
Your No. :)

දිනය)2016.10.27
திகதி)
Date)

සෞඛ්‍ය, පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார,போசணைமற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition& Indigenous Medicine

පොදු චක්‍රලේඛ අංක: 01 - 59/2016

සියලුම පළාත්/ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂකවරුන්,
සියලුම ශික්ෂණ රෝහල් අධ්‍යක්ෂකවරුන්,
සියලුම විශේෂිත ව්‍යාපාර ප්‍රධානීන්,
සියලුම සෞඛ්‍ය ආයතන ප්‍රධානීන්,
සියලුම විශේෂඥ ප්‍රසව හා නාරීවේද වෛද්‍යවරුන්,

ශ්‍රී ලංකාවෙන් සංජානනීය උපදංශය සහ මවගෙන් දරුවාට HIV වැළඳීම තුරන් කිරීමේ වැඩසටහන (EMTCT of HIV and Syphilis)

ශ්‍රී ලංකාව වසර 2017 වසරෙහි අවසානය වනවිට සංජානනීය උපදංශය සහ මවගෙන් දරුවාට HIV වැළඳීම තුරන් කිරීමට හැකි රටක් ලෙස හඳුනාගෙන ඇත.

02. මෙම රෝග තුරන් කිරීම සඳහා ශ්‍රී ලංකාව, ගර්භනී මව්වරුන්ගේ HIV සහ උපදංශය රෝග හඳුනා ගැනීමේ මූලික පරීක්ෂණ පහසුකම් දිපව්‍යාප්තව ආවරණය වන පරිදි කල යුතුය. වසර 2015 අග වනවිට ශ්‍රී ලංකාවේ සියලුම ගර්භනී මව්වරුන්ම පාහේ (98%) උපදංශය සඳහා පරීක්ෂා කර ඇත.

03. සෞඛ්‍ය අමාත්‍යාංශය විසින් සාකච්ඡා වට කිහිපයකින් පසුව සියලුම ගර්භනී මව්වරුන්ගේ HIV සඳහා වන මූලික පරීක්ෂණය කිරීමට ප්‍රතිපත්තිමය තීරණයක් ගත් අතර එය දැනට පවතින උපදංශය සඳහා වන රුධිර පරීක්ෂණය සිදුකරන අවස්ථාවේම කිරීමට තීරණය විය. ගර්භනී මව්වරුන් HIV සඳහා පරීක්ෂා කිරීම 2013 මාර්තේ සිට පුළුල් කල අතර 2012 දී 5.6% ක් වූ එය 2015 අග වන විට 71.2%ක් දක්වා වැඩි කිරීමට සමත් විය. මවගෙන් දරුවාට HIV අසාදනයවීම තුරන් කිරීමේ තත්ත්වයට ළඟාවීමට 2016 අග වනවිට එම අගය 95% ක් දක්වා වැඩි කිරීම අවශ්‍ය වේ.

04. ශ්‍රී ලංකාවෙන් සංජානනීය උපදංශය සහ මවගෙන් දරුවාට HIV ආසාදනය තුරන් කිරීමේ වැඩසටහන ක්‍රියාත්මක කිරීම සඳහා සෞඛ්‍යය අමාත්‍යාංශය, සියලුම රජයේ සහ පෞද්ගලික අංශයේ සේවයේ නියුතු විශේෂඥ ප්‍රසව හා නාරීවේද වෛද්‍යවරුන්ගේ කැපවීම සහ සහයෝගය බලාපොරොත්තු වේ. පහත දැක්වෙන උපදෙස් අනුව ඔබගේ ආයතනය තුල උපදංශය සහ HIV හඳුනා ගැනීමේ පූර්ව ප්‍රසව පරීක්ෂණ සිදු කිරීම සඳහා සේවාවන් වැඩිදියුණු කිරීමට පියවර ගැනීම අත්‍යාවශ්‍ය වේ.

(අ) රාජ්‍ය අංශය

i. සියලුම ගර්භනී මව්වරුන් සති 12 ට පෙර උපදංශය සහ HIV සඳහා පරීක්ෂා කල යුතුය. (එය මුලින්ම සායනයට පැමිණි දින කිරීමට හැකි නම් වඩා යෝග්‍ය වේ).

ii. පූර්ව ප්‍රසව සායන (MOH සහ රෝහල් ANC සායන) මගින් වැකුයුවෙනර් නලයකට රුධිරය 5 cc ගෙන "උපදංශය සහ HIV" සඳහා ලෙස සඳහන් කර ළඟම ඇති ලිංගාශ්‍රිත රෝග සායනයට ලැබෙන්නට සැලැස්විය යුතුය. ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂ (RDHS), වෛද්‍ය නිලධාරි/ගර්භනී සහ ළමාසෞඛ්‍යය (MOMCH), වෛද්‍ය නිලධාරි/ලිංගාශ්‍රිත රෝග (MO/STD) සහ සෞඛ්‍යය වෛද්‍ය නිලධාරීන් (MOHS) හා සාකච්ඡා කිරීමෙන් පසුව රුධිර සාම්පල ප්‍රවාහනය සඳහා තමන්ට ගැලපෙන ක්‍රමයක් සකසා ගත යුතුය.

iii. මව්වරුන් නැවත සායනයට පැමිණෙන දින, උපදංශය සහ HIV පරීක්ෂණ වාර්තා තිබෙදැයි පරීක්ෂාකොට ඒවා නියමිත පරිදි ගර්භනී සටහන් පත්‍රයේ සටහන්කළ යුතුය.

iv. ලිංගාශ්‍රිත රෝග සායන මගින් පූරව ප්‍රසව සායන වලින් එවනු ලබන රුධිර සාම්පල් උපදංශය සහ HIV සඳහා වන මූලිකපරීක්ෂණ සිදු කර එම වාර්තා නැවත අදාළ නිලධාරීන් වෙත ලබා දිය යුතුය.

v. උපදංශය හෝ HIV ආසාදිත ලෙස තහවුරුවන රුධිර සාම්පල පිළිබඳ තොරතුරු අදාළ වෛද්‍ය නිලධාරීන් (MO), සෞඛ්‍ය වෛද්‍ය නිලධාරීන් (MOH) හෝ විශේෂඥ ප්‍රසව හා නාරීවේද වෛද්‍යවරුන් (VOG) වෙත රහස්‍යභාවය රැකෙන පරිදි දැන්විය යුතුය.

vi. වැඩිදුර පරීක්ෂණ සහ ප්‍රතිකාර සඳහා, උපදංශය හෝ HIV මූලික පරීක්ෂණයෙන් සොයාගන්නා රෝගය සහිත ගර්භනී මව්වරුන් ලිංගාශ්‍රිත රෝග සායනයකට යොමුකළ යුතුය.

vii. ගර්භනී සමය තුල උපදංශය සහ HIV මූලික පරීක්ෂණ සිදු නොකළ මව්වරුන්ගේ දරු ප්‍රසූතියෙන් පසුව, රෝහලෙන් පිටවීමට පෙර එම පරීක්ෂණ කල යුතුය.

viii. උපදංශය හෝ HIV සහිත ගර්භනී මව්වරුන්ට රෝහල්ගත වීම ඇතුළු අදාළ සියලුම සේවාවන් කොන්කිරීමකින් හෝ පහත්කොට සැලකීමකින් තොරව ලබාදිය යුතුය.

ix. දිස්ත්‍රික්ක මට්ටමෙන්, සංජානනීය උපදංශය සහ මවගෙන් දරුවාට HIV වැළදීම තුරන් කිරීමේ වැඩසටහන පිළිබඳව සෑම මාස හයකටම වරක් ප්‍රාදේශීය සෞඛ්‍යය සේවා අධ්‍යක්ෂ (RDHS), විශේෂඥ ප්‍රසව හා නාරීවේද වෛද්‍යවරුන් (VOG), වෛද්‍ය නිලධාරි/ ගර්භනී සහ ළමාසෞඛ්‍යය (MOMCH), සෞඛ්‍යය වෛද්‍ය නිලධාරීන් (MOH) හා ලිංගාශ්‍රිත රෝග සායන නිලධාරීන්ගේ සහභාගීත්වයෙන් සාකච්ඡා විය යුතුය.

x. ගබ්සාවීම්, මළදරු උපත් ඇතුළුව සියලුම ගර්භනී සංකූලතා වාර්තා වූ මව්වරුන් උපදංශය සහ HIV සඳහා මුල් ගර්භනී අවධියේ පරීක්ෂාකර නොමැතිනම් පරීක්ෂා කිරීම අවශ්‍ය වේ.

(ආ) පුද්ගලික අංශය

i. සියලුම ගර්භනී මව්වරුන් සති 12 ට පෙර උපදංශය සහ HIV සඳහා පරීක්ෂා කල යුතුය. (එය මුලින්ම සායනයට පැමිණි දින කිරීමට හැකි නම් වඩා යෝග්‍ය වේ).

ii. ගුණාත්මක තත්ත්වයෙන් යුතු පිළිගත් පරීක්ෂනාගරයකින් උපදංශය සහ HIV සඳහා වන මූලික පරීක්ෂණ සිදු කල යුතුය.

iii. උපදංශය සහ HIV පරීක්ෂණ සහ එහි ප්‍රතිඵල වාර්තා නියමිත පරිදි ගර්භනී සටහන් පත්‍රයේ සටහන් කළ යුතුය.

iv. උපදංශය හෝ HIV ආසාදිත බවට තහවුරුවන ගර්භනී මව්වරුන්, ජාතික ප්‍රතිපත්තියට අනුකූලව ලිංගාශ්‍රිත රෝග පිළිබඳ විශේෂඥ වෛද්‍යවරයෙකුට හෝ එම සායනයකට යොමුකළ යුතුය.

v. උපදංශය හෝ HIV සහිත ගර්භනී මව්වරුන්ට රෝහල්ගත වීම ඇතුළු අදාළ සියලුම සේවාවන් කොන්කිරීමකින් හෝ පහත්කොට සැලකීමකින් තොරව ලබාදිය යුතුය.

vi. උපදංශය හෝ HIV සහිත ගර්භනී මව්වරුන් පිළිබඳ විස්තර නියමිත පරිදි අදාළ ආකෘතිපත්‍රය පුරවා ජාතික ලිංගාශ්‍රිත රෝග සහ ඒඩ්ස් මධර්න වැඩසටහන (NSACP) වෙත ලැබීමට සැලැස්විය යුතුය.

05. ශ්‍රී ලංකාවේ HIV ජාතික ප්‍රතිපත්තියට අනුව "HIV ආසාදිත පුද්ගලයන්ට කොන්කිරීමකින් තොරව ප්‍රතිකාර ලබාගැනීමට ඇති අයිතිය ශ්‍රී ලංකා රජය විසින් පිළිගෙන ඇත. දැනට ක්‍රියාත්මක ජාතික සෞඛ්‍ය ප්‍රතිපත්තිය අනුව HIV ආසාදිත පුද්ගලයන්ට ප්‍රතිවෛරස ඖෂධ ලබාදීම සහ ඔවුන්ට වැළඳෙන අනෙකුත් ආසාදන සඳහා ප්‍රතිකාර ලබා දීම ලංකා රජය විසින් සිදු කරයි." (3.8 පිටුව 22)

06. තවද, 14.03.2016 දින SC.FR.No.77/2016 අංකය යටතේ දෙන ලද උසාවි නියෝගයට අනුව "රජය HIV ආසාදිත පුද්ගලයන්ගේ මානව අයිතිවාසිකම් ආරක්ෂා කිරීමට, ප්‍රවර්ධනය කිරීමට සහ එයට ගරු කිරීමටත් ඔවුන්ට පවතින කොන්කිරීම ලංකාවෙන් තුරන් කිරීමටත් ක්‍රියා කල යුතුය." (පිටුව 4)

07. යහපත් දරු උපතකට ගර්භනී මව්වරුනට පූරව ප්‍රසව අවධිය තුල ගුණාත්මක සේවාවක් සැපයීම රජයේ ප්‍රතිපත්තිය බව නැවතත් ප්‍රකාශ කර සිටින අතර උපදංශය සහ HIV සඳහා පරීක්ෂා කිරීම සහ ප්‍රතිකාර කිරීමද එයට ඇතුලත්ය. මෙම කාර්යය සාර්ථක කර ගැනීමට මම ඔබගේ අවංක සහයෝගය බලාපොරොත්තු වෙමි.

වෛද්‍ය පී. ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්
සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය,
"සුවසිරිපාය",
385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත,
කොළඹ 10.

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

පිටපත්:-

1. අධ්‍යක්ෂ, පුද්ගලික සෞඛ්‍ය අංශය, සෞඛ්‍ය පෝෂණ හා දේශීය වෛද්‍ය අමාත්‍යාංශය.
2. සභාපති, විශේෂඥ ප්‍රසව වෛද්‍ය විද්‍යාර්ථයින්ගේ සංගමය.
3. සභාපති, නිදහස් වෛද්‍යවරුන්ගේ සංගමය.
4. සභාපති, ලංකා පවුල් වෛද්‍ය විද්‍යාර්ථයින්ගේ සංගමය.
5. සභාපති, ශ්‍රී ලංකා වෛද්‍ය නිලධාරීන්ගේ සංගමය.

Annexure 2: Standard of care - PMTCT of syphilis and HIV

Standard of care in prevention of mother to child transmission of Syphilis and HIV

Standard

All pregnant women should be screened for syphilis and HIV at the first antenatal visit within the first trimester. At delivery, women who do not have test results should be tested. Women with positive syphilis or HIV test results should be managed according to the national guidelines. Their partners should also be screened and managed and plans should be made to screen and manage their infants at birth.

Aim

To reduce maternal morbidity and mortality, fetal loss and neonatal mortality and morbidity due to syphilis and HIV

Requirements

- National policies and guidelines on syphilis and HIV prevention, management and care in pregnant women are available and are correctly implemented.
- All women have access to appropriate ANC care during pregnancy, childbirth and the postpartum period.
- Health care providers are competent in syphilis and HIV prevention, screening during pregnancy, , counseling on STI prevention, how to prevent re-infection during pregnancy and referral for management of seropositive pregnant women and their partners, prophylaxis and management of the newborn
- Suitable Screening methods for syphilis and HIV are available in antenatal clinics and maternity wards.
- Adequate Laboratory facilities (at least one per district) for testing of syphilis and
- HIV with system to ensure quality of laboratory testing are available.
- Necessary supplies for collection and transport of samples are available at the ANC clinic and Supplies for testing of syphilis and HIV are available at the laboratory level.
- Drugs (penicillin, ART etc) are available in the STD clinics and maternity wards where relevant.
- A functioning referral system is available to ensure the management of pregnant women who are identified as having syphilis or HIV
- An effective information system is available to monitor the programme.
- Health education activities are carried out to raise the awareness of individuals, families and communities of the importance of attending ANC clinics early in pregnancy and syphilis and HIV prevention and management.

Applying the standard

Providers of maternal and neonatal health care, in particular public health staff must:

- Screen all pregnant women for syphilis and HIV at the first antenatal visit. Screening should be done preferably before 12 weeks of gestation to prevent congenital infection.
- Review syphilis and HIV test results at subsequent visits. All the women with positive screening test need to be referred to STD clinic for further management.
- If a woman was not tested during pregnancy, syphilis and HIV screening should be offered after delivery.

- Manage all women who are seroreactive for syphilis according to the stage of syphilis following national guidelines at the STD clinic.
- Manage all women with positive HIV test according to the national guidelines to prevent mother to child transmission of HIV
- Discuss with the woman the importance of treatment for herself, her partner(s) and the baby, explain the consequences of not treating the infection, and discuss the necessity of condom use during treatment.
- Make plans to manage the baby at birth.
- Advise women who test positive that their partner(s) must also be screened and managed according to the stage of syphilis. The babies also need to be screened as soon as possible after birth.
- Advise women and partners who test negative how to remain negative.
- Screen all women with adverse pregnancy outcome (abortion, stillbirth, syphilitic infant, etc.) for syphilis and HIV, if not screened.
- Screen all women with syphilis or HIV for other STIs, and provide counseling and management accordingly.
- Record test results and if positive for syphilis or HIV details of management, in the clinic and pregnancy records.
- Maintain the confidentiality of the information regarding the patients.

Audit

Input indicators

- National policies and guidelines on syphilis and HIV prevention, management and care in pregnant women are available and are correctly implemented.
- The proportion of health facilities providing ANC services that have screening facilities for syphilis and HIV.

Process and output indicators

- Coverage of syphilis screening in pregnant women
- Coverage of HIV screening in pregnant women
- Coverage of correct management of syphilis in pregnant women at the STD clinic
- Coverage of correct management of HIV in pregnant women at the STD clinic
- Coverage of partners tested and managed accordingly
- Coverage of babies born to syphilis positive mothers who received appropriate treatment.
- Coverage of babies born to HIV positive mothers who received prophylactic ARV treatment

Outcome/ Impact indicators

- Incidence of congenital syphilis
- Incidence of HIV among infants
- Perinatal and neonatal mortality and morbidity due to congenital syphilis.
- Perinatal and neonatal mortality and morbidity due to paediatric HIV
- Stillbirth rate.

Annexure 3: Guideline to collect blood samples for VDRL and HIV

<u>පූර්ව ප්‍රසව සායනයන්හි VDRL/HIV පරීක්ෂණයට රුධිරය ගැනීම සඳහා උපදෙස් මාලාව</u>

1. සායනයට පැමිණෙන සියලුම ගැබිණි මව්වරුන්ගේ (කුළුදුල් සහ අනෙකුත්) VDRL/HIV පරීක්ෂණය සඳහා රුධිර නිදර්ශක ලබාගැනීම මුල් මාස 3-4 තුල කල යුතුය.
2. රුධිර නිදර්ශක ලබාගැනීමට ඩිස්පෝසිබල් සිරින්ජර භාවිතා කල යුතුය.
3. මෙම පරීක්ෂණයට රුධිරය අවම වශයෙන් මිලි ලීටර් 5ක් ගත යුතුය.
4. රුධිර ගැනීමට පෙර පැහැදිලිව අංකය ලියු ලේබලය නොගැලවෙන සේ පරීක්ෂණ නලයේ අලවා තිබිය යුතුය.
5. පරීක්ෂණ නලයේ මූඩිය හොඳින් සවි කල යුතුය.
6. සිරින්ජරයට ගත් රුධිර නිදර්ශක පරීක්ෂණ නලයේ මූඩිය මැදින් සිදුරු වන සේ ඉඳි කටුව ඇතුල්කර රුධිරය සෙමින් ගලා යාමට සැලැස්විය යුතුය.
7. පාවිච්චි කල සිරින්ජර සහ ඉඳිකටු ආරක්ෂිත ලෙස විනාශ කල යුතුය.
8. මව්වරුන්ගෙන් ලබා ගත් රුධිර නිදර්ශක අවම වශයෙන් පැය 2ක් වත් කාමර උෂ්ණත්වයේ කූඩා රාක්කයක /පෙට්ටියක් තුල තිරස්ව/ඇලකර තැබිය යුතුය(රුධිර නිදර්ශක ගත් සැනින් ශීතකරණයේ තැබීමෙන් එම රුධිර නිදර්ශක පරීක්ෂණ කටයුතු වලට නුසුදුසු වීම හේතුවේ).
9. හැකි ඉක්මනින් (එදිනම) රුධිර නිදර්ශක අදාල පරීක්ෂණ සිදු කරන රසායනාගාරය වෙත එවිය යුතුය.
10. රුධිර නිදර්ශක ලබා ගන්නා දිනම එවීමට අපහසු වේ නම් රුධිර නිදර්ශක ශීතකරණයේ 4-8°C කොටසේ තැබිය යුතුය.
11. ශීතකරණයේ තැබූ රුධිර නිදර්ශක දින 3ක් තුල අදාල පරීක්ෂණ සිදු කරන රසායනාගාරය වෙත එවිය යුතුය.
12. රුධිර නිදර්ශක රසායනාගාරය වෙත එවීමේදී ඉහිරීම වැලැක්වීම සඳහා පෙට්ටියක හොඳින් අසුරා මූඩිය උඩු අතට සිටින සේ සිරස්ව එවීමට වග බලා ගත යුතුය.
13. රුධිර නිදර්ශක සමඟ එවන පරීක්ෂණ අයදුම්පත්‍රය පැහැදිලිව පුරවා, එනම් අංකය, සායනයේ නම, රුධිරය ලබා ගත් දිනය, එවන තැනැත්තාගේ අත්සන සහිතව වෙනම (රුධිර නිදර්ශක සමඟ නොගැටෙන සේ) එවීමට කටයුතු කල යුතුය.
14. රුධිර නිදර්ශක වල VDRL/HIV පරීක්ෂණ ප්‍රතිඵල හැකි ඉක්මනින් ලබා දීමට ලිංගාශ්‍රිත රෝග සායනය/ඒඩ්ස් මර්දන සායනයේ රසායනාගාරය කටයුතු කරන අතර යම් ලෙසකින් කිසියම් ප්‍රමාදයක් ඇතිවුව හොත් ඒ පිළිබඳව තොරතුරු දුරකතනයෙන් ඇමතීමෙන් දැනගත හැක.

VDRL/HIV පරීක්ෂණයේදී Reactive ප්‍රතිඵල දක්වන රුධිර නිදර්ශක වල නිශ්චිතව ආසාදනය ඇත්දැයි දැන ගැනීමට පරීක්ෂණ මෙම සායනයේදී සිදු කරනු ලැබේ. එහි Positive නම් ප්‍රතිඵල අදාල ආයතනයට දැනුම් දීමෙන් පසු එම ප්‍රතිඵල ඇති ගැබිණි මව අදාල ලිංගාශ්‍රිත රෝග සායනය වෙත හැකි ඉක්මනින් යොමු කල යුතුය .

Annexure 6 : Blood Collection request form

National STD/AIDS Control Programme,
MINISTRY OF HEALTH.

NSACP/ANC/14/V/2

REQUEST FORM FOR SYPHILIS/HIV TESTING IN ANTENATAL MOTHERS.

Institution/clinic ……..

MOH area ……..

Date of sample collection ……..

Patient No (ANC)	Age	Parity.	POA	HIV Results	VDRL Results

…… ……. ……..
Name of collecting officer Designation Signature.

…….. ……. ……..
Name of Medical officer Designation Signature

Lab use only.

Date/Time of receipt of samples:…… ……..am/pm
MLT:…… Medical officer STD/Lab:……..
Date …… Date ……..

Annexure 7 : EMTCT HIV Case Investigation form

EMTCT HIV: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health

Name of the STD clinic:_____ Pregnant Woman's file number & PHN No: _____

Baby's file number & PHN No: _____ Pregnant Woman's HIV clinic registration date:_____

Filled by(name & designation): _____ Pregnant Woman referred from:_____

Note: Fill this form for all HIV confirmed pregnant women registered in the clinic

Details of the pregnant woman with HIV			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc)			
6. KP Status			
7. Parity		8. Past obstetric history	
9. Date of HIV confirmation			
Details of the current pregnancy			
10. LRMP		11. EDD	
12. POA at ANC registration		13. POA when registering for EMTCT services	
14. 1st CD4 count during this pregnancy(Result & date)		15. 1st VL during this pregnancy (Result & date)	
16. Other relevant diagnoses (*TB/Syphilis/Other)		17. Date of ART initiation	
18. ART regimen during this pregnancy			
19. Adherence (>95%, 80-95%, <80%)		20. CD4 count at third trimester	
21. Viral load closest to 36 Weeks of POA		22. Number of ANC visits	
23. Post-partum family planning method			
Details of the sexual partner/s			
24. Partner's HIV status		25. File no.(STD or HIV) & PHN No.	
26. Partner's ART regimen			
27. Partner's KP status			
Details of the baby			
28. Date of birth		29. Facility/Place of birth	
30. Mode of delivery If LSCS – Em/El Indication		31. Gestational age at delivery	
32. Birth weight		33. Infant feeding (exclusive formula/breastfeeding)	
34. ARV prophylaxis (Type/dose/duration)			
35. DNA PCR at birth (date & result)			
36. DNA PCR at 8 weeks		Date	
37. DNA PCR at 16 weeks		Date	
38. HIV ELISA around 18 months		Date	
39. Final diagnosis			
40. If miscarriage – Date & POA of miscarriage			
Remarks			

Annexure 8 : Pregnancy record

Annexure 12: Pregnancy Record (H 512)

සායනික සංරක්ෂණය/பிணியாய்வு நிலைய பராமரிப்பு / Clinic care

සායනයට පැමිණි දිනය/ வருகை தந்த திகதி/ Date of Visit										
ගර්භයට සති / கர்ப்ப வாரங்களின் எண்ணிக்கை / POA										
මුත්‍රා/சிறுநீர் Urine: සීනි/சீனி/ Sugar / ඇල්බියුමින්/அல்புமின் / Albumin	/	/	/	/	/	/	/	/	/	/
සුදුමැලි බව / வெளிறல் / Pallor										
ඉදිමුම வீக்கம் Oedema: වළලුකර / கணுக்கால் Ankle										
ඉදිමුම வீக்கம் Oedema: මුහුණ/முகம்/ Facial										
රුධිර පීඩනය/இரத்த அமுக்கம் /BP										
160										
150										
140										
130										
120										
110										
100										
90										
80										
70										
60										
50										
බුධනයේ උස கருப்பையின் உயரம் Fundal Height										
භ්‍රෑණයේ පිහිටීම සිංகு அமைந்திருக்கும் பாங்கு Foetal Lie										
භ්‍රෑණයේ පිහිටීම சிசுவின் அமைந்திருக்கும் பாங்கு Presentation										
Engagement of the presenting part (வெளிப்படும் பகுதி இடுப்புக்குழியில் இறங்கியிருக்கும் அளவு)										
භ්‍රෑණ චලන சிசுவின் அசைவு FM / හෘද ශබ්ද சிசுவின் இதயத்துடிப்பு FHS	/	/	/	/	/	/	/	/	/	/
යකඩ / ෆෝලේට් இரும்பு போலேட் Iron / Folate / විටමින් සී விட்டமின் C Vitamin C	/	/	/	/	/	/	/	/	/	/
කැල්සියම් கல்சியம் Calcium / මැලේරියා ප්‍රතිකාර மலேரியா எதிர்ப்பு மருந்து Antimalarial Drugs	/	/	/	/	/	/	/	/	/	/
පෝෂක අතිරේක குறை நிரப்பு உணவுகள் Food Supplementation										
පරීක්ෂා කරන ලද නිලධාරියාගේ අත්සන பரிசோதித்தஉத்தியோகத்தரின் கையொப்பம் Signature of the officer examined										
නිල නාමය / பதவி / Designation										

හෘද පරීක්ෂාව இருதய பரிசோதனை **Auscultation**	
පළමු ත්‍රෛමාසිකය முதல் 3 மாதங்கள் First trimester	
දෙවන ත්‍රෛමාසිකය 2 வது 3 மாதங்கள் Second trimester	
තෙවන ත්‍රෛමාසිකය 3 வது 3 மாதங்கள் Third trimester	

ශ්වසන පද්ධතිය சுவாசத்தொகுதி Respiratory System	
පියයුරු පරීක්ෂාව மார்பகப் பரிசோதனை Breast Examination	

පරීක්ෂණ/ பரிசோதனைகள் Investigations

	POA	Result
රුධිරයේ සීනි குருதியில் சீனியின் அளவு Blood Sugar		
හිමොග්ලොබින් ஈமோகுளோபின் Haemoglobin		

වෙනත් පරීක්ෂණ ஏனைய பரிசோதனைகள் Other Investigations	
පණු ප්‍රතිකාර பூச்சித் தடுப்பு மருந்துகள் Antihelminthic Drugs	
Date of issuing kick count chart	

උපදංශය සඳහා පූර්ව පරීක්ෂාව/ சிபிலிசுக்கான முற்பரிசோதனை / **Syphilis Screening**

රුධිර සාම්පලය ගන්නා විට ගර්භයට සති / இரத்தம் எடுக்கப்பட்ட திகதியில் கர்ப்பவாரங்களின் எண்ணிக்கை POA of blood sampling		
රුධිර සාම්පලය ගත් දිනය / இரத்தம் எடுக்கப்பட்ட திகதி Date of blood sampling		
ප්‍රතිඵලය පැමිණි දිනය/ முடிவு பெறப்பட்ட திகதி Date of result received		
ප්‍රතිඵලය/ சோதனை முடிவு / Result	NR	R
ප්‍රතිඵලය (R) නම් වැඩිදුර ප්‍රතිකාර සඳහා යොමුකළ දිනය முடிவு R எனின் மேன்மை சிகிச்சை நிலையத்திற்குப் பரிந்துரைக்கப்பட்டதிகதி If (R) Date of referral		

HIV පූර්වපරීක්ෂාව සඳහා රුධිර සාම්පලය ලබාගත්බව HIV இரத்த மாதிரி பரிசோதனைக்கு முற் பரிசோதனை Blood Sample taken for the HIV Screening	ඔව් ஆம் YES	නැත இல்லை No

පිටගැස්ම ධුලකාභ ප්‍රතිශක්තිකරණය /ஏற்பு நோய் தடுப்பு மருந்து வழங்குதல்/ **Tetanus Toxoid Immunization**

පිටගැස්ම ධුලකාභය ஏற்பு நோய் தடுப்பு மருந்து Tetanus Toxoid	1	2	3	4	5	NE
දිනය/ திகதி / Date						
බාණ්ඩ අංකය குழு இலக்கம் Batch No.						

3

Annexure 9 : Poster for EMTCT of HIV

Annexure 13: Poster EMTCT of HIV

Annexure 10 : Leaflet for pregnant women on service package

Annexure 14.2: Leaflet for pregnant women on service package (Page 2)

සායනයේදී මුත්‍රා හා රුධිරය පරීක්ෂා කල යුත්තේ ඇයි ?

- මුත්‍රා වල ඇල්බියුමින් ප්‍රෝටීන ඇත්දැයි පරීක්ෂා කර එමගින් ගර්භවිෂ රෝග කල්තියා හඳුනා ගෙන පිළියම් කළ හැක.

මව් සායනයේ දී ගනු ලබන රුධිර සාම්පල මගින් පහත සඳහන් සියලුම පරීක්ෂාවන් සිදුකර ගත හැකිය.

- රුධිර වර්ගය හා ආර්.එච් ෂනය (Grouping & Rh)
- හිමොග්ලොබින් (Hb)
- රුධිරයේ සීනි පරීක්ෂණය (Blood Sugar)
- වී.ඩී.ආර්.එල්. පරීක්ෂණය(VDRL)
- එච්.අයි.වී. පරීක්ෂණය(HIV)

රුධිර වර්ගය හා ආර් එච් ෂනය(Grouping & Rh)

දරු ප්‍රසූතියට පෙර ඔබගේ රුධිර වර්ගය කුමක්දැයි දැන ගැනීමෙන් දරු ප්‍රසූතියේදී යම් අවස්ථාවක රුධිරය ලබා දීමට අවශ්‍ය වුවහොත් ඔබට අවශ්‍ය රුධිරය පහසුවෙන් ලබා දිය හැකිවේ.

හිමොග්ලොබින්(Hb)

හිමොග්ලොබින් අඩු බව කල්තියා දැන ගැනීමෙන් නීරක්තයෙන් සිදුවන අහිතකර බලපෑම් වලක්වා ගැනීමට පියවර ගත හැකියි.

රුධිරයේ සීනි පරීක්ෂණය (Blood Sugar)

මෙය පළමු සායනයට පැමිණි අවස්ථාවේ දී සහ නැවත සති 24-28 (මාස 6-7) තුළ පරීක්ෂා කරවා ගැනීමෙන් දියවැඩියා රෝගය පහසුවෙන් හඳුනාගෙන ඉන් සිදුවිය හැකි අහිතකර බලපෑම් වලක්වා ගත හැකිය.

වී.ඩී.ආර්.එල් (VDRL)පරීක්ෂණය

උපදංශ (සිෆිලිස්) රෝගය හඳුනා ගැනීම සඳහා කෙරෙන මූලික පරීක්ෂාවකි. නිසි ප්‍රතිකාර මගින් රෝගය සුව කළ හැකි අතර එමගින් මවගෙන් දරුවාට රෝගය බෝවීමද වැලැක්වේ.

එච්.අයි.වී (HIV) පරීක්ෂණය

HIV ආසාදනය වී ඇතිබව තහවුරු වුවහොත් නිසි ප්‍රතිකාර මගින් මවගේ රෝගී තත්වය පාලනයකළ හැකිය. දරුවාට රෝගය වැළදීමට ඇති හැකියාව මුළුමනින්ම වැලැක්වීම සඳහා අවශ්‍ය සියලුම සේවාවන් ලබා ගත හැකිය.