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

List of Figures ................................................................................................................................................ vi

List of Tables ................................................................................................................................................ vi

List of abbreviations and acronyms ................................................................................................................ vi

1. Introduction ................................................................................................................................................. 1

2. Mother to child Transmission of HIV and congenital syphilis................................................................ 4

3. Comprehensive approach to prevent mother to child transmission of syphilis and HIV ......................... 6

4. Elimination of congenital syphilis programme in Sri Lanka ....................................................................... 7

   4.1. Management of pregnant woman with syphilis ................................................................................. 7

   4.2. Case definition of Congenital Syphilis .............................................................................................. 10

5. Elimination of MTCT of HIV programme in Sri Lanka .............................................................................. 12

6. Stakeholders in EMTCT programme ........................................................................................................... 18

7. Criteria and process for Validation ............................................................................................................. 19

8. Goals and objectives for the elimination of mother to child transmission of syphilis and HIV in Sri Lanka ..................................................................................................................... 22

9. Guiding principles ...................................................................................................................................... 23

10. Strategies and Activities ........................................................................................................................... 25

11. Expected outcomes by 2017 ...................................................................................................................... 28

12. Targets and indicators ............................................................................................................................... 28

References ..................................................................................................................................................... 33

Annexures: ....................................................................................................................................................... 1

   Annexure 1.1  General circular letter No. 02-02/2014 ........................................................................... - 1 -

   Annexure 1.2  General Circular in Sinhalese ............................................................................................ - 3 -

   Annexure 1.3  General Circular in Tamil .................................................................................................. - 5 -

   Annexure 2: Standard of care - PMTCT of syphilis and HIV ................................................................. - 7 -

   Annexure 3: Guideline to collect blood samples for VDRL and HIV ...................................................... - 9 -

   Annexure 4: Laboratory Form ................................................................................................................... - 10 -

   Annexure 5: Protocol to inform HIV test results of ANC mothers, peripheral setting ......................... - 11 -

   Annexure 6: Protocol for antenatal testing for syphilis ......................................................................... - 12 -
Annexure 7: Letter 1- Informing positive HIV screening test to MCH services ........................................... - 13 -
Annexure 8: Letter 2- To mother, requesting early visit to clinic ................................................................. - 14 -
Annexure 9: Letter 3 – Referral letter to STD clinic ................................................................................... - 15 -
Annexure 10: Letter 4 – Letter informing confirmed positive status ......................................................... - 16 -
Annexure 11: Letter informing positive treponemal tests ......................................................................... - 17 -
Annexure 12.1: Details of pregnant mother with confirmed HIV infection ............................................. - 18 -
Annexure 12.2: Details of Paediatric patients with HIV infection .............................................................. - 19 -
Annexure 12.3: Details of pregnant women with syphilis ........................................................................ - 20 -
Annexure 12.4: Details of babies diagnosed with congenital syphilis ....................................................... - 21 -
Annexure 12.5: STI data of pregnant mothers ......................................................................................... - 22 -
Annexure 13: ANC Syphilis Register ........................................................................................................ - 23 -
Annexure 14: Pregnancy Record (H 512) ................................................................................................. - 24 -
Annexure 15: Poster EMTCT of HIV ........................................................................................................ - 25 -
Annexure 16.1: Leaflet for pregnant women on service package (Page 1) ................................................. - 26 -
Annexure 16.2: Leaflet for pregnant women on service package (Page 2) ................................................. - 27 -
Annexure 17: Request for HIV antibody test (H 1214) ............................................................................. - 28 -
List of Figures

Figure 1  Annual number of HIV cases reported - 1987 to 2013 ................................................................. 2
Figure 2: Number of early Syphilis cases reported from all STD clinics by age and sex, 2008-2013 .......... 3
Figure 3: Risk of Mother to Child Transmission of HIV .............................................................................. 4
Figure 4: Antenatal syphilis screening done at NSACP - 2008-2013 ............................................................ 9
Figure 5: Congenital syphilis cases reported to NSACP - 2003-2013 .......................................................... 11
Figure 6: Mode of transmission of HIV cases reported up to end of 2013 .................................................... 13
Figure 7: Management of pregnant women with HIV infection ................................................................. 14
Figure 8: NSACP organogram ................................................................................................................... 17
Figure 9: Stakeholders in EMTCT of HIV and syphilis programmes .......................................................... 18
Figure 10: Cumulative Number of HIV cases reported by District ........................................................... 30

List of Tables

Table 1: Percentage of Age and Sex Distribution of Cumulative HIV Cases ............................................. 3
Table 2: Adverse pregnancy outcomes in syphilis ....................................................................................... 5
Table 3: Paediatric HIV cases reported to NSACP from 1994 - 2012 .......................................................... 12
Table 4: When to start ART in pregnant women ......................................................................................... 14
Table 5: Major activities conducted in 2013 and 2014 ............................................................................. 29
Table 6: Country plan to introduce HIV testing among pregnant women .................................................. 31
Table 7: Future activities planned for the years 2015-2017 ..................................................................... 32
List of abbreviations and acronyms

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

MDG 3: Promote gender equality and empower women

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

MDG 4: Reduce child mortality

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 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>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>1988</td>
<td>11</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>1989</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>1990</td>
<td>13</td>
<td>22</td>
<td>35</td>
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<td>1991</td>
<td>27</td>
<td>37</td>
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<td>1992</td>
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<td>1995</td>
<td>55</td>
<td>42</td>
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<td>1996</td>
<td>47</td>
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<td>1998</td>
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<td>91</td>
<td>159</td>
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<tr>
<td>1999</td>
<td>129</td>
<td>95</td>
<td>224</td>
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<td>2000</td>
<td>119</td>
<td>102</td>
<td>221</td>
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<td>2001</td>
<td>137</td>
<td>121</td>
<td>258</td>
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<tr>
<td>2002</td>
<td>146</td>
<td>146</td>
<td>292</td>
</tr>
<tr>
<td>2003</td>
<td>186</td>
<td>196</td>
<td>382</td>
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<tr>
<td>2004</td>
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<td></td>
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<tr>
<td>2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1: Percentage of Age and Sex Distribution of Cumulative HIV Cases

Source - Annual report of NSACP 2013

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

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: Risk of Mother to Child Transmission of HIV](image)
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

<table>
<thead>
<tr>
<th>outcome</th>
<th>Hartman*</th>
<th>Ingraham</th>
<th>Hira et al</th>
<th>Global burden of STI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Still birth or miscarriage</td>
<td>17%</td>
<td>22%</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>Perinatal death</td>
<td>23%</td>
<td>12%</td>
<td>No data</td>
<td>15%</td>
</tr>
<tr>
<td>Infected infant</td>
<td>21%</td>
<td>33%</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>Prematurity</td>
<td>No data</td>
<td>No data</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>Lower Birth Weight (LBW)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any adverse outcome</td>
<td>61%</td>
<td>67%</td>
<td>57%</td>
<td>75%</td>
</tr>
</tbody>
</table>

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**

**Number of pregnant women with positive TPHA**

![Graph showing the number of pregnant women with positive TPHA from 2008 to 2013.](image)

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.

<table>
<thead>
<tr>
<th>Major criteria</th>
<th>Minor criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swelling of joints</td>
<td>Hepatosplenomagaly</td>
</tr>
<tr>
<td>Bullous skin lesions</td>
<td>Jaundice</td>
</tr>
<tr>
<td>Snuffles</td>
<td>Anaemia</td>
</tr>
<tr>
<td>Radiological changes in long bones</td>
<td></td>
</tr>
</tbody>
</table>

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.
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).

Milestones 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1995</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>1996</td>
<td>-</td>
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<td>-</td>
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<td>0</td>
<td>1</td>
<td>1</td>
</tr>
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<td>1998</td>
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<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>1</td>
<td>3</td>
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<td>2001</td>
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<td>1</td>
<td>2</td>
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<td>2005</td>
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<td>4</td>
<td>10</td>
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<tr>
<td>2006</td>
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</tr>
<tr>
<td>2011</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>2012</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>2013</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>

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)

![Mode of transmission of HIV Cases](image)

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

<table>
<thead>
<tr>
<th>National PMTCT programme option</th>
<th>Pregnant women with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider using lifelong ART for all pregnant women (“Option B+”) *</td>
<td>Start ART regardless of WHO clinical stage or CD4 count</td>
</tr>
<tr>
<td></td>
<td>Maintain after delivery lifelong</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>Antenatal &amp; Post Natal Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Intranatal and Newborn Care Unit</td>
</tr>
<tr>
<td>3</td>
<td>Family Planning Unit</td>
</tr>
<tr>
<td>4</td>
<td>Child Nutrition Unit</td>
</tr>
<tr>
<td>5</td>
<td>Child Development &amp; Special Needs</td>
</tr>
<tr>
<td>6</td>
<td>School and Adolescent Health Unit</td>
</tr>
<tr>
<td>7</td>
<td>Gender &amp; Women’s Health Unit</td>
</tr>
<tr>
<td>8</td>
<td>Planning, Monitoring &amp; Evaluation Unit</td>
</tr>
<tr>
<td>9</td>
<td>Oral Health</td>
</tr>
<tr>
<td>10</td>
<td>Maternal &amp; Child Morbidity, Mortality Surveillance Unit</td>
</tr>
<tr>
<td>11</td>
<td>Research and Development Unit</td>
</tr>
<tr>
<td>12</td>
<td>Reproductive Health Unit</td>
</tr>
</tbody>
</table>
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%
Summary 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
2. Expand HIV interventions in the workplace
3. Expand and strengthen the provision of good quality STI services ensuring correct diagnosis based on laboratory testing or by syndromic approach
4. Condom promotion programmes
5. 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 paediatric 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 HIV for other STI
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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision taken on universal screening of pregnant women</td>
<td></td>
</tr>
</tbody>
</table>
| 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>
<thead>
<tr>
<th>Year</th>
<th>Region/Province/District</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Western province&lt;br&gt;Southern province&lt;br&gt;Kandy district</td>
</tr>
<tr>
<td>2014</td>
<td>North western province&lt;br&gt;North central province&lt;br&gt;Northern Province</td>
</tr>
<tr>
<td>2015</td>
<td>Sabaragamuwa province&lt;br&gt;Uva province&lt;br&gt;Eastern province&lt;br&gt;Matale, Nuwaraeliya districts</td>
</tr>
<tr>
<td>2016</td>
<td>increase coverage</td>
</tr>
<tr>
<td>2017</td>
<td>maintain coverage</td>
</tr>
</tbody>
</table>
Table 7: Future activities planned for the years 2015-2017

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness programmes among general population</td>
<td>IEC material development Training for health care staff of MCH and STI services on prevention</td>
<td>NSACP</td>
</tr>
<tr>
<td>Prevention of unintended pregnancies among women living with HIV</td>
<td>Awareness programmes for PLHIV</td>
<td>NSACP</td>
</tr>
<tr>
<td>Ensuring advocacy and sustained political commitment</td>
<td>Regular meetings of steering committee, NAC, HDC Meetings with professional colleges</td>
<td>FHB and NSACP</td>
</tr>
<tr>
<td>Increasing access to testing</td>
<td>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.</td>
<td>FHB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NSACP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NSACP</td>
</tr>
<tr>
<td>Prevention of HIV and syphilis transmission from women living with HIV/ syphilis to their children</td>
<td>Maintain quality of PMTCT services through regional training and workshops Availability of drugs and safe delivery kits</td>
<td>FHB and NSACP</td>
</tr>
<tr>
<td>Strengthen surveillance, monitoring and evaluation of EMTCT programmes of syphilis and HIV</td>
<td>Establish performance review in relation to EMTCT at each level Monthly MOH review meetings Quarterly review by RDHS Annual review by NSACP and FHB</td>
<td>Provincial authorities NSACP FHB</td>
</tr>
</tbody>
</table>
References


2. UNAIDS. *HIV in Asia and the Pacific UNAIDS report 2013*. 1st ed ; 2013


5. WHO *Global guidance for validation of elimination of mother-to-child transmission (EMTCT) of HIV and Syphilis, Criteria and Processes*. Department of HIV/AIDS, Department of Reproductive Health and Research, WHO


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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

07.11.2013

සාමාන්‍ය පළමු පැතිරීමේ පිළිකාර්ථක කාර්යඥයන්, පාජේයගේ අංකය. ලංගාශ්‍රීත ලංඋපදාශය ලංහෙන්ගේ ආච්.ආයි.වී.පැතිරීමට ලංකීය බසක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, 12ක් පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍යයි.

• පදනමුදුරු පැතිරීමට ලංකීය විශේෂඥයන්, පසුකෝට්ට පිළිකාර්ථක කාර්යඥයන්ට ලංකීය ආච්.ආයි.වී.පැතිරීමට ලංකීය ප්‍රතිපතිමය ලංකීයක් බවට පැතිරීමට නැත්‍যයි.
රාජානා හා ගාලික විදේශ විදේශ විදිහිත කාර්ය සම්පාදනය සහ පලිත නැවත ලබා ආරාම කළේ.

මම ප්‍රාහේරින් පිළිබද කාර්ය විදේශ පලකාව විසි්, නැවත් ලබාගැනීමක්ම මම මායකටව ක්ෂාම කල.

මම ප්‍රාහේරින් හා බිම්විය දක්නට විශේෂ විදේශ විදිහිත කාර්ය සම්පාදනය හා පදනම් අදාලයන්හි හා ආරාම කාර්යකාරීන්ට විසරහි ලැබේ, අවසන් ලාවේ සියලුම මව්වුන්, විටලන්ති, හා විශේෂ විදේශ විදිහිත කාර්යකාරීන් මහත් තියුණු කැමැත්ගත නොවීයේ.

විශේෂයක්,
සසුරාල දැක්වේන්ම,

විශේෂය:

1. ප්‍රාහේරි ප්‍රහස අංශයක් පිළිබද
2. ප්‍රාහේරි ප්‍රහස ප්‍රාහේරි
3. ප්‍රාහේරි ප්‍රහස අංශයක් පිළිබද (පැහැදිලි ප්‍රහස ශීල්) 1,2
4. ප්‍රාහේරි ප්‍රහස අංශයක් පිළිබද (පැහැදිලි ප්‍රහස ශීල්)
5. අංශය / ප්‍රාහේරි ප්‍රහස ප්‍රහස ප්‍රාහේරිගේ අංශය
6. අංශය / ප්‍රාහේරි ප්‍රහස කිරීම
7. අංශය / ප්‍රාහේරි ප්‍රහස කිරීම
Annexure 1.3 General Circular in Tamil

எனது இல:........................................................................................
சுகாதார சேவைகள் பணிப்பாளர் நாயகம் அலுைலகம்
சுைேிரிபாய, சுகாதார அவைச்சு,
ககாழும்பு , 07.11.2013

அவனத்து ைாகான சுகாதார சேவைகள் பணிப்பாளர்கள்,
அவனத்து பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்கள்,
அவனத்து சபாதனா, கபாது, மைட்டியோவலகளின் பணிப்பாளர்கள்,

இலங்கையில் தாயிருந்து குழந்றக்கு பரவும் மேற்மய் (CONGENITAL SYPHILIS) கற்றும் எச்.ஐ.வி.
மேற்தகல் (MOTHER TO CHILD TRANSMISSION OF HIV) இல்லாகதாழிக்கும் தெயல் முகைத்திட்டம்

(EMTCT OF SYPHILIS AND HIV)

இலங்கையில் தாயிருந்து குழந்றக்கு பரவும் பிறப்பியல் சைக சநாய் கற்றும் எச்.ஐ.ைி. கதாற்றுதல் முதலியனைற்றுைி்ய

இலங்வகயிலிருந்து இல்லாகதாழிக்கும் நிவலவய அவடவயைதற்கு , உரிய கேயலூக்கமுவடய ,
முழு நாடளைிலான கபாதுத் தழுவுககாண்ட கேயல்த்திட்ட நவடமுவற அைேியைாகும்.

இன்றால் இலங்வகயில் தாயிருந்து குழந்வதக்கு பரவும் சைக சநாய் க்கான திவரயிடல் பரிசோதவனயானது ,  கிட்டத்தட்ட முழு

நாடளைிலானதாக முதிந்துள்ளது(98%).

கர்ப்பிணித் தாய்ைார்களுக்கான எச்.ஐ.ைி. திவரயிடல் பரிசோதனவய, ஏற்கனசை உள்ள சைக சநாய் க்கான

திவரயிடல் பரிசோதவனகவள 12 கிழவை கர்ப்பகாலத்தில் அல்லது முதலாைது கிளினிக்குகின்சபாது

கேய்யப்படல் சைண்டும்.

பிரேைமுன்கால கிளினிக்குகளில் -

சுகாதார சேவை பணிைவன அதிகாரிகள், வைத்தியோவல

பிரேைமுன்கால கிளினிக்குகள் (ANTENATAL CLINICS - MOH OFFICE; HOSPITAL ANCS) கர்ப்பிணிக்கு

கேய்யப்படல் சைண்டும்.

கேய்யப்படல் சைண்டும்.

தாய்-சேய் சுகாதார அதிகாரி (MOMCH), பாலுறவு
சநாய் கிளினிக் பாலுறவு சேவைகள் (MO-STDs) மற்றும் கர்ப்பிணித் தாயின் சுகாதார அதிகாரிகள் (MOHs) வருகையைக் கொண்டு காரணிகள் ஒன்றிலேயே ஆங்கில வட்டம் கணிக்கப்படும் வங்கியாகிறோம்.

- பாலுறவு சுகாதார எதிர்ப்பாளர்கள், நோய் குழுப்பெடுக்கும் தாட்சியுடன் தைவான்றின் சுகாதார சேவைப் பணிநவன சுகாதார அதிகாரிகள் (MOHs)

சைங்கை முன்னிலையில் பிைச்சேடுடன் கலந்துவரும் சுகாதார சேவைப் பணிநவன சுகாதார அதிகாரிகள் (MOHs) பேண்டிலும் வைத்தியோலகவிலும் வழங்கப்படும் சுகாதார சேவைகள் பணிநவன அதிகாரிகளுக்கு முன்னாட்சியைக் கொண்டு பங்குபற்றும் வங்கியாகிறோம்.

- சைங்கை முன்னிலையில் பிைச்சேடுடன் கலந்துவரும் சுகாதார சேவைப் பணிநவன சுகாதார அதிகாரிகள் (MOHs) பேண்டிலும் வைத்தியோலகவிலும் வழங்கப்படும் சுகாதார சேவைகள் பணிநவன அதிகாரிகளுக்கு முன்னாட்சியைக் கொண்டு பங்குபற்றும் வங்கியாகிறோம்.

- கர்ப்பிணித் தாய் பிரேைகால வைத்தியோலக குறியீடுகள் (EMTCT OF SYPHILIS AND HIV) குழுவின் 6 மரபு சுகாதார பிரேைகால வைத்தியோலக குறியீடுகளை வழங்கப்படும் வங்கியாகிறோம்.

சுகாதார சேவைகள் பணிநவன அதிகாரிகள் (MOMCH), பாலுறவு சுகாதார எதிர்ப்பாளர்கள் (MO-STDs), கர்ப்பிணித் தாய் சுகாதார அதிகாரிகளுக்கு முன்னாட்சியைக் கொண்டு பங்குபற்றும் வங்கியாகிறோம்.

மொத்தத்தானது வங்கியாகிறோம் கர்ப்பிணித் தாய்களின் குறியீடுகளை முன்னச் செய்து கொண்டிருக்கும் வங்கியாகிறோம்.

சுகாதார சேவைகள் பணிநவன அதிகாரிகள் குறியீடுகள்:

1. புதுப்பிப்பர் வைத்தியோலக, கர்ப்பிணித் தாயின் வைத்தியோலக
2. புதுப்பிப்பர், சநாய் பிரிவுகள்
3. புதுப்பிப்பர் வைத்தியோலக- பிரேைகால தாய் சுகாதார 1,2
4. புதுப்பிப்பர் வைத்தியோலக- பிரேைகால தாய் சுகாதார
5. புதுப்பிப்பர், தந்தியனும் பிரேைகால தாய் சுகாதார
6. புதுப்பிப்பர், தந்தியன் பிரேைகால தாய் சுகாதார
7. புதுப்பிப்பர், சநாய் பிரிவுகள் வைத்தியோலக

சுகாதார வைத்தியோலக உள்ளே பிரேைகால சுகாதார சேவைகள் குறியீடுகள்:

- 6 -
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

1. Ensure that the sample is collected in sterile conditions and within 3-4 hours of collection.

2. Collect blood samples from both VDRL/HIV reactive and non-reactive individuals.

3. Ensure proper labeling of samples to avoid mix-ups.

4. Samples should be collected at the recommended temperature to prevent deterioration.

5. Do not mix samples from different individuals in the same container.

6. Ensure proper transport of samples to the laboratory.

7. Test for VDRL and HIV reactive and non-reactive samples separately.

8. Results should be recorded accurately and promptly.

9. Positive and Reactive results should be reported separately.

VDRL/HIV results:

- Reactive: Positive results indicate active infection with the respective virus.
- Non-reactive: Negative results indicate absence of infection.

Ensure proper record-keeping and reporting of results.
Annexure 4: Laboratory Form
NATIONAL STD/ CONTROL PROGRAMME,
MINISTRY OF HEALTH.

REQUEST FORM FOR SYPHILIS/HIV TESTING IN ANTENATAL MOTHERS.

Institution/clinic .................................................................

MOH area ...........................................................................

Date of sample collection ....................................................

<table>
<thead>
<tr>
<th>Patient No (ANC)</th>
<th>Age</th>
<th>Parity</th>
<th>POA</th>
<th>HIV Results</th>
<th>VDRL Results</th>
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Name of collecting officer ...........................................

Name of Medical officer .............................................

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

**Screening test**

- **Positive**
  - Send the sample to Reference Laboratory NSACP for further testing with the 1214 form
  - **Positive**
    - Inform MOH/VOG to trace mother and send to STD clinic for confirmatory test. (Confidentiality)
    - When mother visit the STD clinic, Counsel mother
      - Repeat HIV test
      - Positive confirmatory test results (Ref. lab.NSACP)
        - Microbiologist inform the Venereologist/MO STD and PMTCT coordinator
          - Inform the results to MOH/VOG
            - Decide the future management
              - Get down patient immediately and start on PMTCT services
              - ART/obstetric care/infant feeding options/family planning/ appropriate delivery follow up
              - Screen partners & children
              - Manage patient with the obstetric team an MCH team as necessary

- **Negative**
  - Send negative reports to ANC clinic
    - Negative results inform to the pregnant woman
      - Enter the date on which results informed, in the ANC record
Annexure 6: Protocol for antenatal testing for syphilis

- Collect blood from the mother
- Send it to NSACP/nearest STD Clinic/testing institution

Positive VDRL
- Confirm by TPPA
- Inform the results to relevant MOH by the MO/IC
- Hard copy of the test results should be sent to the MOH
- When BFP is detected it should be informed to
  - MOH should inform the relevant PHM to find the mother
  - Mother should be given a referral to visit the STD clinic (Confidentiality should be maintained)

When the mother attend the STD clinic
- 2nd sample should be taken for reconfirmation
- When 2nd sample positive start the management
  - All negative test should be entered in Pregnancy record (H512 A & B) with the POA by PHM.
  - Sero negative mothers should be informed that they are free of syphilis.
  - BFP results should be entered by MOH as VDRL reactive and TPPA negative (not as syphilis positive)

1. Detailed History + examination + staging of syphilis
2. Screening for other STIs
3. Treat according to the stage of syphilis
4. Screening partners and epidemiological treatment
5. Counsel on safer sex
6. Promote HIV testing
7. Follow up
8. Make arrangement for management of the baby (Prophylaxis penicillin or IV penicillin)
Urgent & Confidential

Director/CSHW/DMH/MOH/VOG

Dear Sir/Madam,

**Screening of antenatal blood samples**

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

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වය: ....................

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නිග ගී දුන උපත රක්ෂ බොහෝ මිය නොවාදින අත්න්,න.

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සිංහලෙන් ක්‍රමය ලබා ගනිමු, මෙම දොරු පදකාර අව නොදෙකුවන්,න.

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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

..............................................

..............................................
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

/ / 

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TPPA:

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### Details of pregnant mother with confirmed HIV infection

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<th>STD Clinic:</th>
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<tr>
<th>Date of registered:</th>
<th>Master No:</th>
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<th>Age:</th>
<th>LMP</th>
<th>EDD:</th>
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<th>CD 4 count in early pregnancy (Date):</th>
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**Diagnosed:** During pregnancy / Already diagnosed

**If already diagnosed:** on ART / not on ART

**If already diagnosed POA at the time informed pregnancy:**

**Pregnancy:** Planned / Unplanned

**If diagnosed in Pregnancy**

**POA-at the time confirmed test positive**

**ART for:** her own health / for PMTCT

**ART regimen:**

<table>
<thead>
<tr>
<th>ART started at POA:</th>
<th>Date:</th>
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**Adherence:** Unsatisfactory /Satisfactory / >95% Satisfactory

**Close to term viral load (Date):**

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<th>CD 4 Count (Date):</th>
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**Delivery Date:**

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<th>Elective LSCS/Emergency LSCS/ NVD</th>
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**Any Invasive procedure during delivery:** None/Forceps/ Vacuum

**Family planning method after delivery:**

<table>
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<tr>
<th>Baby</th>
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**Feeding method:** Formula feeding/Breast feeding under ART covers

**ART syrup for 6 weeks:** Completed / Defaulted

**Age of First DNA PCR:**

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<th>Positive/Negative</th>
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**Age of second DNA PCR:**

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<th>Positive/Negative</th>
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**HIV antibody test at 18 months:** Positive/Negative

**Partner:** Screened – Yes / No

**If yes:** Positive / Negative.

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<th>_ART Consultant Venereologist/MO STD</th>
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### Details of Paediatric patients with HIV infection

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<tr>
<th>Master Number:</th>
<th>Date of Registration:</th>
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**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:**

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Annexure 12.3: Details of pregnant women with syphilis

<table>
<thead>
<tr>
<th>Details of pregnant women with syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>STD clinic:</td>
</tr>
<tr>
<td>Master No:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>LMP:</td>
</tr>
<tr>
<td>EDD:</td>
</tr>
<tr>
<td>VDRL:</td>
</tr>
<tr>
<td>TPPA:</td>
</tr>
<tr>
<td>Staging: Early Syphilis / Late Syphilis</td>
</tr>
<tr>
<td>Diagnosed: during pregnancy / already diagnosed</td>
</tr>
</tbody>
</table>

**If already diagnosed** whether adequately treated before pregnancy: YES / NO

**If diagnosed during pregnancy**

POA at the time of diagnosis (week): 

Treatment given: 

Adequately treated before 36/52 of POA: Yes / No

Partner: Managed Satisfactory: Yes / No

**Baby**

<table>
<thead>
<tr>
<th>VDRL</th>
<th>TPPA</th>
<th>EIA IGM</th>
</tr>
</thead>
</table>

Management – Benzathine penicillin prophylaxis / congenital syphilis treatment

**If congenital syphilis, case definition:**

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

<table>
<thead>
<tr>
<th>Baby’s last VDRL</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby’s last TPPA</td>
<td>Age</td>
</tr>
</tbody>
</table>

Consultant Venereologist /MO STD
## Details of babies diagnosed with Congenital Syphilis

<table>
<thead>
<tr>
<th>STD clinic:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Master No:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VDRL:</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPPA:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EIA IgM:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Case definition of Congenital Syphilis
1. Case definition 01
2. Case definition 02
3. Case definition 03

<table>
<thead>
<tr>
<th>Given treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

顺次

Consultant Venereologist/MO STD
Annexure 12.5: STI data of pregnant mothers

<table>
<thead>
<tr>
<th>Name of the MOH area</th>
<th>Number of Pregnant women diagnosed for the Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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.
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 1.12 Antenatal Syphilis Register

<table>
<thead>
<tr>
<th>Date</th>
<th>Serial No</th>
<th>Sample no &amp; Place of referral, MOH area</th>
<th>Name, address and Telephone No.</th>
<th>Age</th>
<th>Parity (ANC)</th>
<th>Test results</th>
<th>STD file no</th>
<th>Treatment given</th>
<th>Baby's detail</th>
<th>Partners detail</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>VDRL</td>
<td>TPPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, TPPA
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 treatment
### Annexure 14: Pregnancy Record (H 512)

#### Clinic care

<table>
<thead>
<tr>
<th>Date of Visit</th>
<th>180</th>
<th>150</th>
<th>120</th>
<th>90</th>
<th>60</th>
</tr>
</thead>
<tbody>
<tr>
<td>POA</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>POA</td>
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</tr>
<tr>
<td>POA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Auscultation

- **First trimester**
  - 3rd month
- **Second trimester**
  - 2nd month
- **Third trimester**
  - 1st month

#### Respiratory System

- Sputum examination
- Chest X-ray

#### Investigations

<table>
<thead>
<tr>
<th>Test</th>
<th>POA</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Investigations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Syphilis Screening

<table>
<thead>
<tr>
<th>Date of blood sampling</th>
<th>POA of blood sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of result received</td>
<td></td>
</tr>
</tbody>
</table>

#### Tetanus Toxoid Immunization

<table>
<thead>
<tr>
<th>Batch No.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annexure 15: Poster EMTCT of HIV
Annexure 16.1: Leaflet for pregnant women on service package (Page 1)
Annexure 16.2: Leaflet for pregnant women on service package (Page 2)