The Strategy for Elimination of New Paediatric HIV Infections and Congenital Syphilis in Sri Lanka - 2014

The Strategy for Elimination of New Paediatric HIV Infections and Congenital Syphilis in Sri Lanka

2014

NATIONAL STD/AIDS CONTROL PROGRAMME

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Table of Contents

List of Figures Page

List of Tables Page

List of abbreviations and acronyms

AIDS	**Acquired Immune Deficiency Syndrome**
ANC	**Antenatal Clinic**
ART	**Antiretroviral Treatment**
BFP	**Biological False Positive**
CME	**Continuing Medical Education**
MO MCH	**Medical Officer maternal and child health**
MO	**Medical Officer**
EID	**Early Infant Diagnosis**
EMTCT	**Elimination of mother to child transmission**
FHB	**Family Health Bureau**
FP	**Family Planning**
HAART	**Highly Active Antiretroviral Therapy**
HIV	**Human Immunodeficiency Virus**
IEC	**Information, Education and Communication**
MCH	**Maternal and Child Health**
MDG	**Millennium Development Goals**
M&E	**Monitoring and Evaluation**
MoH	**Ministry of Health**
MOH	**Medical officer of Health**
MTCT	**Mother to child transmission**
MSD	**Medical Stores Department**
NSACP	**National STD AIDS Control Programme**
NGO	**Non Governmental Organization**
OI	**Opportunistic Infection**
PEP	**Post-Exposure Prophylaxis**
PITC	**Provider Initiated Testing and Counseling**
PLHIV	**Person(s) Living with HIV**
PMTCT	**Prevention of Mother to Child Transmission of HIV**
QA	**Quality Assurance**
STD	**Sexually Transmitted Disease**
STI	**Sexually Transmitted Infection**
TB	**Tuberculosis**
TOT	**Training of Trainers**
UN	**United Nations**
UNICEF	**United Nations Children's Fund**
VCT	**Voluntary Counseling and Testing**
WHO	**World Health Organization**

1. Introduction

Sexually transmitted infections are one of the commonest communicable diseases found in the world today. STI are mainly transmitted through unprotected sexual exposures. Transmission can occur through blood and body fluids as well as through mother to child transmission. Syphilis and HIV are important STI which cause increased mortality and morbidity in children due to mother to child transmission.

1.1 Global and Regional situation of syphilis and HIV in pregnancy

Syphilis is a sexually transmitted infection caused by the bacterium Treponema pallidum. It is estimated that globally about 12 million cases of syphilis occur annually and of them about 2 million are pregnant women.

There is limited information on the prevalence of syphilis among pregnant women in Asian countries, although studies from China and India in the 1990s found rates of between less than 1% and 5%. In recent years, WHO has noted high rates of syphilis among pregnant women from several countries in eastern Asia, the Pacific, and North Africa (Sudan 2·4%, Morocco 3·0%, Djibouti 3·1%, Papua New Guinea 3·5%, Cambodia 4·0%, and the South Pacific Islands 8·0%). In Latin America and the Caribbean, prevalence of syphilis among pregnant women is between 1·7% and 7·0%. (Damian G Walker and Godfrey J A Walker, 2002)

The human immune deficiency virus pandemic has caused serious social health and developmental challenges to many countries in the world. There are estimated 35.3 million of people living with HIV by end of 2012 and out of which 1 7.7 million are women. Globally HIV is the leading cause of death in women of reproductive age group. Nearly all HIV infections among children are acquired from infected mothers during pregnancy, delivery or while breast feeding. An estimated 3.5 million people are living in the region and women account for 37% of total population. The estimate for children living with HIV in the region accounts for 200 000 in the year 2012.

1.2 How EMTCT contributes to achieving the millennium development goals (MDG)

The elimination of new syphilis and HIV infections among children and keeping their mothers alive contributes directly towards achieving four of the MDGs.

<u>MDG 3 : Promote gender equality and empower women</u>

By supporting women's empowerment through access to HIV prevention information and HIV prevention and treatment services women's vulnerability to HIV is reduced.

<u>MDG 4: Reduce child mortality</u>

By reducing the number of infants infected with HIV and by providing care and support for children living with HIV survival rates of children born to women living with HIV are increased.

MDG 5: Improve maternal health

Through preventing HIV among women, providing family planning services and PMTCT services for women living with HIV can improve health of women and reduce maternal morbidity and mortality.

MDG 6: Combat HIV/AIDS malaria and other diseases

By preventing the spread of HIV through preventing infection among women, prevent HIV transmission to children child and maternal morbidity and mortality can be reduced.

1.3 Situation of syphilis and HIV in Sri Lanka

Sri Lanka is having a low prevalence HIV epidemic with HIV seroprevalence rate of <0.1% among general population. By the end of the 2013, 1845 adult new infections have been identified including 730 females with HIV infection. Majority of these females are in the reproductive age group (77.5%), increasing the risk of transmission from mother to child. Seventy one paediatric HIV infections have been detected by 2013. Though the numbers are small it is obvious that the numbers are increasing gradually over the years.

Figure 1 Annual number of HIV cases reported - 1987 to 2013

Source - Annual report of NSACP 2013

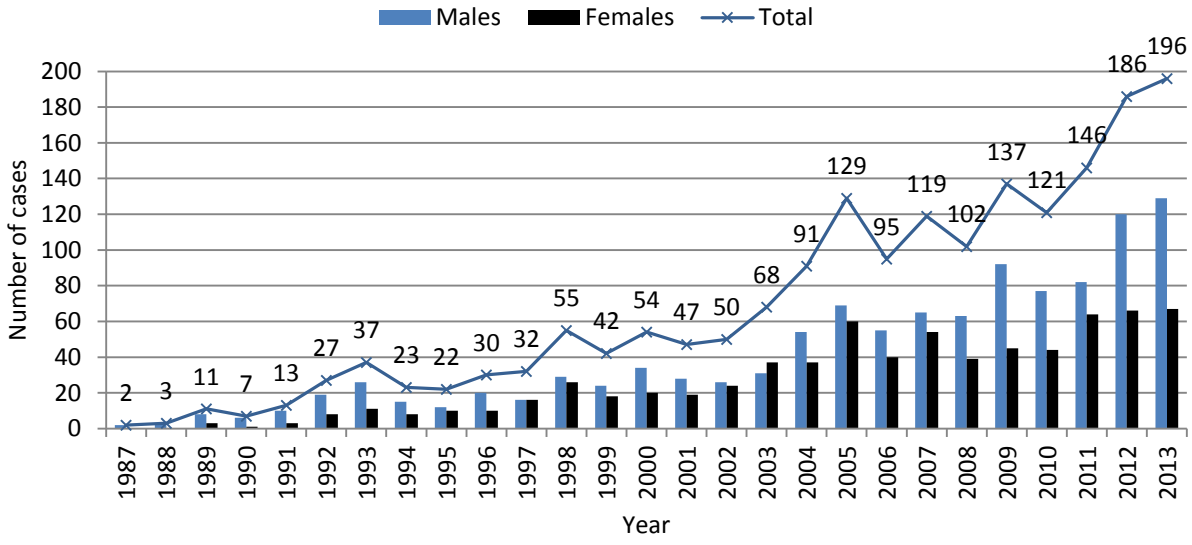


Table 1: Percentage of Age and Sex Distribution of Cumulative HIV Cases

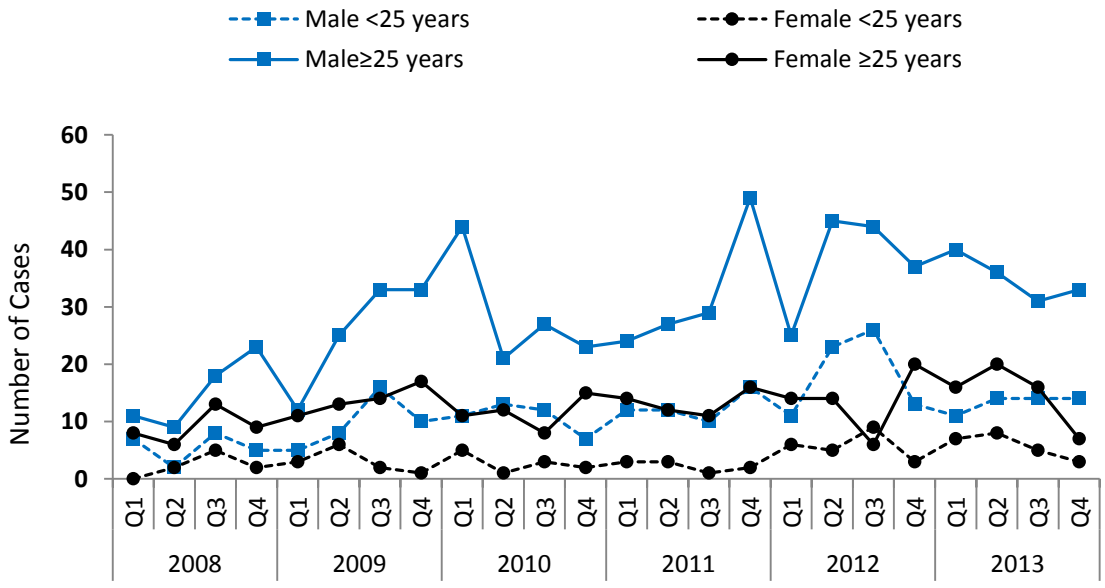
Source - Annual report of NSACP 2013

Age Group	Male	Female	Total	Percentage(%)
0-14 Yrs.	42	29	71	(4%)
15-24 Yrs.	76	52	128	(7%)
25-49 Yrs.	850	566	1416	(77%)
50+ Yrs.	119	62	181	(10%)
Unknown	28	21	49	(3%)
Total	1115	730	1845	**(100%)**

Sero-prevalence of syphilis among ANC population remains at <0.1% for last two decades. Since early 1980s the annual number of new diagnosis of infectious Syphilis cases has decreased markedly. The rate per 100,000 has shown a decline which has continued without much change over the years till 2008. Since then a gradual increase in the infectious syphilis was noticed mainly among males and this has continued till 2013.

Figure 2: Number of early Syphilis cases reported from all STD clinics by age and sex, 2008- 2013

Source - Annual report of NSACP 2013



2. Mother to child Transmission of HIV and congenital syphilis

MTCT of HIV

HIV among children is a growing problem. Majority of infected children acquire the infection through mother to child transmission. In the absence of any intervention, rates of mother to child transmission of HIV remains high in developing country settings.

Mother to child transmission occurs when a HIV positive mother passes the virus to her child during pregnancy, labour, delivery or breast feeding (Figure 3). Each year around 1.5 million women living with HIV become pregnant and without ARV drugs, there is a 30-45% chance of child getting infected. The risk of HIV transmission can be reduced with provision of comprehensive PMTCT services for women living with HIV.

Nearly all HIV infections due to mother to child transmission can be prevented by wide implementation of evidence based interventions built around primary prevention, use of antiretroviral drugs, safe delivery practices and safe infant feeding practices.

However, according to the latest global estimates, only 21% women in middle and low income countries were tested as part of antenatal care and only 33% of HIV pregnant women received the necessary treatment. Low testing coverage in ANC settings is a concern as services cannot be provided without identifying pregnant women with HIV.

Figure 3: Risk of Mother to Child Transmission of HIV

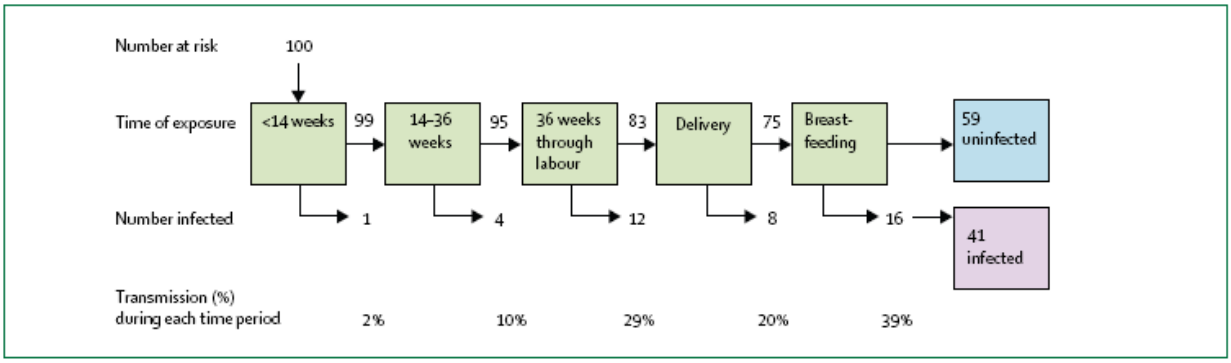


Figure 3: **Estimation of timing of mother-to-child HIV-1 transmission in a population that practises prolonged breastfeeding of 18–24 months**
Estimates are based on a hypothetical cohort of 100 children born to HIV-infected women without any interventions. Upper line numbers indicate number of children at risk for infection.

MTCT of syphilis

Syphilis, another sexually transmitted infection (STI) also remains a global problem with an estimated two million pregnant women getting infected each year. In Asia-Pacific region, approximately 69 per cent of pregnant women with syphilis experience adverse pregnancy outcomes such as stillbirths, neonatal deaths and newborn infections. Effective and inexpensive interventions exist to prevent these outcomes.

If a pregnant woman has untreated syphilis infection the infection can be transmitted to the foetus causing adverse pregnancy outcomes including congenital syphilis. Adverse pregnancy outcomes may occur in up to 80% of pregnant women with untreated early syphilis including still birth, perinatal death and neonatal infection (Table 2). The adverse pregnancy outcomes due to syphilis too can be prevented by providing services during pregnancy with early detection and provision of adequate treatment.

Table 2: Adverse pregnancy outcomes in syphilis

Source - Global elimination of congenital syphilis, WHO

outcome	Hartman*	Ingraham	Hira et al	Global burden of STI*
Still birth or miscarriage	17%	22%	22%	20%
Perinatal death	23%	12%	No data	15%
Infected infant	21%	33%	2%	20%
Prematurity LBW	No data	No data	33%	20%
Any adverse outcome	61%	67%	57%	75%

Several countries in the Asia-pacific region have considered a combined approach to prevent mother to child transmission of HIV and syphilis.

The rationale for the elimination of MTCT of HIV and syphilis is that dual elimination will help to improve a broad range of maternal and child health outcomes and also directly contribute to the MDGs 4, 5 and 6.

3. Comprehensive approach to prevent mother to child transmission of syphilis and HIV

3.1 UN comprehensive approach to prevent MTCT of HIV

Prevention of MTCT of HIV has been an important component of HIV prevention since 1998. Low cost strategies have been used effectively to reduce MTCT of HIV in many countries. According to the data published recently, significant progress has been made in delivering PMTCT services in concentrated and low level epidemic settings. In many developed countries paediatric HIV and Congenital syphilis has been virtually eliminated.

Countries can achieve dramatic reduction in new paediatric HIV infections through a comprehensive approach to prevention and treatment. The approach has four key prongs:

Prong 1: Primary prevention of HIV among women of childbearing age
Prong 2: Prevention of unintended pregnancies among living with HIV
Prong 3: Prevention of HIV transmission from a woman living with HIV to her infant.
Prong 4: Provision of appropriate treatment, care and support to women living with HIV and their Children and families.

Each prong plays a key role in preventing new paediatric HIV infections and improving maternal and child health and survival in the context of HIV. Indeed, recent analyses have demonstrated the need for action and progress in all four prongs in order to achieve dramatic and sustained reductions in new paediatric HIV infections.

3.2 WHO global strategy for the Elimination of Congenital syphilis (ECS)

In 2007 WHO outlined a similar comprehensive strategy for the global ECS. The goal of the initiative is to prevent transmission of syphilis from mother to child through strengthened antenatal care (ANC) systems. The strategy consists of promoting four pillars

1. **Ensure advocacy and sustained political commitment**
2. **Increase access to, and quality of, maternal and newborn health services**
3. **Screen and treat pregnant woman and partners for syphilis**
4. **Establish surveillance, monitoring and evaluation systems**

4. Elimination of congenital syphilis programme in Sri Lanka

The ministry of health of Sri Lanka has clearly identified antenatal screening for syphilis as a major component of antenatal care services and the syphilis screening services for pregnant mothers have been offered since early 1950s.

At the central level, Family Health Bureau, the major institution responsible for maternal and child health works closely with the National STD AIDS Control Programme and emphasizes the importance of prevention of mother to child transmission of syphilis and HIV. The primary health care team which provides MCH services link with the district STD clinic through the provincial team which consist of provincial authorities, including medical officer of maternal and child health. When the pregnant woman gets registered for antenatal care in the public health services, VDRL testing is offered as a routine screening test. The STD clinic provides VDRL testing services for pregnant mothers. All VDRL positive samples are subjected to confirmatory testing using treponemal tests such as TPPA or TPHA.

Women with positive treponemal tests are referred to STD clinics for comprehensive management. Pregnant women with syphilis are given appropriate treatment preferably with penicillin. The objective is to complete treatment in early pregnancy, latest by 36 weeks. After completion of treatment mother is followed up regularly till delivery and partner treatment is also completed during this period to prevent re-infection. The obstetrician responsible for delivery is informed regarding the management of the mother and the baby. Irrespective of mothers treatment all babies born to mothers with positive treponemal tests are given a single dose of Benzathine penicillin for prophylaxis. If congenital syphilis cannot be excluded babies are managed under the care of a paediatrician and given daily injections of Benzyl penicillin for 10 days.

Smooth functioning of the programme depends on the involvement of several stakeholders. While MCH staff is responsible for collecting blood samples from pregnant mothers and delivering samples to the laboratories, STD clinic provides testing facilities and further management of mothers with syphilis. The links between these units are maintained through regular reviews and in-service training. Continuing advocacy among key players including authorities is also an essential component in the programme.

4.1. Management of pregnant woman with syphilis

All pregnant women should be screened for syphilis at the first antenatal visit preferably before 12 weeks of gestation to prevent congenital infection. Women testing positive should be treated. Their partners should also be treated and plans should be made to treat their infants at birth.

Review syphilis test results at subsequent visits and at the time of delivery. If the woman was not tested during pregnancy, syphilis screening should be offered after delivery.

All identified pregnant women with positive non treponemal tests (VDRL/RPR) should be tested further using confirmatory treponemal test (TPPA/TPHA/FTA IgG) to confirm the presence of treponemal infection. If the treponemal test is positive the pregnant woman should be treated with penicillin injections according to the stage of infection.

Treatment for early syphilis in pregnancy

Benzathine penicillin 2.4 million units intramuscularly as a single dose, after having excluded allergy to penicillin

However, when maternal treatment is initiated in the third trimester, a second dose of Benzathine penicillin may be given 1 week after the first.

Treatment for Late syphilis in pregnancy

Benzathine penicillin 2.4 MU intramuscularly, weekly for 3 weeks

Pregnant women who miss any dose must repeat the full course of therapy.

Penicillin Allergy

Erythromycin 500mg qds for 14 days in early syphilis and for 28 days in late syphilis. (In pregnancy Doxycycline is contraindicated.)

The pregnant woman should be managed in coordination with the community MCH care services and/or obstetrician in a tertiary care unit.

Follow up

Serological (VDRL) follow-up should be at months 1, 2, 3, 6 and 12, then 6 monthly until VDRL negative or for 2 years

A sustained fourfold or greater increase in the VDRL titre suggests re-infection or treatment failure.

Specific treponemal tests may remain positive for life following effective treatment. Therefore, proper documentation is important to prevent unnecessary retreatment.

Epidemiological treatment

The woman's partner should be screened for syphilis and given epidemiological treatment.

Recommended regimen for epidemiological treatment

Benzathine penicillin 2.4 MU single dose intramuscularly after ST.

Penicillin allergy

Doxycycline 100mg twice daily for 14 days

Erythromycin 500mg qds for 14 days (used when Doxycycline is contraindicated)

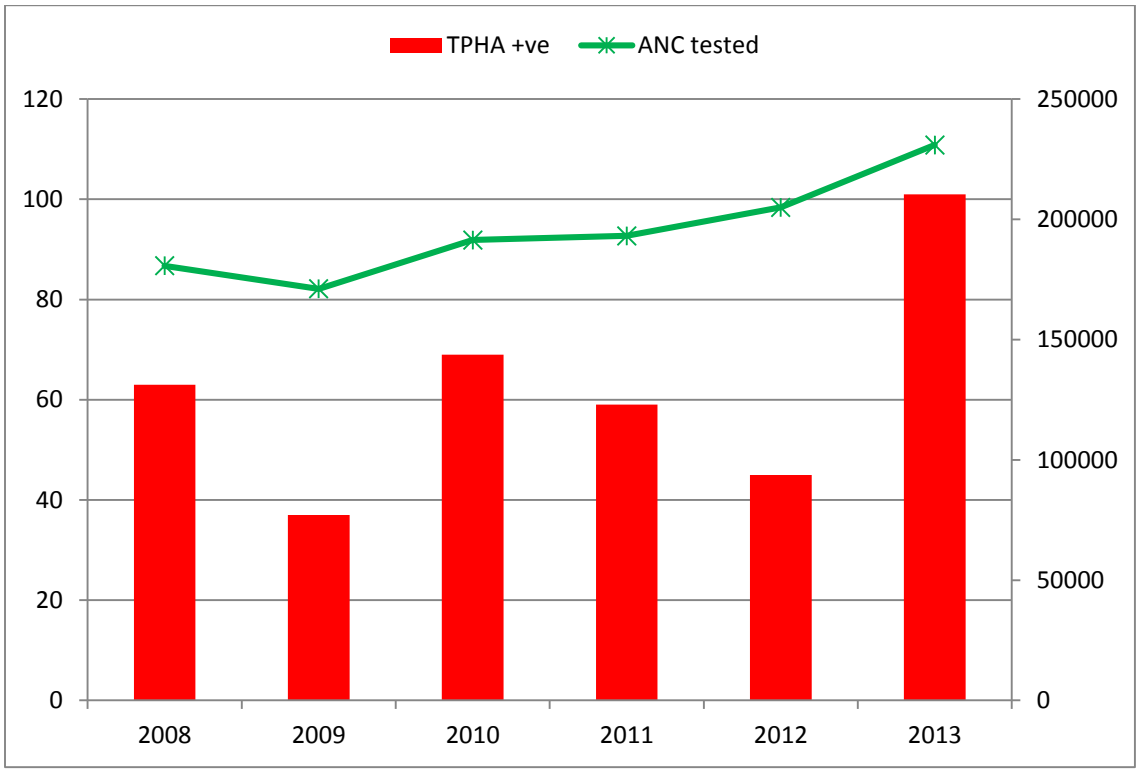
Treatment of the baby

If the mother had been adequately treated before 36 weeks of POA the risk of MTCT is low. However, irrespective of mother’s treatment all babies born to mothers with positive treponemal tests are given prophylactic penicillin. Baby is given one dose of Benzathine penicillin 50,000IU/Kg/ BW as prophylactic treatment.

If congenital syphilis could not be excluded, or if the woman has not completed treatment before 36 weeks of POA, baby need to be treated with Crystalline penicillin injections for 10 days.

Crystalline penicillin 50,000IU/KG/day bd for 7 days and 8 hourly for further 3 days to complete the 10 day period.
(Further details - refer guidelines for the management of maternal syphilis and congenital syphilis)

Figure 4: Antenatal syphilis screening done at NSACP - 2008-2013 and



Source - SIM unit, NSACP

4.2 Case definition of Congenital Syphilis

Case definition -1-a

Congenital syphilis is defined as a live born infant with clinical evidence (one major and 2 minor criteria) and serologic evidence of syphilis to a mother with confirmed syphilis.

Major criteria	Minor criteria
Swelling of joints	Hepatosplenomagaly
Bullous skin lesions	Jaundice
Snuffles	Anaemia
	Radiological changes in long bones

Case definition -1-b

Congenital syphilis is defined as a death of a neonate born to a mother with confirmed syphilis and has postmortem/ histological evidence of congenital syphilis

Case definition -2

Congenital syphilis is defined as a live born asymptomatic infant/ foetal loss/stillbirth** to a mother with confirmed syphilis and anyone of the following

- Reactive non-treponemal test which is four fold higher than that of the mother's titre at delivery
- A reactive syphilis specific IgM antibody test
- Rising non-treponemal titre
- Persistently reactive treponemal test in the infant beyond 6 months of age

** if it is a stillbirth, there should be postmortem/ histological evidence

An Incidence case of congenital syphilis is an infant who fall into either case definition 1or 2

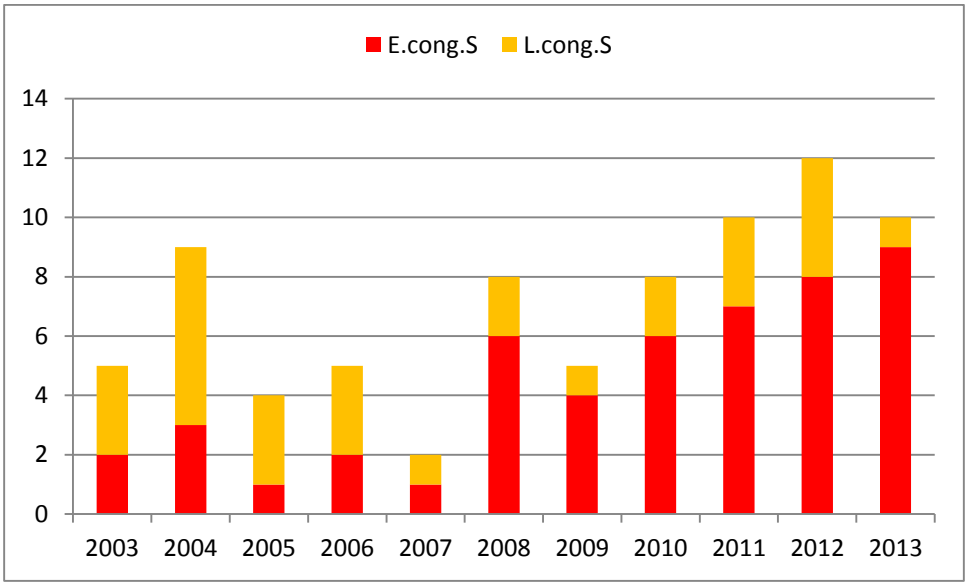
Case definition -3

Congenital syphilis is defined as a live born asymptomatic infant, still birth, or foetal loss to a mother with syphilis where

- Mother was treated < 4weeks prior to delivery or
- Mother was untreated , treatment status undocumented or unknown, or
- Mother not completed the recommended course of penicillin during pregnancy or
- Mother treated with non penicillin antibiotics

Case definition-3 is for programmatic purposes. Since some babies of the above mothers would be uninfected although they fall into case definition-3 and should have a TPPA test after 6 months of age. The diagnosis of congenital syphilis is ruled out when the TPPA test is negative after 6 months. Yet, the recommended therapy for babies in category -3 and born to mothers who have been inadequately treated should have the IV penicillin regimen.

Figure 5: Congenital syphilis cases reported to NSACP - 2003-2013



Source - SIM unit, NSACP

In Sri Lanka the rate of CS is around 0.03 per 1000 births which is much lower than the target for ECS (5 per 10,000 births).

Mile stones of prevention of mother to child transmission of syphilis and HIV in Sri Lanka

- Prevention of MTCT of syphilis - 1952
- Prevention of MTCT of HIV - 2002
- Elimination of congenital syphilis - 2009
- Elimination of MTCT of HIV - 2013

5. Elimination of MTCT of HIV programme in Sri Lanka

The elimination of mother to child transmission of HIV is now considered a realistic public health goal. Timely administration of antiretroviral treatment to HIV positive pregnant mothers significantly reduces the risk of HIV transmission to the baby. In the absence of intervention the transmission rate is 25-45%.

In Sri Lanka measures to prevent mother to child transmission of HIV were initiated in early 2002 with the introduction of ART for PMTCT. Strategies and guidelines have been developed and regularly updated to introduce effective interventions to prevent MTCT of HIV. However, these services can be made available to women only if they are tested and identified as having HIV.

WHO recommends provider initiated testing and counseling (PITC) for HIV in pregnant mothers in low prevalent countries. Until the year 2012 the screening services to detect HIV among pregnant women in Sri Lanka was limited to few centers with coverage of 5.6%.

Table 3: Paediatric HIV cases reported to NSACP from 1994 - 2012

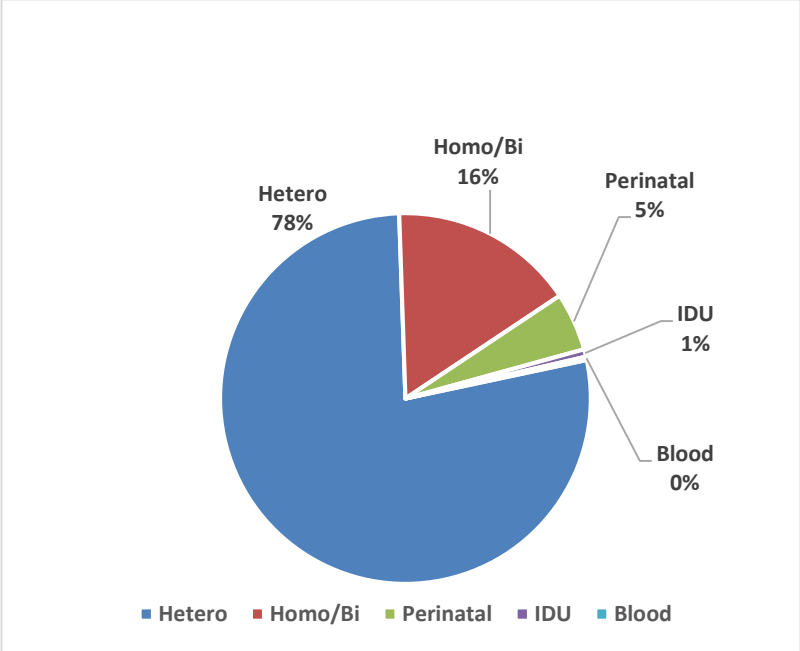
Year	Male	Female	**Total**
1994	1	0	**1**
1995	-	-	**-**
1996	-	-	**-**
1997	0	1	**1**
1998	-	-	**-**
1999	-	-	**-**
2000	2	1	**3**
2001	4	0	**4**
2002	-	-	**-**
2003	3	-	**3**
2004	1	1	**2**
2005	6	4	**10**
2006	2	-	**2**
2007	3	1	**4**
2008	2	1	**3**
2009	4	6	**10**
2010	1	2	**3**
2011	3	2	**5**
2012	4	2	**6**
2013	5	6	**11**

Source surveillance unit, NSACP

By the end of year 2013, 5% of the total case load of HIV was due to paediatric cases. Though Sri Lanka is a low prevalent country this trend warns about the importance of preventing mother to child transmission of HIV.

Figure 6: Mode of transmission of HIV Cases reported up to end of 2013

N=1378 (In 427 (31%) cases mode of transmission is not reported)



Source- Annual report of NSACP 2013

Scaling up the diagnostic services for preventing mother to child transmission of HIV is given priority by Ministry of health Sri Lanka. In 2013 a policy decision was taken to introduce universal screening for HIV among pregnant women.

5.1 Management of pregnant women with HIV

When women are identified with HIV during pregnancy, EMTCT services are offered according to the guidelines on Management of HIV infected pregnant women. Antiretroviral therapy for prevention of mother to child transmission is started from 14 weeks or if identified later, as early as possible according to the current guidelines. Patients are managed in coordination with the consultant obstetrician and paediatrician. Babies are given ART from birth to 6 weeks and mothers are counseled on appropriate feeding practices.

Figure 7: Management of pregnant women with HIV infection

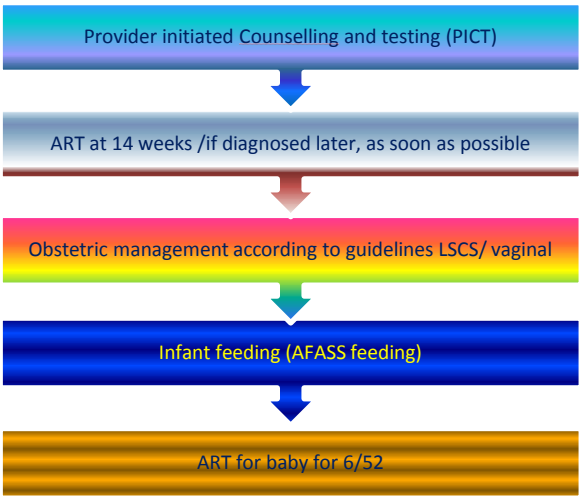


Table 4: When to start ART in pregnant women

National PMTCT programme option	Pregnant women with HIV
Consider using lifelong ART for all pregnant women (" Option B+") *	**Start ART regardless of WHO clinical stage or CD4 count**
	Maintain after delivery lifelong

All pregnant women with HIV should initiate ART in early pregnancy irrespective of the CD4 count and should continue treatment after delivery.

ART options -

AZT+3TC+LPV/rt
AZT+3TC+EFV/NVP
TDF+3TC(FTC)+EFV/NVP
TDF+3TC(FTC)+LPV/rt

Infants should receive six weeks of ART starting from birth with daily NVP dose adjusted according to the weight as given in the ART guideline.

(Further details - refer Guidelines on management of HIV infection in pregnancy in Sri Lanka 2011)

5.2 Infant feeding practices

Infants born to HIV infected mothers may escape HIV infection during pregnancy and delivery but remain vulnerable to transmission through breastfeeding. The cumulative risk of postnatal transmission is 12%-16% with 18–24 months of breastfeeding. In the absence of interventions, the overall risk of MTCT of HIV in utero, peripartum and via breast milk is 30-45% with transmission through breast milk accounting for a substantial proportion of these infant HIV infections. The only method known to completely eliminate breastfeeding associated HIV transmission is to avoid breastfeeding. This is recommended in settings in which infant replacement feeding is acceptable, feasible, affordable, sustainable and safe(AFASS) where clean water is widely available, hygiene and sanitation conditions are good and death due to diarrheal and other infectious conditions are relatively uncommon (10).

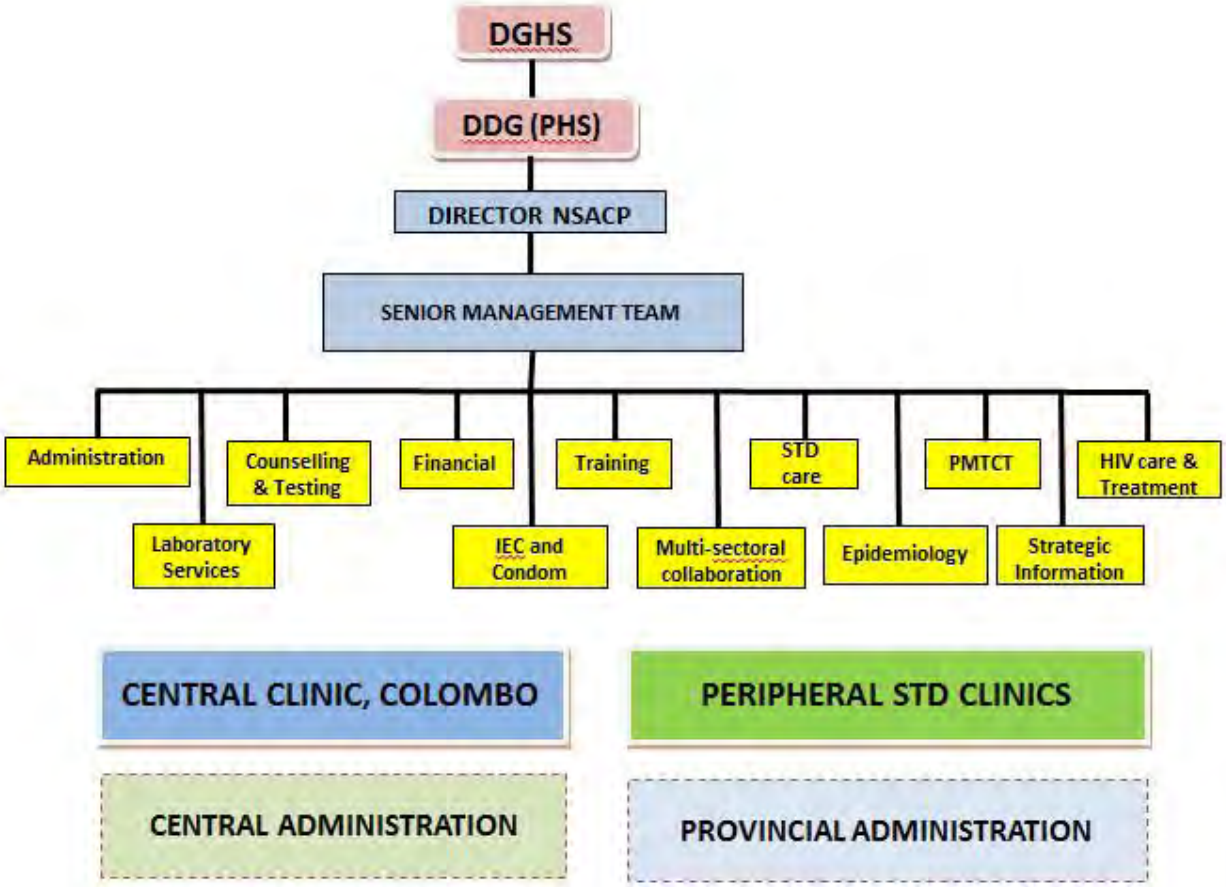
Infant feeding in the context of HIV is complex because of the major influence that feeding practices exerts on child survival. In Sri Lanka, the most appropriate infant feeding option for an HIV positive mother depends on her individual circumstances, including her health status and the local situation, the health services available and the counselling and support she is likely to receive. The expectant mother is counseled by a counselor who has adequate knowledge on the safer feeding options that are currently recommended. The counselor considers the risk of infants acquiring HIV through breast milk with the higher risk of death from causes other than HIV, in particular malnutrition and serious illness such as diarrhoea among non-breastfed infants in identifying suitable options. Counseling is done by Venereologist and Pediatrician to assist the mother in arriving at a decision. For mothers who decide on formula feeding, formula milk is provided free of charge for one year by a Nongovernmental organization through NSACP.

Units of Family Health Bureau

1	Antenatal & Post Natal Care Unit
2	Intranatal and Newborn Care Unit
3	Family Planning Unit
4	Child Nutrition Unit
5	Child Development & Special Needs
6	School and Adolescent Health Unit
7	Gender & Women's Health Unit
8	Planning, Monitoring & Evaluation Unit
9	Oral Health
10	Maternal & Child Morbidity, Mortality Surveillance Unit
11	Research and Development Unit
12	Reproductive Health Unit

Figure 8: NSACP organogram

Source- Annual report of NSACP 2013



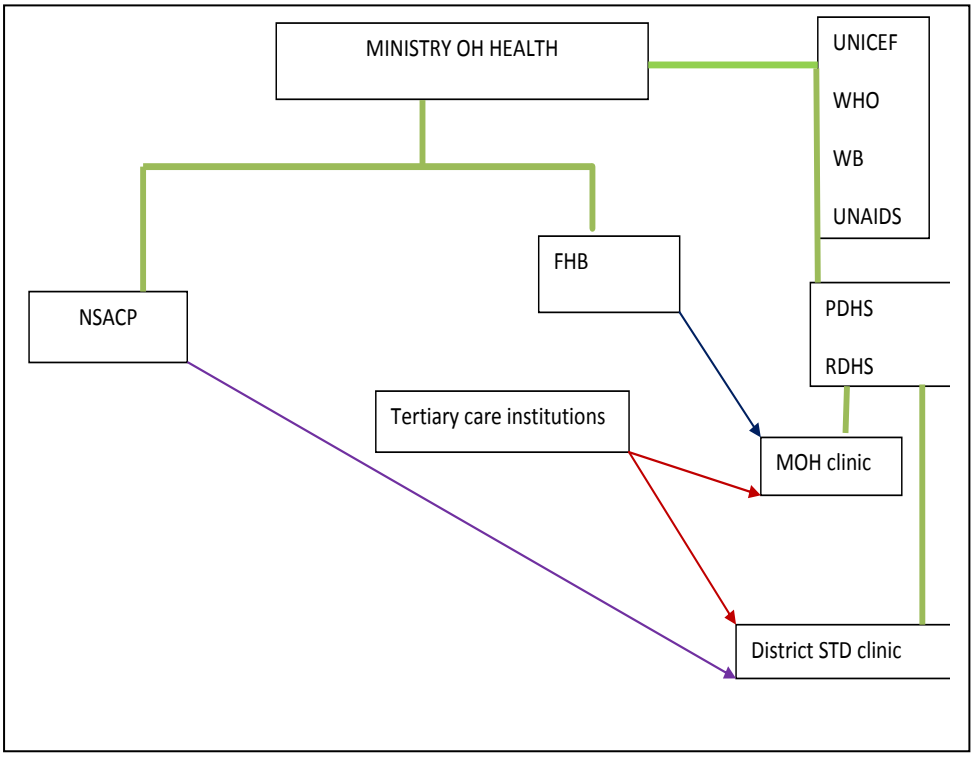
6. Stakeholders in EMTCT programme

At the national level the Family Health Bureau (FHB) which is responsible for MCH services has played an active role in initiating multiple programmes in partnership with NSACP. These include elimination of mother to child transmission of syphilis and HIV. FHB and NSACP function under the Deputy Director General of Public Health Services (DDG PHS) of ministry of health.

The link developed at the national level extends to the grass root level through the district STD clinics and District team responsible for MCH services. At the district level the district team comprising of provincial authorities, maternal and child health services and STD services complement the services in addressing the reproductive health needs of the population.

At various levels WHO and UN partners as well as international and local NGO contribute to the national programme.

Figure 9: Stakeholders in EMTCT of HIV and syphilis programmes



7. Criteria and process for Validation

Sri Lanka has initiated prevention of MTCT of syphilis programme in 1952 and has completed 50 years by 2013. Congenital syphilis cases have reduced markedly during this period. In the year 2013, 10 congenital syphilis cases were reported.

Details of congenital syphilis cases reported in Sri Lanka in 2013
Case definition 1 - 0
Case definition 2 - 1
Case definition 3 - 6

According to global validation criteria the minimum impact indicator is <50 CS cases per 100,000 live births. In Sri Lanka the figure for the year 2013 is 3 per 100,000 live births. However, to qualify for validation, Sri Lanka has to prove satisfactory performance on process indicators as well.
Any country that feels it can meet the qualifying global requirements is encouraged to apply for validation. Before applying for validation the country must meet the following global minimum criteria.

When these minimum indicators are fulfilled Sri Lanka can apply for validation.

Minimum indicators for validation for Sri Lanka

HIV
Impact indicators
<50 new paediatric HIV infections per 100,000 live births
Process indicators
ANC coverage one visit >95%
Coverage of HIV testing of pregnant women at first ANC visit (before 12 weeks) >95% by end 2014
ARV coverage of HIV positive pregnant women of >90%
Syphilis
Impact indicator
Incidence of congenital syphilis <50 per 100,000 live births
Process indicators
ANC coverage one visit >95%
Coverage of syphilis testing of pregnant women at first ANC visit (before 12 weeks) >95% by end 2014
Treatment of syphilis seropositive pregnant women >95%

Ssummary of procedures for validation of EMTCT of HIV and/or syphilis

- RVC selects RVT for each candidate country.
- RVT reviews national validation report.
- RVT and NVT conduct in-country validation visit and interviews with key stakeholders.
- RVT prepares and submits national validation report to the regional secretariat.

Country validation

- MOH submits a validation request to the regional secretariat.
- MOH and the RVC jointly establish an NVC.
- NVC decides whether to establish an NVT.
- NVC (or NVT where active) collects, assesses, and summarizes data for national validation report.
- NVC reviews national validation report and submits to the RVC.

Country pre-validation

- Regional secretariat convenes RVC.
- RVC reviews national validation report for compliance with minimum regional and global criteria.
- If approved, RVC prepares and submits regional validation report to the global secretariat.
- If not approved, RVC notifies NVC and provides clear recommendations.

Regional validation

- Global secretariat convenes GVC.
- GVC reviews regional validation report for compliance with minimum global criteria.
- GVC prepares global validation report and submits to global secretariat.

Global validation

- Global secretariat issues letter officially notifying the candidate country of validation status and recommending follow-up actions for maintenance of validation status. Official validation
- Global secretariat monitors maintenance of validation indicators through existing annual global reporting systems.
- Global secretariat reports any concerns noted to RVC for follow-up and more in-depth assessment.

RVC -Regional validation committee RVT - Regional validation team MOH - ministry of health GVC - Global validation committee
NVC - National validation committee RVC - regional validation committee

8. Goals and objectives for the elimination of mother to child transmission of syphilis and HIV in Sri Lanka

Vision

'Women and children alive and free from HIV and syphilis'

Goal

'Eliminate congenital syphilis and new paediatric HIV infections and improve maternal and child health

Targets by 2017 –

Reduce the incidence of congenital syphilis to <50 cases/100,000 live births
Reduce mother to child transmission of HIV to <50 cases/100,000 live births

Objectives of EMTCT of syphilis and HIV programme by 2017

EMTCT of HIV

- >95% of ANC attendees received Provider Initiated Testing and counseling services for HIV
- 100% of identified HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child transmission
- 100%of infants born to identified HIV-infected mothers received ARV drugs

EMTCT of Syphilis

- >95% of ANC attendees tested for syphilis
- 100% syphilis sero-positive mothers receive effective treatment
- 100% exposed infants receive effective treatment

9. Guiding principles

Building blocks

1. Ensure commitment to achieve goals
2. Enhance comprehensive, linked services between HIV/STI and MNCH programmes
3. Employ highly effective interventions for HIV/STI prevention and treatment
4. Improve coverage and advocate for equitable access
5. Promote health systems development
6. Improve measurement of programme performance and impact

1. A Public Health approach

Sri Lanka provides maternal and health services and STD services using a public health approach to ensure equitable access to high quality STI/ HIV and MCH care at the population level and aim to provide the best proven standard of care in a cost effective manner.

The overall goals of PMTCT and ECS programme are to eliminate new paediatric HIV infections and congenital syphilis and improve maternal and child health and survival. MCH services are considered as an access point for STI/HIV prevention, diagnosis, treatment and care.

2. Integrated health systems approach

Sri Lanka has a well established preventive primary health care system and secondary and tertiary level services. The coordinated maternal and health care services at all levels have helped Sri Lanka achieve excellent MMR, IMR and CMR which are in par with those of some developed countries. Antenatal syphilis screening has been in existence for the last four decades and it has been a function of the primary health care services to screen all antenatal mothers for syphilis. PMTCT and ECS are integrated to the MCH services to achieve the ultimate goal of eliminating paediatric HIV and congenital syphilis. Provider initiated testing for HIV is encouraged at the antenatal setting.

Gender linkages have been given attention in the integrated approach where male involvement for PMTCT and ECS is encouraged in a culturally acceptable and appropriate manner. Testing opportunities and treatment is available for men.

Vertical integration is available through a referral system to STD services from MCH settings. ART is made available to the mother if she is eligible for ART for her own health or as prophylaxis. Similarly, mothers diagnosed with syphilis are referred to the STD services for evaluation and appropriate management as well as partner and infant management. Horizontal linkages between obstetricians and pediatricians in the management of newborns of HIV infected mothers or mothers with syphilis have helped in reducing mortality and morbidity of the newborn.

3. Rights- based approach

All individuals regardless of gender, race, religion, caste or creed have a right to access government health care services. They also have the right to protect themselves from STI/HIV infection. The delivery of EMTCT of syphilis and HIV interventions will safeguard standard human rights. No individual shall be denied access to health care because of their HIV positive status. People living with HIV and their families should not be stigmatized and discriminated against based on their HIV status. Confidentiality is maintained at all levels. Shared confidentiality on a need to know basis is adopted for the provision of holistic care.

10. Strategies and Activities

The strategies identified for PMTCT of HIV and syphilis in the National Strategic plan of NSACP 2012-2017 includes;

- Primary prevention of HIV transmission among women in childbearing age
- Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices
- Ensure high level commitment and advocacy to eliminate the incidence of congenital syphilis
- Increase access to and quality of syphilis and HIV services at maternal and child health services
- Prevention of HIV and syphilis transmission from women living with HIV/ syphilis to their children by promotion and integration/linkage of PMTCT with related services
- Strengthen surveillance, monitoring and evaluation systems

Strategy 1

Primary prevention of HIV transmission among women in childbearing age

Major activities

1. Awareness programmes among general population including young people
1. Expand HIV interventions in the workplace
2. Expand and strengthen the provision of good quality STI services ensuring correct diagnosis based on laboratory testing or by syndromic approach
3. Condom promotion programmes
4. Improving access to HIV testing and counseling services

Strategy 2

Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices

Major activities

1. Train MCH and STD clinic staff to provide appropriate family planning services
2. Integrate family planning services to STD clinic services
3. Reduce unmet family planning needs in the community
4. Awareness programmes for PLHIV on MTCT

Strategy 3

Ensuring advocacy and sustained political commitment for a successful EMTCT programme

Major activities

1. Mobilize political commitment and advocacy in order to give high priority to the EMTCT of syphilis and HIV programme and allocate resources (central and provincial level / international funding agencies)
2. Raise awareness of decision makers, public health officials, health care providers on the burden of HIV and syphilis, problems related to syphilis in pregnancy and its adverse outcomes, such as stillbirths and low birth weight and peadiatric AIDS.
3. Underline the value of the EMTCT of HIV and syphilis programmes to maternal and newborn health services
4. Strengthen linkages between MCH and STI and HIV services to enable more accurate forecasting of needs, procurement and supply of diagnostics and essential medicine.
5. Demonstrate the cost benefit of interventions
6. Establish a national level steering committee
7. Identify roles and responsibilities of the stakeholders

Strategy 4

Increasing access to and improve the quality of maternal and newborn health services

Major activities

1. Expand provider initiated testing and counseling for HIV in ANC settings.
2. Screen all antenatal mothers for syphilis and HIV at the first booking visit preferably before 12 weeks and results are given without delay
3. Test mothers who have not been tested for syphilis and HIV during pregnancy or have no documented evidence of treatment, at delivery
4. Regular training of primary health care workers on STI and HIV
5. Establish a referral system which is non stigmatizing
6. Maintain quality of testing by ensuring training
7. Maintain established quality control systems
8. Establish a system to maintain continuous supply of equipment and reagents for testing
9. Development of STD clinic laboratories and provide resources including human resource to provide syphilis and HIV testing services

Strategy -5

Prevention of HIV and syphilis transmission from women living with HIV/ syphilis to their children by promotion and integration/linkage of PMTCT with related services

Major activities

1. Ensure that all positive mothers and partners are treated or managed adequately by referring to the closest STD clinic.
2. Confirm the diagnosis of syphilis or HIV and manage according to national guidelines
3. Screen all mothers with syphilis or/and HIV for other STI
4. Document test results, treatment status of mother in the clinic and pregnancy records.
5. Screen mother's sexual partners for STI and treat appropriately
6. Follow up positive mothers at both the registered antenatal clinic and at the STD clinic until delivery
7. Evaluate infants born to mothers with syphilis or HIV by a pediatrician and manage in consultation with the STD clinic

Strategy -6

Strengthen surveillance, monitoring and evaluation of EMTCT programmes of syphilis and HIV

Major activities

1. Strengthen data collection systems in relation to maternal syphilis and HIV
2. Develop data collection formats where necessary
3. Develop indicators to monitor the EMTCT programme (input, process, output and outcome)
4. Establish performance review in relation to EMTCT at each level

- Monthly MOH review meetings
- Quarterly review by RDHS
- Annual review by NSACP and FHB

5. Promote operational research
6. Review and revise the existing information systems to fulfill the EMTCT requirements

11. Expected outcomes by 2017

- 95% of ANC attendees received HIV Testing and counseling services
- 100% of identified HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child transmission
- 100%of infants born to identified HIV-infected mothers received ARV drugs
- >95% of ANC attendees tested for syphilis
- 100% Syphilis seropositive mothers receive effective treatment
  100% exposed infants receive effective treatment

12. Targets and indicators

The targets to be reached by 2017

- Reduce mother to child transmission of HIV to <50 cases/100,000 live births
- Maintain the incidence of congenital syphilis at <50 cases/100,000 live births

The following indicators will be used to assess the programme

- Percentage of pregnant women attending ANC in selected districts offered testing services for HIV
- Percentage of pregnant women attending ANC identified as having HIV infection
- Percentage of identified HIV infected pregnant women receiving PMTCT services according to national guidelines
- Percentage of pregnant women screened for syphilis at delivery (first trimester)
- Percentage of pregnant women identified as having maternal syphilis
- Percentage of identified women with syphilis receiving effective (penicillin) treatment

Table 5: Major activities conducted in 2013 and 2014

Activity	Details
• Decision taken on universal screening of pregnant women	
• Advocacy	• Meeting with Directors of major maternity units in the country DMH, CSHW • Meeting with Director, FHB • Meeting on EMTCT at Kathmandu, Nepal organized by UNICEF September 2013 – • Advocacy meeting - country programme to introduce EMTCT services – sensitization (UNICEF) at Hotel Taj Samudra – with participation of all provincial MCH staff and STD staff
• National level steering committee	• Quarterly meeting
• Circular issued by the MOH	• to inform relevant authorities regarding decisions taken
• Commence ANC HIV testing	• Year 2013 – cover Colombo, Gampaha, Galle, Matara, Hambantota and Kandy districts.
• Training programmes for health care workers –	• MCH staff - • Colombo district • Kandy district • Southern province • Gampaha district • Consultative workshops - 3 • Institutional staff • DMH, CSHW,CMC • Kalubowila, Homagama, • Awissawella hospital staff • STD clinic staff of SP, Kandy, WP
• Improvement of laboratory	• Procure test kits • ELISA machines – UNICEF • NSACP, Matara, Badulla, Negombo • Vacutainer tubes • Protective gear kits – for the team involved in delivery • Carrier boxes – to transport samples to be distributed among MOH offices
• Other improvements	• Computers, multimedia projectors, printers for Colombo, Klautara, Matara, Galle, Kandy
• IEC material	• Posters, leaflets, strategy

Figure 10: Cumulative Number of HIV cases reported by District

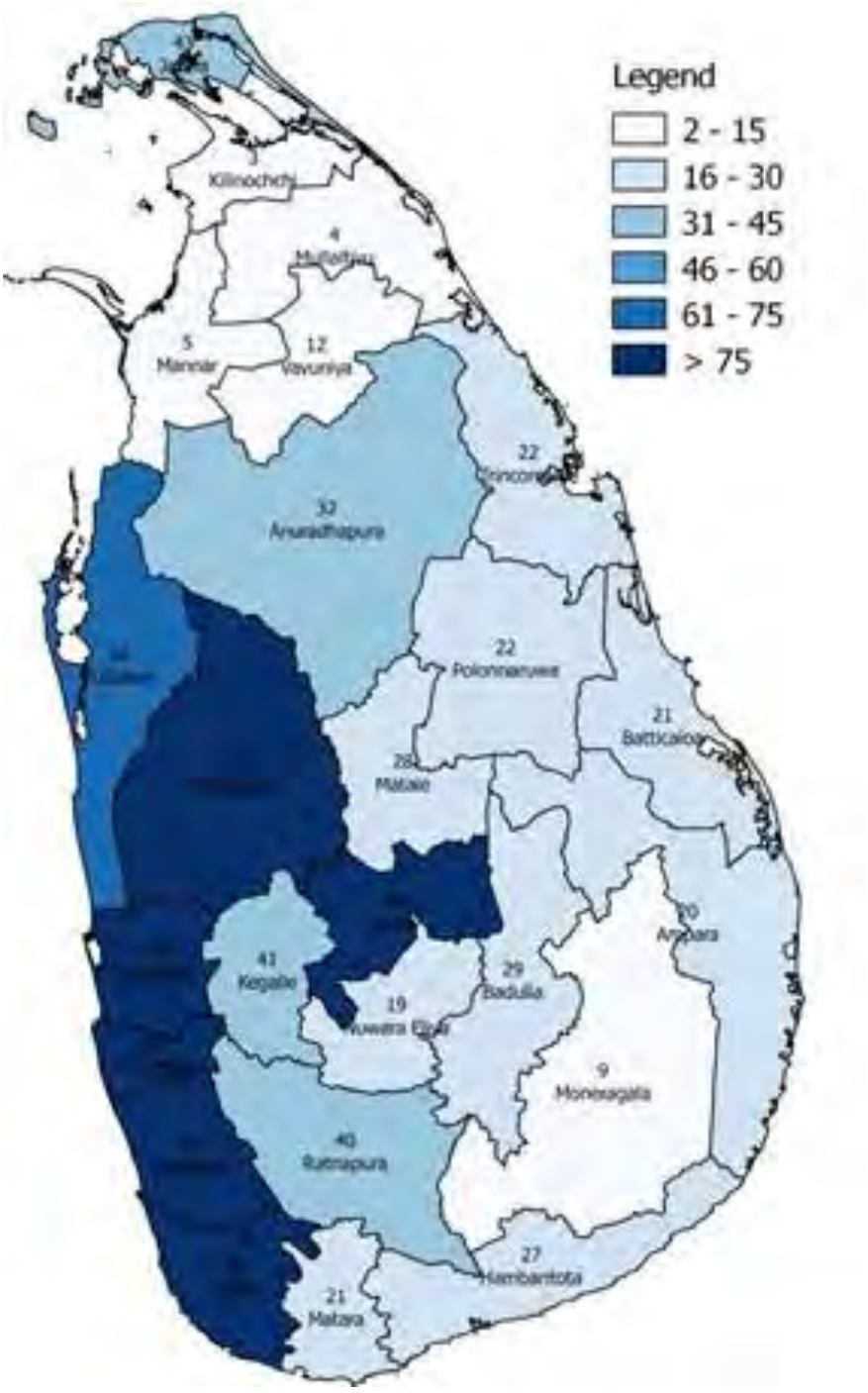


Table 6: Country plan to introduce HIV testing among pregnant women

• *2013*	• *2014*	• *2015*	• *2016*	• *2017*
• *Western province* • *Southern province* • *Kandy district*	• *North western province* • *North central province* • *Northern Province*	• *Sabaragamuwa province* • *Uva province* • *Eastern province* • *Matale, Nuwaraeliya districts*	• *increase coverage*	• *maintain coverage*

Table 7: Future activities planned for the years 2015-2017

Activity	Details	Responsibility
Awareness programmes among general population	IEC material development Training for health care staff of MCH and STI services on prevention	NSACP
Prevention of unintended pregnancies among women living with HIV	Awareness programmes for PLHIV	NSACP
Ensuring advocacy and sustained political commitment	Regular meetings of steering committee, NAC, HDC Meetings with professional colleges	FHB and NSACP
Increasing access to testing	Regular training of primary health care workers on STI and HIV provide resources including human resource to STD clinic laboratories Procurement of ELISA machines, test kits, improves early infant diagnosis facilities.	FHB NSACP NSACP
Prevention of HIV and syphilis transmission from women living with HIV/ syphilis to their children	Maintain quality of PMTCT services through regional training and workshops Availability of drugs and safe delivery kits	FHB and NSACP
Strengthen surveillance, monitoring and evaluation of EMTCT programmes of syphilis and HIV	Establish performance review in relation to EMTCT at each level Monthly MOH review meetings Quarterly review by RDHS Annual review by NSACP and FHB	Provincial authorities NSACP FHB

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Annexures:

Annexure 1.1 General circular letter No. 02-02/2014

My No. STD/A/
Suwasiripaya
Ministry of Health
Colombo,
10.03.01.2014

To All Provincial Directors of Health Services
All Regional Directors of Health Services
All Directors of Teaching Hospitals and District General Hospitals

The Programme for Elimination of Mother to child transmission of syphilis and HIV (EMTCT of syphilis and HIV) in Sri Lanka

Sri Lanka has been identified as a country which can achieve the Elimination status of congenital syphilis and mother to child transmission of HIV.
To achieve the elimination status, effective universal coverage of screening for syphilis and HIV during pregnancy need to be established. In Sri Lanka, screening for syphilis during pregnancy has achieved almost universal coverage (98%).
The policy decision of screening pregnant women for HIV was taken by the Ministry of Health after a series of consultations and the decision was to couple it with existing syphilis screening. Ministry of Health seeks the commitment and cooperation of provincial health authorities in the identified districts to implement the EMTCT of syphilis and HIV programme.

It is necessary to take measures to scale up services for antenatal screening of Syphilis and HIV in your district/institutions as per the guidelines given below.

- All mothers are to be screened before 12 weeks of gestation for Syphilis and HIV (preferably at the first visit).
- 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.
- STD clinics have to carry out Syphilis and HIV screening tests on the blood samples received from ANC clinics and send reports to the relevant officers.
- 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.
- The screening test positive pregnant women need to be referred to the STD clinic for further management.
- All pregnant women with Syphilis or HIV should be provided appropriate services including institutional care, without stigma or discrimination.
- 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 and RDHS.

The districts identified for the year 2013/2014 are Colombo, Gampaha, Kandy, Galle, Matara and Hambantota.

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.

Secretary Ministry of Health

Cc 1.Director General of Health Services

2. Representative – World Health Organization
3. Deputy Director General (Public Health services) 1, 2
4. DDG Laboratory services Director, National STD AIDS Control Programme
5. Director, Family Health Bureau

Annexure 1.2 General Circular in Sinhalese

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07.11.2013

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මෙම තුරන්කිරීමේ තත්වය යථාර්තයක් බවට පමුණුවාගැනීමටනම් ගර්භණී සමය තුළ සියලුම මව්වරුන්ගේ රුධිර පරීක්ෂා කිරීමේ විධිමත් සමස්ත වැඩපිළිවෙළක් ස්ථාපිත කළයුතුය. ගර්භණී සමය තුළ උපදංශ රෝගය සඳහා රුධිර පරීක්ෂා කිරීම සියලුම මව්වරුන් පාහේ ආවරණයවන තත්වයකට දැනට ශ්‍රී ලංකාව ළඟාවී ඇත (98%).

දීර්ඝ සාකච්ඡාවට කිහිපයකින් පසු ගර්භණී සමය තුළ එච්.අයි .වී. සඳහා රුධිර පරීක්ෂා කිරීමේ ප්‍රතිපත්තිමය තීරණයක් සෞඛ්‍ය අමාත්‍යාංශය විසින් ගෙන ඇති අතර එය දැනට කෙරීගෙන යන උපදංශ රෝගය සඳහා රුධිර පරීක්ෂා කිරීමේ වැඩපිළිවෙල සමඟ එක්කිරීමට තීරණය කර ඇත.

ගර්භණී මවකගෙන් උපදින දරුවාට උපදංශය හා එච්.අයි.වී පැතිරීම තුරන්කිරීමේ වැඩපිළිවෙළ ක්‍රියාවේ යෙදවීම පිණිස සියලුම පළාත් සෞඛ්‍ය බලධාරීන්ගේ පූර්ණ කැපවීම හා සහයෝගය සෞඛ්‍ය අමාත්‍යාංශය අපේක්ෂා කරසිටී.

ඔබගේ දිස්ත්‍රික්කය / ආයතනය තුළ ගර්භණී සමය තුළ උපදංශය හා එච්.අයි .වී. සඳහා රුධිර පරීක්ෂා කිරීම වඩා ශක්තිමත් කිරීම පිණිස පහත සඳහන් නිර්දේශ ක්‍රියාත්මක කිරීමට පියවර ගතයුතුයි.

- සියලුම මව්වරුන් ගර්භණීවී සති 12ක් ගතවීමට පෙර උපදංශය හා එච්.අයි .වී. සඳහා රුධිර පරීක්ෂා කිරීම (මුල් සායනික දිනයේම වීම වඩාත් යෝග්‍යයි).
- පූර්වප්‍රසව සායන (සෞඛ්‍ය වෛද්‍ය නිලධාරී කාර්යාල සායන සහ රෝහල් පූර්වප්‍රසව සායන) මගින් රික්තක පරීක්ෂා නලවලට මවගෙන් රුධිරය මිලි ලීටර 5ක් ලබාගෙන උපදංශය හා එච්.අයි .වී. පරීක්ෂා සඳහා ලිංගාශ්‍රිත රෝග සායනයට යැවීමට කටයුතු යුතුයි. රුධිර සාම්පල ප්‍රවාහනය සඳහා අවශ්‍ය කටයුතු කලාප සෞඛ්‍ය සේවා අධ්‍යක්ෂක, මාතෘ හා ළදරු සෞඛ්‍ය වෛද්‍ය නිලධාරී, ලිංගාශ්‍රිත රෝග සායන වෛද්‍ය නිලධාරීවරුන්, සෞඛ්‍ය වෛද්‍ය නිලධාරීවරුන් සමඟ සාකච්ඡාවලින් පසු ප්‍රාදේශීයව සකස් කරගත යුතුයි.
- පූර්වප්‍රසව සායන මගින් ලැබුණු රුධිර සාම්පල උපදංශය හා එච්.අයි .වී. සඳහා පරීක්ෂා කිරීම ලිංගාශ්‍රිත රෝග සායන විසින් සිදුකර වාර්තා අදාළ නිලධාරීන්ට ලබාදීමට කටයුතු කරනු ඇත.
- වී.ඩී.ආර්.එල්, එච්.අයි.වී. ධනාත්මක ප්‍රතිචාරයක් හා තවදුරටත් පරීක්ෂා කලයුතු වාර්තා සම්බන්දයෙන් අදාළ සෞඛ්‍ය වෛද්‍ය නිලධාරී / විශේෂඥ ප්‍රසව හා නාරී වෛද්‍ය නිලධාරී දැනුවත් කලයුතු අතර තොරතුරු සම්බන්ධයෙන් පූර්ණ රහසිගතභාවය රැකගැනීමට අවශ්‍ය කටයුතු යෙදිය යුතුයි.
- මූලික පරීක්ෂණ ධනාත්මක ප්‍රතිචාරයක් පෙන්වූ ගර්භණී මවුවරුන් වැඩිදුර පරීක්ෂා සඳහා ලිංගාශ්‍රිත රෝග සායන වෙත යොමු කලයුතුය.
- උපදංශය හෝ එච්.අයි .වී. ආසාදිත සියලුම ගර්භණී මවුවරුන් වෙනුවෙන් අවශ්‍ය සියලුම සේවා නේවාසික ප්‍රතිකාර සේවාද ඇතුළුව කිසිදු වෙන්කොට සැලකීමකින් හෝ කොන්කිරීමකින් තොරව සැපයීමට වගබලාගත යුතුය.
- ගර්භණී මවගෙන් උපදින දරුවාට උපදංශය හා එච්.අයි.වී පැතිරීම තුරන්කිරීමේ ප්‍රාදේශීය වැඩපිළිවෙළ පිළබඳව කලාප සෞඛ්‍ය සේවා අධ්‍යක්ෂක, මාතෘ හා ළදරු සෞඛ්‍ය වෛද්‍ය නිලධාරී, ලිංගාශ්‍රිත රෝග

සායන හා සෞඛ්‍ය වෛද්‍ය නිලධාරී කාර්ය මණ්ඩලය විසින් නැවත විමසා බැලීමක් සෑම මාස හයකට වරක්ම කළ යුතුය.

සෑම ගර්භණී මවකටම පෘථුල පූර්වප්‍රසව සංරක්ෂණ සේවා රැසක් තුළින් සාර්ථක දරු ප්‍රතිඵලයක් උදාකරදීම ශ්‍රී ලංකා රජයේ ප්‍රතිපත්තිය බවත් ඒතුළ සියලුම මව්වරුන් උපදංශය හා එච්.අයි .වී. සඳහා රුධිර පරීක්ෂා කිරීමත්, අවශ්‍ය සේවා සැපයීමත් අන්තර්ගත බව යළිත් සිහිකැඳවනු කැමැත්තෙමි.

මේ සඳහා ඔබගේ පූර්ණ කැපවීම මහත් සේ බලාපොරොත්තු වෙමි.

ලේකම්,
සෞඛ්‍ය අමාත්‍යාංශය,

පිටපත්:

1. සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජෙනරාල්
2. ලෝක සෞඛ්‍ය සංවිධාන නියෝජිත
3. නියෝජ්‍ය සෞඛ්‍ය අධ්‍යක්ෂ ජෙනරාල් (ප්‍රජා සෞඛ්‍ය සේවා) 1,2
4. නියෝජ්‍ය සෞඛ්‍ය අධ්‍යක්ෂ ජෙනරාල් (රසායනාගාර සේවා)
5. අධ්‍යක්ෂ / ජාතික ලිංගාශ්‍රිත රෝග හා ඒඩ්ස් මර්ධන ව්‍යාපාරය
6. අධ්‍යක්ෂ / පවුල් සෞඛ්‍ය කාර්යාංශය
7. අධ්‍යක්ෂ / පුද්ගලික සෞඛ්‍ය අංශ ප්‍රවර්ධන

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 சுற்றறிக்கையை 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 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 4: Laboratory Form

NATIONAL STD/ 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

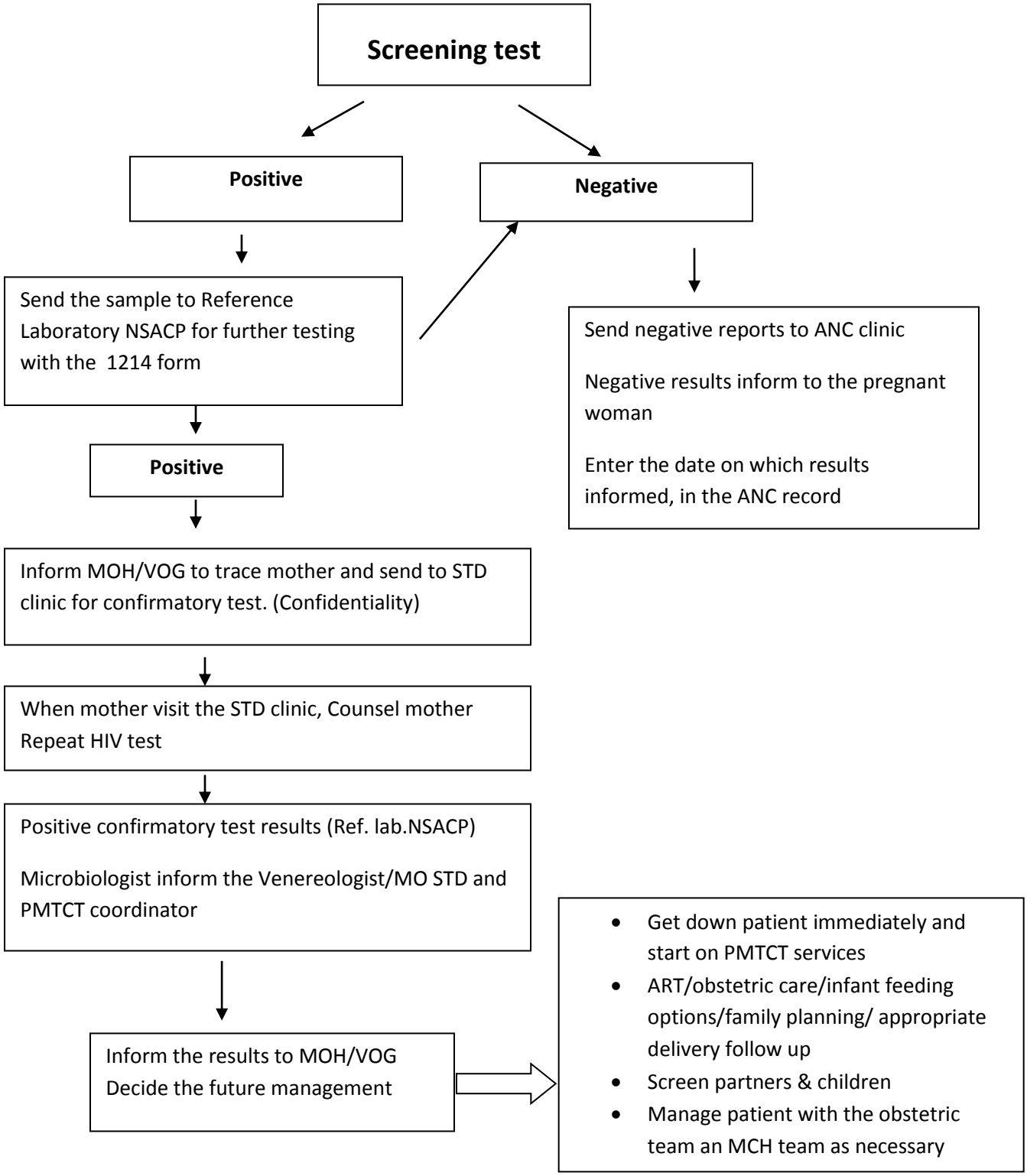
…… ……. ……..
Name of collecting officer Designation Signature.

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

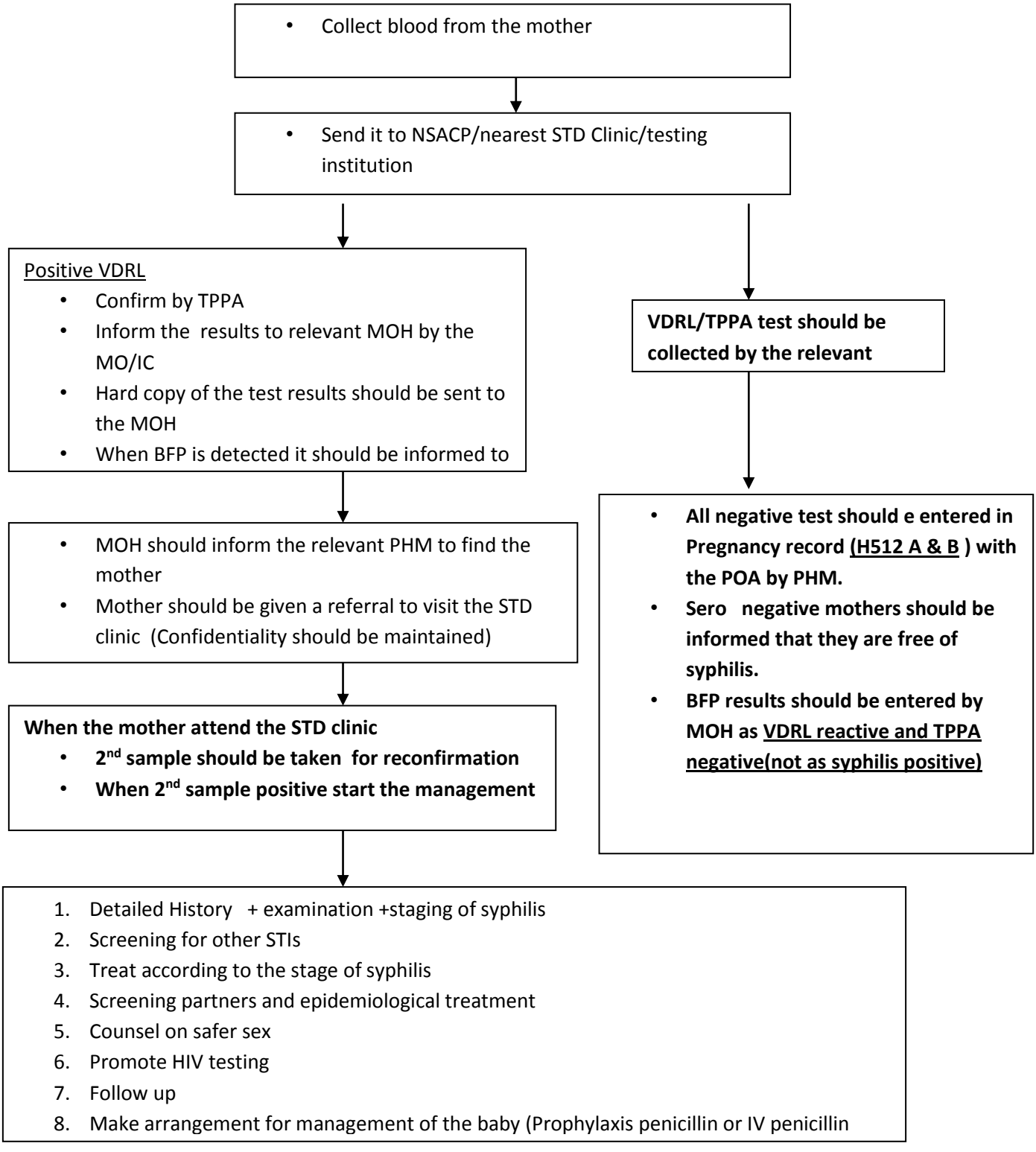
Lab use only.

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

Annexure 5: Protocol to inform HIV test results of ANC mothers, peripheral setting



Annexure 6: Protocol for antenatal testing for syphilis



Annexure 7: Letter 1- Informing positive HIV screening test to MCH services

දුරකථන අංක: 011 2667029
தொலைபேசி 011 2667163
Telephone

අධ්‍යක්ෂ 011 2695183
அத்தியட்சகர்
Director

කාර්යාලය 011 2696433
காரியாலயம்
Office

ෆැක්ස් 011 5336873
பக்ஸ்
Fax

Email: dir@aidscontrol.gov.lk
Web: www.aidscontrol.gov.lk

ජාතික ලිංගාශ්‍රිත රෝග හා ඒඩ්ස් මර්දන වැඩසටහන
தேசிய பாலியல் நோய்/எயிட்ஸ் தடுப்பு வேலைத்திட்டம்
National STD/AIDS Control Programme

29 ද සේරම් පෙදෙස කොළඹ 10 (ශ්‍රී ලංකාව)
29 டி சேரம் இடம், கொழும்பு 10, இலங்கை
29 De Saram Place, Colombo 10, Sri Lanka

මගේ අංකය:
எனது இல:
My No:

ඔබේ අංකය:
உமது இல:
Your No:

දිනය:
திகதி:
Date:

Urgent & Confidential

Director/CSHW/DMH/MOH/VOG

……

Dear Sir/Madam,

<u>Screening of antenatal blood samples</u>

ANC Clinic area/PHM area:

ANC clinic NO:…….

Date of specimen collection:

Initial screening test for HIV is reactive in this patient. To exclude the false positivity and/ or to confirm, please send us a second sample of blood to the STD clinic immediately.

Thank you

…….

Director NSACP/ Venereologist/ MO STD

Annexure 8: Letter 2- To mother, requesting early visit to clinic

නම:.....

වයස: .....

පූර්ව ප්‍රසව සායනය :.....

පූර්ව ප්‍රසව අංකය : .....

පූර්ව ප්‍රසව සායනයේදී කල පරීක්ෂාවන් සම්බන්ධයෙන් වැඩිපුර තහවුරු කිරීමක් සඳහා, පූර්ව ප්‍රසව සයනයේ හෙද සොයුරිය වහාම හමුවන්න.

නිරෝගී දරු උපතක් සඳහා මෙය ඉතා වැදගත් බව සලකන්න.

මීට

.....

Annexure 9: Letter 3 – Referral letter to STD clinic

Confidential.

……..

Consultant Venereologist /MO STD
National STD/AIDS control Programme /STD Clinic

……

Referral of antenatal mother with positive screening test

Name: …… Age……..
ANC clinic No ……..…
This mother is referred for further investigations, counseling and management. She will have routine antenatal follow up care at ……..
Her reports are sent herewith for your information.

Thank you

……

……

Annexure 10: Letter 4 – Letter informing confirmed positive status

දුරකථන අංක: 011 2667029
தொலைபேசி 011 2667163
Telephone

අධ්‍යක්ෂ 011 2695183
அத்தியட்சகர்
Director

කාර්යාලය 011 2696433
காரியாலயம்
Office

ෆැක්ස් 011 5336873
பக்ஸ்
Fax

Email: dir@aidscontrol.gov.lk
Web: www.aidscontrol.gov.lk

ජාතික ලිංගාශ්‍රිත රෝග හා ඒඩ්ස් මර්දන වැඩසටහන
தேசிய பாலியல் நோய்/எயிட்ஸ் தடுப்பு வேலைத்திட்டம்
National STD/AIDS Control Programme

29 ද සේරම් පෙදෙස කොළඹ 10 (ශ්‍රී ලංකාව)
29 டி சேரம் இடம், கொழும்பு 10, இலங்கை
29 De Saram Place, Colombo 10, Sri Lanka

මගේ අංකය:
எனது இல:
My No:

ඔබේ අංකය:
உமது இல:
Your No:

දිනය:
திகதி:
Date:

Urgent & Confidential

MOH/VOG

Dear Sir/Madam,

Confirmatory test results of ANC blood samples

ANC Clinic area/PHM area:

ANC clinic NO:…….

This is to inform you that the above antenatal blood sample, was found to be positive in HIV confirmatory testing. The necessary measures to prevent baby getting infection will be arranged from the STD clinic. Further details of shared care will be informed in due course.

We would appreciate if you could take necessary measures to maintain confidentiality.

The copy of the report is attached here with.

Thank you.

…….

Director NSACP/Venereologist/ MO STD

Annexure 11: Letter informing positive treponemal tests

ලිංගාශ්‍රිත රෝග /ඒඩ්ස් මර්දන වැඩසටහන

/ /

සෞඛ්‍ය වෛද්‍ය නිලධාරී

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මා වෙත යොමු කරන ලද ඉහත අංක දරන මවගේ රුධිර සාම්පලයේ

TPPA:

එමනිසා මව වැඩිදුර පරීක්ෂාව සඳහා ..... ලිංගික රෝග සායනය වෙත යොමුකරන මෙන් ඉල්ලා සිටිමි.

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විශේෂඥ වෛද්‍ය නිලධාරී

ලිංගාශ්‍රිත රෝග /ඒඩ්ස් මර්දන වැඩසටහන

Annexure 12.1: Details of pregnant mother with confirmed HIV infection

Details of pregnant mother with confirmed HIV infection

STD Clinic:

Date of registered: **Master No:**

Age : : **LMP** **EDD:**

CD 4 count in early pregnancy (Date):

Diagnosed: During pregnancy / Already diagnosed

If already diagnosed: on ART / not on ART

<u>If already diagnosed</u> POA at the time informed pregnancy:

Pregnancy: Planned / Unplanned

<u>If diagnosed in Pregnancy</u>

POA-at the time confirmed test positive **ART for:** her own health / for PMTCT

ART regimen:

ART started at POA: **Date:**

Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory

Close to term viral load (Date): **CD 4 Count (Date):**

Delivery Date:

Elective LSCS/Emergency LSCS/ NVD

Any Invasive procedure during delivery: None/Forceps/ Vacuum

Family planning method after delivery:

Baby

Feeding method: Formula feeding/Breast feeding under ART covers

ART syrup for 6 weeks: Completed / Defaulted

Age of First DNA PCR: Positive/Negative

Age of second DNA PCI Positive/Negative

HIV antibody test at 18 months: Positive/Negative

Partner: Screened – Yes / No **If yes**: Positive / Negative.

……

Consultant Venereologist/MO STD

Annexure 12.2: Details of Paediatric patients with HIV infection

Details of Paediatric patients with HIV infection

STD Clinic: ☐

Master Number: ☐ **Date of Registration:** ☐☐☐

Age at the time of diagnosis ☐

Sex: Male / Female

Baby confirmed diagnosis on (Date): ☐☐☐

Reason for diagnosis: Mother knows HIV Positive/Symptoms/Others

Date of Last CD 4 count/ CD4%: ☐☐☐ **CD%/ CD4 count:** ☐

WHO clinical stage at the diagnosis: ☐

Is child on ART: Yes/No

Date ART started: ☐☐☐

Reason to start ART: ☐ **ART regimen:** ☐

Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory

Current WHO clinical Stage now: ☐

Remarks:

……

……Consultant Venereologist/MO STD

Annexure 12.3: Details of pregnant women with syphilis

Details of pregnant women with syphilis

STD clinic:

Master No:

Date:

Age:

LMP: **EDD:**

VDRL: **TPPA**:

Staging: Early Syphilis / Late Syphilis

Diagnosed: during pregnancy / already diagnosed

<u>If already diagnosed</u> whether adequately treated before pregnancy: YES / NO

<u>If diagnosed during pregnancy</u>
POA at the time of diagnosis (week):

Treatment given:

Adequately treated before 36/52 of POA: Yes / No
<u>Partner:</u> Managed Satisfactory: Yes / No

<u>Baby</u>

VDRL **TPPA** **EIA IGM**

Management – Benzathine penicillin prophylaxis / congenital syphilis treatment

If congenital syphilis, case definition:

1. Case definition 01
2. Case definition 02
3. Case definition 03

Baby's last VDRL Age
Baby's last TPPA Age

……

Consultant Venereologist /MO STD

Annexure 12.4: Details of babies diagnosed with congenital syphilis

Details of babies diagnosed with Congenital Syphilis

STD clinic:

Master No: **Date:**

Age:

VDRL:

TPPA:

EIA IgM:

Case definition of Congenital Syphilis

1. Case definition 01
2. Case definition 02
3. Case definition 03

Given treatment:

……

Consultant Venereologist/MO STD

Annexure 12.5: STI data of pregnant mothers

Name of the STD clinic	**: _____**
Period of the return	**: __ /__ / 20_ _ to __ /__ / 20_ _ (_Q. of 20_ _)**
Return completed by (Name and designation)	**:_____**
Checked by (Name and designation)	**:_____**
Date of completion	**: __ / __ / 20_ _**

Name of the MOH area	Number of Pregnant women diagnosed for the Quarter							
	HIV	Early Syphilis	Late Syphilis	GC[1]	NGI[2]	Genital Herpes	Genital warts	Other STIs

1. Gonorrhea *2. Non-gonococcal Infections*

Instructions: Please send these antenatal STI data to Director/NSACP, 29, De Saram Place, Colombo 10 before 20th of the month following each quarter.

Annexure 13: ANC Syphilis Register

11. Antenatal Syphilis Register

Main objective of this Register is to record information on antenatal mothers who were screened and tested positive for Syphilis, in order to follow up and prevent congenital syphilis.

Table 1.12Antenatal Syphilis Register

Date	Serial No	Sample no & Place of referral, MOH area	Name, address and TelephoneNo:	Age	Parity (ANC)	Test results				STD file no	Treatment given	Baby's detail	Partners detail	Remarks
						VDRL		TPPA						

Notes

- Only the antenatal mothers who are positive for syphilis should be entered here. (Both treated or untreated)
- Blood samples sent from institutions or field clinics in MOH areas and mothers who personally visit the clinic should be entered in a laboratory register. And once such a sample is positive for syphilis, it has to be entered into the Antenatal syphilis positive register and main register.
- To identify the number of antenatal mothers positive for syphilis, use the serial number of this table.

Instructions to complete columns of Antenatal syphilis positive register.

1. **Date– in dd/mm/yyyy format**
2. **Serial Number –** Start as one from 1st of January in each year.
3. **Sample number & place of referral – Indicate the MOH Clinic and ANL Number**
4. **Name, address and Telephone No – Home Address**
5. **Age**
6. **Parity –** P - Pregnancy, C - Living children
7. **Test results – VDRL, TPHA**
8. **File No. STD clinic – Master number**
9. **Remarks –**Expected date of delivery (EDD), Date of issue of the letter to VOG etc.
10. **Baby's Details –**Baby's STD clinic file no. Date of treatment/Prophylaxis, VDRL and EIA IgM Reports.
11. **Partners Details –** Partner's STD clinic file No, syphilis diagnosed or not Date of epi-treatment

Annexure 14: 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										
මුත්‍ර/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 ලීලාව சிசு அமைந்திருக்கும் பாங்கு Foetal Lie										
භ්‍රෑණයේ පිහිටීම சிசுவின் அமைந்திருக்கும் பாங்கு Presentation										
ප්‍රමුඛ කොටස ශ්‍රෝණි කුහරය තුළ පිහිටීම வெளிப்படும் பகுதி இடுப்புக்குழியில் இறங்கியிருக்கும் அளவு Engagement of the presenting part										
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

	ගර්භ සති ගණන கர்ப்பகாலம் POA	ප්‍රතිඵල பெறுபேறு Result
රුධිරයේ සීනි குருதியில் சீனியின் அளவு Blood Sugar		
හිමෝග්ලොබින් ஈமோகுளோபின் Haemoglobin		

වෙනත් පරීක්ෂණ ஏனைய பரிசோதனைகள் Other Investigations	
පණු ප්‍රතිකාර பூச்சித் தடுப்பு மருந்துகள் Antihelminthic Drugs	
භ්‍රෑණ චලන සටහන්පත ලබා දුන් දිනය குழந்தை துடிப்பு கணக்கிடும் பட்டியல் வழங்கிய திகதி 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 ධූලකාභ ප්‍රතිශක්තිකරණය /ஏற்பு நோய் தடுப்பு மருந்து வழங்குதல்/ **Tetanus Toxoid Immunization**

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

3

Annexure 15: Poster EMTCT of HIV

Annexure 16.1: Leaflet for pregnant women on service package (Page 1)

- අදාල පරීක්ෂණයන් කර ගැනීමෙන්
- අවශ්‍ය උපදෙස් පිළිපැදීමෙන්

නීරෝගී බිළිඳකු වෙනුවෙන්
ඔබේ පැතුම ඉටු වේ.

ඔබේ වගකීම වනුයේ

ගැබ්ගත් බව දැනගත් වහාම

- සායනයට පැමිණීම
- පළමු මාස 03 ඇතුලත අදාල සියලුම පරීක්ෂාවන් සිදු කරවා ගැනීම
- ලබාදෙන ප්‍රතිකාර නියමාකාරව ගැනීම
- ලබාදෙන උපදෙස් නිසිලෙස පිලිපැදීම

ඔබට සහය වීම සඳහා සෞඛ්‍ය සේවාවන්
නිබඳවම ඔබ සමීපයේ.....

ප්‍රකාශනය
ජාතික ලිංගාශ්‍රිත රෝග හා එඩ්ස් මර්දන වැඩසටහන
නො 29, ද සේරම් පෙදෙස
කොළඹ 10.
දුරකථන - 011-2667163

ඔබේ පැතුම සැබෑ වීමට නම්

සෑම කාන්තාවකගේම පැතුම නිරෝගී දරු සම්පතකි.

ඒ සඳහා මව් සායනයේදී
සිදු කරනු ලබන පරීක්ෂණ කරවා ගැනීම
මවක වන ඔබගේ වගකීමයි.

Annexure 16.2: 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.

Annexure 17: Request for HIV antibody test (H 1214)

Health 1214

CONFIDENTIAL

REQUEST FOR HIV ANTIBODY TEST/NOTIFICATION

(To be retained by the Physician Requesting Test)

PATIENT No. : ☐☐☐☐☐☐

NAME OF PATIENT : ....

ADDRESS : ....

....

DATE OF REQUEST ☐☐☐☐☐☐
D M Y

ETHNICITY : ....

Tear Off : —

DATE OF REQUEST ☐☐☐☐☐☐
D M Y

PATIENT No. : ☐☐☐☐☐☐

INFORMED CONSENT FOR HIV TESTING OBTAINED FROM PATIENT 1. YES 2. NO ☐

NAME OF PATIENT (FIRST TWO LETTERS : ....
OF GIVEN NAME AND SURNAME ONLY)

DISTRICT OF RESIDENCE : .... ☐

DATE OF BIRTH : ☐☐☐☐☐☐
D M Y

AGE ☐☐

SEX : 1. MALE 2. FEMALE ☐

MARITAL STATUS : 1. NEVER MARRIED ☐
2. CURRENTLY MARRIED/LIVING TOGETHER
3. SEPARATED/DIVORCED/WIDOWED

OCCUPATION : .... ☐☐
(Please Specify)

REASON FOR TESTING : 1. PATIENT WITH SYMPTOMS (Confirmatory test) ☐
2. ASYMPTOMATIC 3. VISA SCREENING 4. ORGAN DONOR
5. SURVEY 6. STD CLINIC ATTENDEE 7. OTHER (Specify) ....

RISK FACTORS : .... ☐
(Please Specify) ....

SPECIMEN : 1. BLOOD 2. OTHER (Specify) ☐

REFERRING DOCTORS NAME : ....
(In Capitals)

DESIGNATION : ....

SIGNATURE : ....

ADDRESS (Clinic, Hospital, GP etc.) : ....