Guidelines on Management of Pregnant Women with Syphilis 2024

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

National STD/AIDS Control Programme
Ministry of Health
Sri Lanka

National
STD/AIDS
Control
Programme

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2024

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Guidelines on Management of Pregnant Women with Syphilis

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Contents

List of Abbreviations

ANC	Antenatal clinic
BFP	Biological False Positive
CS	Congenital Syphilis
CSF	Cerebrospinal Fluid
ECS	Elimination of congenital syphilis
EIA	Enzyme Immuno Assay
ELISA	Enzyme Linked Immunosorbent Assay
EMTCT	Elimination of Mother to Child Transmission
FBC	Full Blood Count
FSW	Female Sex Worker
GAM	Global AIDS Monitoring
GVAC	Global Validation Advisory Committee
HIV	Human Immunodeficiency virus
JH	Jarisch Herxheimer
MCH	Maternal and Child Health
MO	Medical Officer
MOH	Medical Officer of Health
MOIC	Medical Officer in Charge
MTCT	Mother to Child Transmission
NO	Nursing Officer
NR	Non-Reactive
PHI	Public Health Inspector
PHM	Public Health Midwife
PHNS	Public Health Nursing Officer
PO	Per Oral
POA	Period of Amenorrhea
RDT	Rapid Diagnostic Test
RPR	Rapid Plasma Reagin
RST	Rapid Syphilis Test
RVC	Regional Validation Committee
RVS	Regional Validation Secretariate
RVT	Regional Validation Team
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TPHA	Treponema Pallidum Hemagglutination
TPPA	Treponema Pallidum Particle Agglutination
UNAIDS	United Nations for AIDS
VDRL	Venereal Disease Research Laboratory
VOG	Visiting Obstetrician and Gynecologist
WHO	World Health Organization

The guidelines for management of pregnant women with syphilis -2024 was prepared to assist policymakers to plan PMTCT interventions and healthcare workers to provide optimal services to pregnant women.

1. Introduction

Syphilis is a sexually transmitted disease which may cause genital ulcers in the primary or secondary stages. However, most persons infected with syphilis remain asymptomatic making it difficult to identify the infection. These asymptomatic patients can be identified only through serological screening. If a woman has symptomatic or asymptomatic syphilis, infection can be transmitted vertically from mother to child resulting in congenital syphilis of the infant.

Maternal syphilis causes half a million stillbirths and miscarriages annually around the world. The number of fetal and neonatal deaths attributed to syphilis is estimated to be over 500,000. Every year, at least half a million infants are born with congenital syphilis.

Unlike many neonatal infections, congenital syphilis is a preventable disease which could be eliminated through effective antenatal screening and early treatment of infected pregnant women. The risk of vertical transmission and foetal disease are directly related to the stage of maternal syphilis during pregnancy. Primary and secondary syphilis, if left untreated, can result in 40% of foetal loss presented as spontaneous abortions, still births or perinatal death and another 40% of foetuses born to mothers with untreated early-stage syphilis may have congenital syphilis. The risk of foetal loss and congenital syphilis drops slightly in the early latent stage and reduces to 10% in late latent stage.

Syphilis is a condition which can be cured with penicillin treatment. Treatment of pregnant women having syphilis with penicillin treatment prevents congenital infection. Early identification and treatment of syphilis among females will reduce the risk of both sexual transmission and mother to child transmission.

1.1. WHO global strategy for the elimination of congenital syphilis (ECS)

In 2007 WHO outlined a 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 the following 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

2. Validation of EMTCT of HIV and syphilis programme

Sri Lanka has been declared as a country that eliminated MTCT of HIV and syphilis by the WHO, Geneva in 2019 and was able to maintain the standards of validation for the year of 2021 as well. The overall goal for EMTCT of HIV and syphilis is to ensure the prevention of MTCT of HIV and syphilis to a level that it is no longer a public health problem. Sri Lanka had to achieve the following impact and process indicators to achieve the elimination status.

Table 1- Indicators and targets for validation of EMTCT of the syphilis programme

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

Global guidance on criteria and processes for validation: EMTCT of HIV and syphilis, second edition 2017.WHO

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

Sero-prevalence of syphilis among antenatal population has remained at <0.1% for the last two decades in Sri Lanka.

The probability of mother to child transmission of syphilis can be eliminated with appropriate management. If there is no intervention, mother to child transmission of syphilis in an untreated mother is between 10% to 80% depending on the stage of the infection.

2.1. Maintenance of eliminated status of MTCT of syphilis

The impact and process indicators must be maintained each year for the WHO to certify a country to be successfully maintaining the EMTCT of syphilis programme. Countries that fail to maintain the required EMTCT impact and process indicators or maintain human, sexual or reproductive rights for women, can lose validation status.

Maintenance of validation reports are expected to be submitted by countries every 2 years after initial validation. These reports will be submitted through the RVCs and reviewed by the GVAC and the global secretariat to verify maintenance of validation.

To sustain elimination, a country requires comprehensive surveillance and monitoring

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

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

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

At the time of assessment of maintenance of validation, countries will be required to prepare a report that should include data tables on validation targets (process and impact indicators for the previous 2 years). For countries with small populations and small numbers of HIV-positive and/or syphilis-positive pregnant women per year, 4 years of pooled data can be used to assess maintenance of validation. Human rights, gender equality and civil society engagement must be reassessed and included in the report at this time to ensure that there are no violations or changes in laws pertaining to this component of validation since the last validation review. Maintenance reports should include updates on any programmatic data, laboratory and human rights recommendations provided by the GVAC at the time of validation. Maintenance reports should be submitted to the RVS, which will review the report and, if the validation criteria are still being met, will submit the report to the RVC (if applicable) and the GVAC for final revalidation.

Syphilis and HIV testing services should be offered to all pregnant women during the first visit with the other routine investigations before 12 weeks of gestation.

- All pregnant women should be made aware of these tests and testing would be voluntary following adequate information on MTCT of syphilis and how it can be prevented.
- If the woman does not consent for testing her decision should be respected and she should be explained that it would not impact on the provision of ANC services by the MCH staff.
- If the pregnant woman is at high risk for syphilis in pregnancy a second syphilis test should be offered at 28 weeks of gestation from the closest STD clinic or through RST

3. Laboratory Diagnosis of Syphilis

Syphilis diagnosis relies on patient history, physical examination, laboratory tests, and occasionally radiology. Many individuals with syphilis, however, remain unaware of their infection due to asymptomatic state or only mild symptoms. Early detection and treatment of these positive cases help prevent further transmission , avoid negative pregnancy outcomes and congenital syphilis. The available laboratory tests for syphilis include direct detection methods (i.e. dark-field microscopy, direct fluorescent antibody test and nucleic acid amplification test) and serology (treponemal and non-treponemal tests).

Tests for syphilis:

- Direct microscopic examination to demonstrate Treponema pallidum
- Non-treponemal serological tests used for screening
- Treponemal serological tests used for confirmation

3.1. Demonstration of *Treponema pallidum* - Dark field/Dark ground microscopy

This method is used when lesions are present. Lesions could be primary chancre, mucosal lesions or lymph nodes. A special method of microscopy called dark field microscopy is used to demonstrate Treponema pallidum. Positive dark ground microscopy for T. pallidum indicates a definitive diagnosis of syphilis.

3.2. Serological Tests for syphilis

Two types of serological tests are essential to confirm the diagnosis.

- Non-specific /non-treponemal antibody tests:

These tests detect anti-lipid immunoglobin M or G (IgM or IgG) antibodies. Since these antibodies can also be produced in other diseases and conditions, non-treponemal tests are not highly specific for syphilis and can give false-positive results in conditions such as acute febrile viral infections and some chronic autoimmune diseases. Most false-positive results have low titres of less than 1:4.

The two commonly used tests are:

- VDRL- Venereal Disease Research Laboratory
- RPR – Rapid Plasma Reagin

VDRL test is performed as a qualitative test for screening and a quantitative test to detect disease activity/stage of syphilis and response to therapy.

3.2.1. Specific/ Treponemal antibody tests:

These tests are highly specific because they detect antibodies against treponemal-specific antigens. One of these tests is used as a confirmatory test following a positive non- treponemal test. Treponemal tests usually remain positive (85%) for the patient's lifetime,

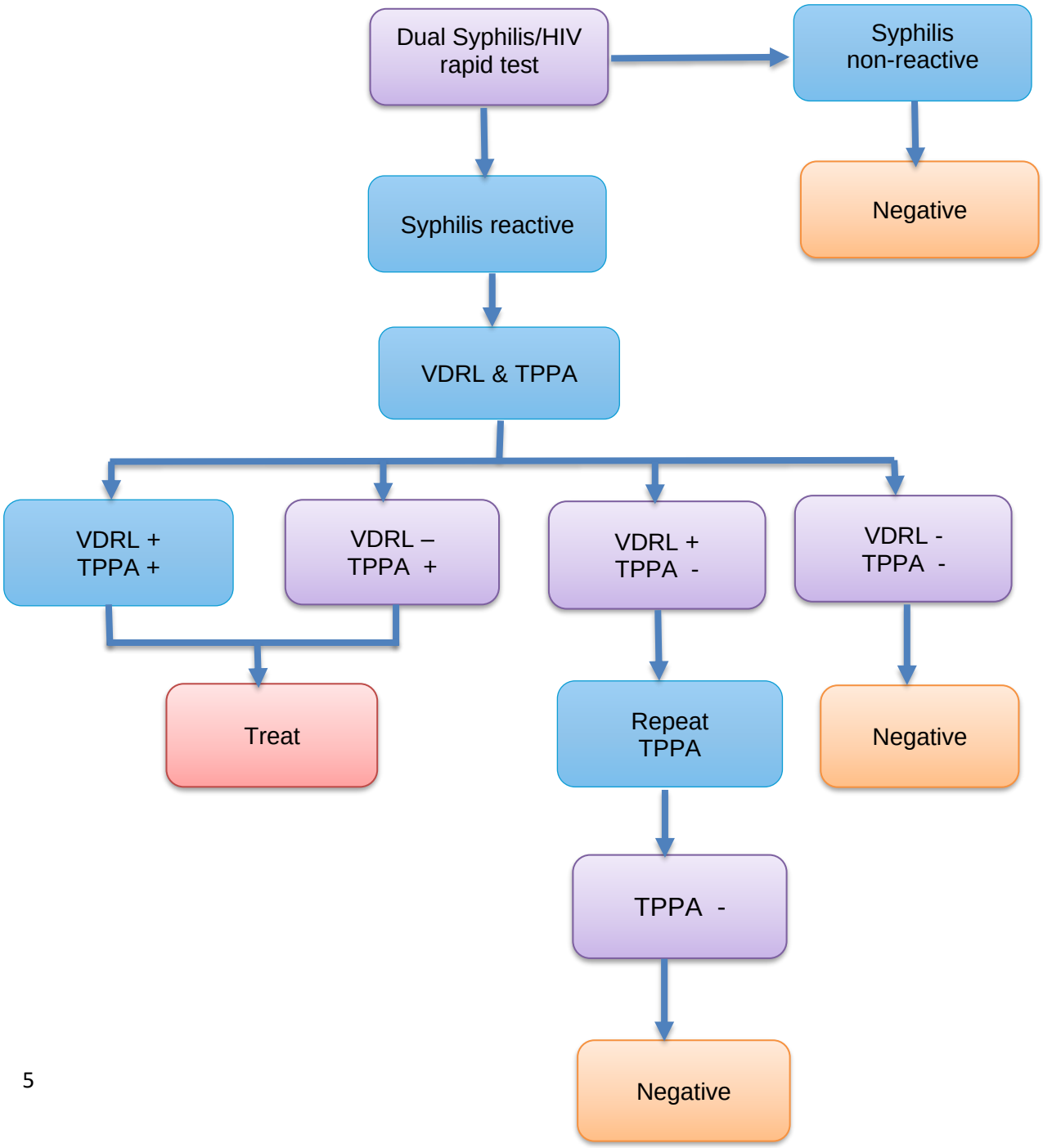
regardless of treatment. Thus, a positive treponemal test does not distinguish between active infection and infection that has been previously treated.

Commonly used tests in the country are:

- TPHA -T.pallidum haem-agglutination Assay
- TPPA -T.pallidum particle-agglutination Assay
- ELISA - Enzyme Linked Immuno-Sorbent Assay

Recent advances in the development of Rapid syphilis test and dual treponemal (syphilis) –HIV rapid tests also newly added screening tests for diagnosis of syphilis in Sri Lanka.

Protocol for serological tests for syphilis in pregnant women in Sri Lanka



A sample with reactive syphilis will be tested using TPPA for confirmation and VDRL for identification of active syphilis. Once syphilis is confirmed, the STD laboratory immediately informs the consultant venereologist, or MO, of the STD clinic. Mostly on the same day they will convey the results to the MOH, or VOG, of the ANC clinic. The pregnant woman who is diagnosed with syphilis is referred to the STD clinic without delay. This leads to early treatment initiation, which is necessary to prevent congenital syphilis in infants. MOH ensures the maintenance of confidentiality during the coordination with the STD clinic. Once pregnant women come to the STD clinic, a Dual Syphilis/HIV test will be performed for identification.

Interpretation of results.

If both VDRL and TPPA become reactive or only TPPA becomes reactive, the sample can be considered syphilis positive. When both become non-reactive, it can be regarded as syphilis negative. Once TPPA is non-reactive and VDRL is reactive, we need to do a repeat TPPA to ensure it is negative.

Biological False Positive (BFP) reaction

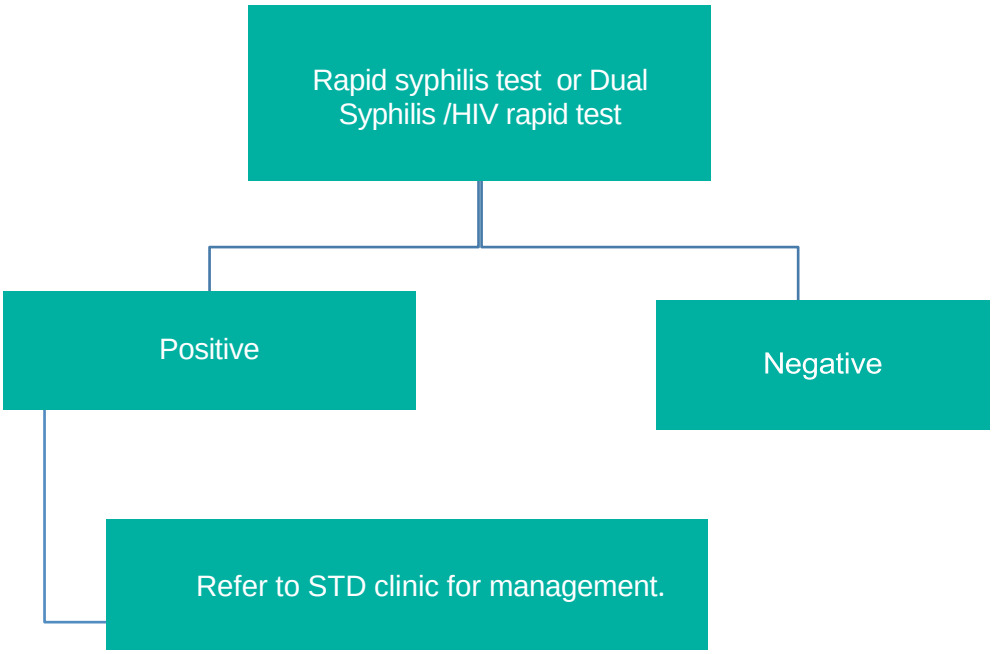
Nonspecific tests detect antibodies against cardiolipins released from damaged tissues. This type of tissue damage can occur in acute infections, immunization or immune reactions, auto immune conditions or vaccination. The specific test for syphilis remains negative and this state is (BFP) reaction BFP reactions for VDRL are common in pregnancy. The titre of the nonspecific test is usually low, rarely more than 1:8.

Point of care tests

Point of care tests are used in some settings which have challenges such as geographical inaccessibility or in late presentations.

The on-site RST (rapid syphilis test) or DUO syphilis/HIV rapid test can be provided as a point of care test at ANC clinics or delivery rooms. Pregnant women with positive results are referred to the STD clinic for further testing and management accordingly. The RST or DUO test does not distinguish between the presence of previously adequately treated syphilis and untreated syphilis.

Rapid syphilis test algorithm



3.3. Steps to follow in antenatal clinic for early diagnosis of syphilis

- All mothers are to be offered syphilis and HIV screening tests before 12 weeks of gestation (Preferably at the first visit).
- Antenatal clinic services- MOH clinics and hospital ANC have to arrange collection of 5cc of blood in a vacutainer tube and transport to the STD clinic for syphilis and HIV testing.
- 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 syphilis reports and HIV positive reports needs 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.
- Correctly record the syphilis and HIV test related information appropriately in the ANC record.
- Review syphilis test results at subsequent visits and at the time of delivery. If the woman has not been tested during pregnancy, syphilis screening should be offered immediately.

3.4. Counselling

3.4.1. Counselling a pregnant woman with a positive syphilis test at the ANC clinic

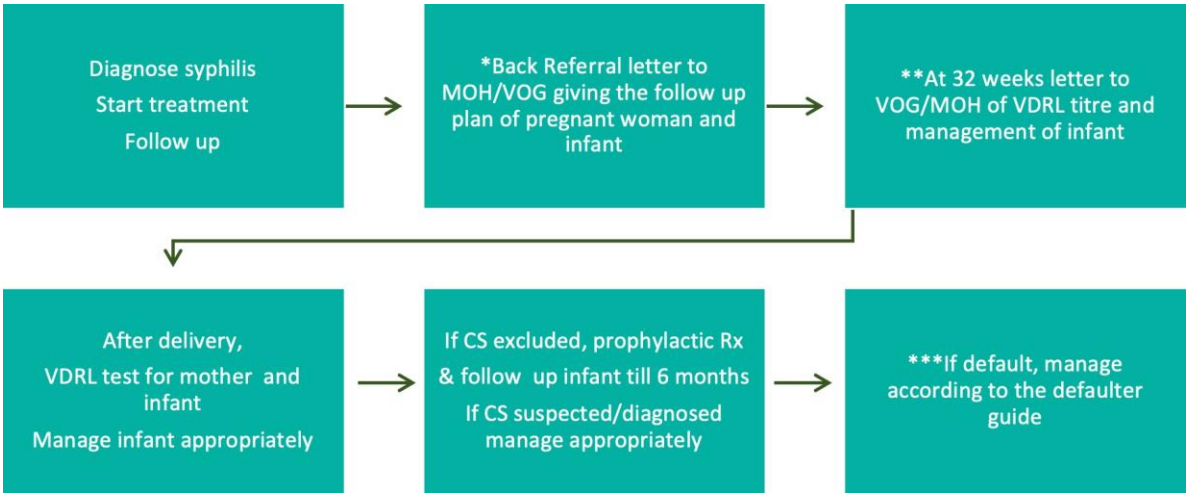
- Reassure privacy, confidentiality and build a good rapport with the pregnant woman.
- Brief the pregnant woman on possibilities of mother to child transmission with syphilis in pregnancy. Explain to her that mother to child transmission can be prevented effectively and efficiently when adequate measures are taken promptly after early diagnosis.
- Try to understand the social background of the pregnant woman. Give her time to talk. Listen attentively to understand her problems and concerns. Inquire about any clarifications or worries.
- Explain that she needs to go to the STD clinic as early as possible. Talk to the relevant consultant or MO of the STD clinic in her presence. Give the referral letter and the details of the relevant consultant or MO to the pregnant woman.
- Conclude the session after giving the next clinic appointment date emphasizing the importance of attending the antenatal clinic on the given date for further services.
- Provide a telephone number to contact if she has any concerns later.
- If needed send her to the STD clinic with a responsible health care worker.

3.4.2. Counselling of a pregnant woman referred from ANC clinic with a positive syphilis test at the STD clinic.

- Greet and introduce yourself.
- Reassure and try to minimize anxiety associated with referral to STD clinic.
- Reassure privacy, confidentiality and build a good rapport with the pregnant woman.
- Convey the syphilis serology test results.
- Brief her on the possibilities of mother to child transmission with syphilis in pregnancy.
- Explain that mother to child transmission can be prevented effectively and efficiently when adequate measures are taken promptly after early diagnosis.
- Brief on the availability of services during pregnancy and after delivery for both mother and the child.
- Explain to her the treatment, duration of treatment, follow up plan and management of the infant.
- Explain to her the importance of partner management.
- Safe sex and condom promotion until treatment completion and partner management.
- Explain to the pregnant woman about the shared confidentiality with VOG and neonatologist later in pregnancy.
- Give her time to talk. Listen attentively to understand her problems and concerns.

- Inquire about any clarifications or worries.
- Emphasize the importance of attending the clinic on the given date for further services.
- Provide a telephone number to contact if she has any concerns later.

3.5. The referral system to minimize loss to follow up of pregnant women with Syphilis



*Back referral letter is sent by post under confidential cover to MOH addressed to the name of the MOH. Copy to be filed in the pregnant woman's case record.

**Letters to VOG to be sent by post to the name of the VOG under confidential cover, copy handed over to the pregnant woman and one copy filed in the case records.

***If the pregnant woman default action has to be taken as given in the defaulter tracing guide.

If the pregnant woman requests to be transferred to another area, transfer form to be sent by post to the respective STD clinic and copy to be handed over to the pregnant woman and one copy filed in the case records.

3.6. A guide to offering second HIV and syphilis test to prevent incident cases

The current practice of doing serology tests for HIV and syphilis need to be offered to all pregnant women at the first booking visit.

Pregnant women belonging to the following categories need to be referred to STD clinics for STI screening. A second HIV test and VDRL test need to be offered at 28 weeks of POA at the STD clinic.

1. Pregnant women belonging to key populations eg: FSW (both women who offer sexual services for money and favours are included), drug users, prisoners.
2. Pregnant women with symptoms of STI or sexual health problems
3. You may also consider street women who are pregnant, women who do not have a guardian or mentally retarded to offer a second test. This group has a high chance of coming to the hospital at the time of delivery without any ANC services. These women are important to show that no one is left behind in provision of services.
4. Pregnant women having multiple partners need to be referred to STD clinic for screening.
5. Sero discordant pregnant women (HIV negative pregnant women having HIV positive partners)

In the event a pregnant woman refuses to go to the STD clinic, rapid HIV test and if available rapid syphilis test needs to be arranged. Rapid HIV testing facilities are available at all hospitals up to base hospital level.

4. Management of syphilis in pregnancy

Pregnant women with syphilis should be treated with penicillin injections according to the stage of infection. It is important to note that early treatment with penicillin is required for better pregnancy outcomes. Adequate penicillin treatment will end infectivity within 24-48 hours.

It is not necessary to re-treat mothers who have documented evidence of adequate therapy for previous syphilis if there is no serological or clinical evidence of re-infection or relapse. Infants born to such mothers do not require prophylactic penicillin therapy.

If there are doubts about the adequacy of previous therapy, re-treatment should be commenced promptly.

Important considerations in the management of pregnant women with syphilis

- Reassure the pregnant woman that syphilis is a curable condition, and she and her partner/s can be cured and the possibility of mother to child transmission can be prevented by early and adequate treatment.
- Follow basic principles of non-judgmental attitude, maintenance of confidentiality and privacy for patients' rights.
- Obtain a detailed history to determine the stage of syphilis. History of past or present genital ulcers, skin rash, treatment of syphilis in the past and relevant symptoms of the partner/s.
- Carry out a detailed clinical examination to identify significant signs of syphilis.
- Screen for other STI's including HIV (If not done already).
- Identifying the correct stage of syphilis is important as the risk of transmission is high during early infection. Consider symptoms, signs, sexual history, partner's symptoms, VDRL titres of the patient and the partner to decide the stage of syphilis. (If necessary, get advice from a consultant venereologist).
- Screen spouse/partner to understand the stage of syphilis and give treatment or treat epidemiologically. Advise both on safer sex practices and importance of prevention of reinfection.
- Preferably both the pregnant woman and her partner should be treated at the same time to prevent reinfection.
- Arrange management of pregnant woman in collaboration with an obstetrician of a specialist care unit – Inform the diagnosis and plan of management to the obstetrician while taking measures to maintain confidentiality.
- Identify a link person from the tertiary care unit (such as infection control nurse) to look after patient's and infant's needs during prenatal period and while admitted for delivery.

- The pregnant woman should be followed up monthly till delivery. If necessary, defaulter tracing should be done without delay.
- Make arrangements for the management of infant immediately after delivery. Both mother and infant need to be referred to the STD clinic. (Infant prophylaxis with benzathine penicillin or treatment for congenital syphilis) If the infant needs ten days IV penicillin treatment, inform the neonatologist/ paediatrician regarding the plan of management of the infant.
- Infants should be followed up in the STD clinic at 0, 3 and 6 months of age.
- Understand the sensitive nature of the issue when a pregnant woman gets to know that she has syphilis. Provide counselling to both the woman and the partner to cope with the situation.

Penicillin G is the only known effective anti-microbial, for preventing maternal transmission to the foetus and treating foetal infection.

4.1. Treatment of the pregnant women

4.1.1. Treatment for early* syphilis in pregnancy (*Primary, secondary and early latent syphilis)

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

(A second dose of benzathine penicillin may be considered 1 week after the first dose when maternal treatment is initiated in the third trimester).

4.1.2. Penicillin Allergy

No proven alternatives to penicillin are available for treatment of syphilis during pregnancy. Desensitization to penicillin is the best option in penicillin allergy if it is feasible.

When benzathine or procaine penicillin cannot be used (e.g. due to penicillin allergy where penicillin desensitization is not possible)

- Erythromycin 500 mg orally four times daily for 14 days

  or

- Ceftriaxone 1 g intramuscularly once daily for 10 days

  or

- Azithromycin 500mg once orally for 10 days

Remarks: *Although erythromycin and azithromycin treat the pregnant women, they do not cross the placental barrier completely and as a result the fetus is not treated. It is therefore necessary to treat the newborn infant soon after delivery. Ceftriaxone is an expensive option and is injectable*.

4.1.3. Treatment for Late latent syphilis or latent syphilis of unknown duration in pregnancy

Benzathine penicillin 2.4 MU intramuscularly, weekly 3 doses. (Days 1, 8 and 15)

The interval between consecutive doses of benzathine penicillin should not exceed more than one day.

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

When benzathine or procaine penicillin cannot be used (e.g. due to penicillin allergy where penicillin desensitization is not possible)

- Erythromycin 500 mg orally four times daily for 30 days.

Although erythromycin treats the pregnant women, it does not cross the placental barrier completely and as a result the fetus is not treated. It is therefore necessary to treat the newborn infant soon after birth.

Doxycycline should not be used in pregnant women.
If the mother was treated with non-penicillin treatment, the infant should be treated as having congenital syphilis.

Since adequate maternal treatment is defined as at least one injection of 2.4 million units of intramuscular benzathine benzylpenicillin given at least 30 days before delivery, it is recommended to administer benzathine penicillin on the same day of her first visit to the STD clinic to avoid default or loss to follow-up.

Jarisch Herxheimer (JH) reaction

Though it is rare, JH reaction need to be considered and women need to be advised to seek obstetric services if they notice fever, uterine contractions or decrease in foetal movements after treatment.

Corticosteroid treatment is not recommended to alter the risk of JH reaction (No data available to suggest that corticosteroid treatment alters the risk for treatment related complications in pregnancy- CDC 2015)

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

5. Management of sexual partner/s

In managing contacts, partners during the last 3 months should be traced if diagnosis is primary syphilis. For secondary and early latent syphilis partner/s need to be traced up to last two years.

It is important to trace the partner/s and screen for syphilis. If a partner/s has syphilis appropriate management needs to be provided according to the “guidelines on management of STI” to prevent reinfection.

If the woman's partner/s is negative, arrange epidemiological treatment.

Recommended regimen for epidemiological treatment

- Benzathine penicillin 2.4 MU single dose intramuscularly after ST.

Penicillin allergy

- Doxycycline 100mg twice daily/PO for 14 days.
- Erythromycin 500mg 6 hourly/PO for 14 days (When doxycycline is contraindicated).

6. Follow up

- Serological (VDRL) follow-up should be done monthly during pregnancy and thereafter according to national guideline. (After treatment at months 1, 2, 3, 6 and 12, then 6 monthly until VDRL negative or sero-fast up to 2 years)
- A sustained fourfold or greater increase in the VDRL titre suggests re-infection or treatment failure and needs re-treatment.
- Specific treponemal tests may remain positive for life following effective treatment. Therefore, proper documentation is important to prevent unnecessary retreatment.

7. HIV infection

Evidence suggests that treatment for syphilis in pregnant women who are HIV positive should be similar to that of HIV negative pregnant women and follow up should be the same as for adults with HIV infection.

8. Defaulter tracing of pregnant women with syphilis

1. When a pregnant woman with syphilis comes to care, at the end of the consultation, follow up date should be entered clearly at the end of clinic notes and the file has to be sent to PHNS/PHI/NO.
2. The PHNS/PHI/NO has to maintain a diary indicating the follow-up dates.
3. The PHNS/PHI/NO has to enter the patient's file number under the date for follow up in her diary in red ink.
4. It is the responsibility of the PHNS/PHI/NO to check whether the patient has attended for follow up on the given date.
5. If the pregnant woman has attended for follow up on the given date, the number in the diary should be cut across in red colour.
6. If the pregnant woman does not attend for follow up on the given date the file should be personally handed over to the consultant/MO for defaulter tracing.
7. All efforts need to be taken to complete treatment without delay and to follow up pregnant women up to delivery.
8. All exposed infants need to be followed up till syphilis infection is excluded.
9. Assistance can be obtained from the area MOH and if necessary, blood samples can be collected following home visits based on the advice of the consultant.

Taking prompt action is of utmost importance in managing pregnant women with syphilis who have defaulted services to sustain elimination services.

9. Back referral to MOH regarding pregnant woman with syphilis

This letter is developed to minimize post-partum serological follow up defaulter rates.
All efforts should be maintained not to breach confidentiality of the patient.

Steps to follow

- When a pregnant woman referred by the MOH is diagnosed with syphilis, after completion of treatment a back referral letter needs to be sent to the MOH to facilitate postpartum serological follow up.
- When these letters are posted it should be stamped as confidential.
- Letter should be addressed to the MOH by name.
- Inform the MOH that a letter has been posted to prevent breach of confidentiality.
- Referral letter should highlight the importance of postpartum follow up of mother and infant seeking the attention of MOH for continuation of follow up.

Post-partum back referral to MOH for syphilis positive pregnant women

CONFIDENTIAL

Date:

……

……

Dear Colleague,

Re: Name: Age:

PHM Area: ANC No: STD clinic No:

She was diagnosed of early syphilis/late syphilis at the POA of ..... weeks and treated adequately. according to her stage of syphilis.

Please facilitate the following by linking mother and infant for STD care:

1. Infant to have prophylactic benzathine penicillin ☐
2. Infant for serological follow up ☐
3. Mother for serological follow up ☐

(Infants are followed up at 0,3,6 months if VDRL is NR or till VDRL becomes nonreactive)

Remarks

……

……

Thank you,

…….

Consultant Venereologist/MOIC/MO STD

10. Management of the infant

If the mother has been adequately treated with at least a single dose of benzathine penicillin 30 days before delivery, the risk of MTCT is very low. However, irrespective of mothers' treatment all infants born to mothers with positive treponemal tests are given prophylactic penicillin.

Recommended prophylactic penicillin dose for the infant:

- **Benzathine penicillin G 50,000IU/Kg Body Weight IM as a single dose**

The following scenarios describe the recommended congenital syphilis evaluation and treatment of neonates born to women with syphilis.

Scenario 1: Confirmed Proven or Highly Probable Congenital Syphilis

Any neonate with

- An abnormal physical examination that is consistent with congenital syphilis.
- A serum quantitative nontreponemal serologic titer that is fourfold[§] (or greater) higher than the mother's titer at delivery (e.g., maternal titer = 1:2, neonatal titer ≥1:8 or maternal titer = 1:8, neonatal titer ≥1:32)[¶]; or

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein
- Complete blood count (CBC) and differential and platelet count
- Long-bone radiographs
- Other tests as clinically indicated (e.g., chest radiograph, liver function tests, neuroimaging, ophthalmologic examination, and auditory brain stem response)

Recommended Regimens, Confirmed or Highly Probable Congenital Syphilis

Aqueous crystalline penicillin G 100,000–150,000 units/kg body weight/day, administered as 50,000 units/kg body weight/dose by IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days

Scenario 2: Possible Congenital Syphilis

Any neonate who has a normal physical examination and a serum quantitative nontreponemal serologic titer equal to or less than fourfold of the maternal titer at delivery (e.g., maternal titer = 1:8, neonatal titer ≤1:16) and one of the following:

- The mother was not treated, was inadequately treated, or has no documentation of having received treatment.
- The mother was treated with erythromycin or a regimen other than those recommended in these guidelines (i.e., a nonpenicillin G regimen).
- The mother received the recommended regimen, but treatment was initiated 4 weeks before delivery.

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein
- FBC, differential, and platelet count
- Long-bone radiographs

This evaluation is not necessary if a 10-day course of parenteral therapy is administered, although such evaluations might be useful. For instance, a lumbar puncture might document CSF abnormalities that would prompt close follow-up. Other tests (e.g., FBC, platelet count, and long-bone radiographs) can be performed to further support a diagnosis of congenital syphilis.

Recommended Regimens, Possible Congenital Syphilis

Aqueous crystalline penicillin G 100,000–150,000 units/kg body weight/day, administered as 50,000 units/kg body weight/dose by IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days

OR

Benzathine penicillin G 50,000 units/kg body weight/dose IM in a single dose

Before using the single-dose benzathine penicillin G regimen, the recommended evaluation (i.e., CSF examination, long-bone radiographs, and FBC with platelets) should be normal, and follow-up should be certain. If any part of the neonate's evaluation is abnormal or not performed, if the CSF analysis is uninterpretable because of contamination with blood, or if follow-up is uncertain, a 10-day course of IV penicillin is required.

10.1. Diagnosis of congenital syphilis in infants born to pregnant women with syphilis

The diagnosis of congenital syphilis can be difficult as maternal non treponemal and treponemal IgG antibodies can be transferred through the placenta to the foetus.

Treatment decisions should be based on

- Identification of syphilis in the mother
- Adequacy of maternal treatment
- Presence of clinical, laboratory and radiographic evidence of syphilis in the neonate
- Comparison of maternal VDRL results at delivery and neonatal VDRL titres conducted at the same time.

Serologic evidence of congenital syphilis

- Serum quantitative non treponemal serologic titre (VDRL titre) that is fourfold higher than the mother's titre at the time of delivery or
- Presence of IgM antibodies in the infant (EIA test) or
- Rising non treponemal antibodies in infant's serum

Blood sample of the neonate born to a mother with syphilis should be tested for VDRL immediately after delivery. The sample of the neonate should be sent to the closest STD clinic along with a sample of blood from the mother for VDRL test.

VDRL in both mother and newborn infant need to be performed and if VDRL titre of infant is more than fourfold of that of the mother, it indicates congenital syphilis. However, lack of fourfold increase does not exclude congenital syphilis.

Infant should be managed by a paediatrician in collaboration with a consultant venereologist according to the national STI management guidelines.

Treponemal test (TPPA) of the neonate is not indicated as it can be positive up to 18 months due to the presence of maternal antibodies.

10.2. Follow up of infants

10.2.1. Follow up of infant after treatment for congenital syphilis

VDRL tests in months 1, 2, 3, 6, then six monthly until it becomes Non-Reactive (NR) or sero-fast. Treated neonates that exhibit persistently elevated VDRL titers by 6–12 months should be re- evaluated through CSF examination and managed in consultation with an expert. At 6 months if the VDRL titre is NR, no further evaluation or treatment is needed. If VDRL remains reactive after 6 months, the infant is likely to be infected and needs to be re treated as having congenital syphilis. Treponemal tests should not be used for evaluation of treatment response as maternal treponemal IgG antibody might persist for up to 18 months.

10.2.2. Follow up of infant born to a pregnant woman adequately treated for syphilis in pregnancy four weeks before delivery

All syphilis exposed newborns should have blood tested for VDRL at birth along with the mothers VDRL test done at the same time.

Infants with nonreactive (NR) VDRL at birth should be followed up at 3 months and 6 months and syphilis can be excluded if VDRL remains NR.

Infants with a reactive VDRL at birth, but congenital syphilis excluded, should have repeat VDRL at 3 and 6 months. Serological follow up can be discontinued if VDRL is non-reactive at 6 months.

Any infant more than 6 months of age with a reactive VDRL should be considered a case of congenital syphilis and receive appropriate screening and treatment. (Global guidance on criteria and processes for validation: EMTCT of HIV and syphilis, second edition 2017, WHO)

10.3. The global surveillance case definitions for congenital syphilis

A live birth or fetal death at >20 weeks of gestation or >500 g (including stillbirth) born to a woman with positive syphilis serology and without adequate syphilis treatment*

* Adequate maternal treatment is defined as at least one injection of 2.4 million units of intramuscular benzathine benzylpenicillin at least 30 days prior to delivery.

OR

a live birth, stillbirth or child aged <2 years born to a woman with positive syphilis serology or with unknown serostatus, and with laboratory and/or radiographic and/or clinical evidence of syphilis infection (regardless of the timing or adequacy of maternal treatment).

Laboratory and radiographic evidence consistent with a diagnosis of congenital syphilis includes any of the following:

a. Demonstration by dark-field microscopy or fluorescent antibody detection of Treponema pallidum in the umbilical cord, placenta, nasal discharge or skin lesion material or autopsy material of a neonate or stillborn infant;
b. Analysis of cerebrospinal fluid (CSF) is reactive for Venereal Disease Research Laboratory (VDRL) test, or elevated CSF cell count or protein;
c. Long bone radiographs suggestive of congenital syphilis (e.g. osteochondritis, diaphyseal osteomyelitis, periostitis);
d. Infant with a reactive non-treponemal serology titre fourfold or more than that of the mother;
e. Infant with a reactive non-treponemal serology titre less than fourfold more than that of the mother but that remains reactive ≥6 months after delivery;
f. Infant with a reactive non-treponemal serology test of any titre AND any of the clinical signs listed below born to a mother with positive or unknown serology, independent of treatment.

Early clinical signs that may be present in an infant with congenital syphilis include non-immune hydrops, hepatosplenomegaly, rhinitis (snuffles), skin rash, pseudoparalysis of an extremity or failure to thrive or achieve developmental milestones. An older infant or child may develop additional signs or symptoms such as frontal bossing, notched and pegged teeth (Hutchinson teeth), clouding of the cornea, blindness, bone pain, decreased hearing or deafness, joint swelling, sabre shins, and scarring of the skin around the mouth, genitals and anus.

For stillbirths, maternal syphilis serostatus should be determined. Any case with a reactive maternal test should be considered a congenital syphilis case (i.e. a syphilitic stillbirth).

A woman with a past history of syphilis diagnosis and for whom previous syphilis treatment can be confirmed, should be evaluated for risk of reinfection. Those without physical (e.g. ulcer, unexplained rash) or laboratory evidence of syphilis (increasing non-treponemal titre) need not be classified as having current syphilis.

11. References

1. NSACP, Management of pregnant women with syphilis, 2016
2. WHO guideline on syphilis screening and treatment for pregnant women 2017
3. WHO guidelines for the Treatment of Treponema pallidum (syphilis) 2016
4. Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis 2017
5. NSACP, Strategy for EMTCT of syphilis and HIV programme 2018
6. NSACP, A guide for healthcare workers EMTCT of HIV and syphilis, 2017
7. STI Treatment Guideline, Centers for Disease Control and Prevention (gov)
8. https://www.bashh.org/resources/25/syphilis_2015/

12. Annexures

Annexure 1- Circular on Ending AIDS by 2025 in Sri Lanka (English)

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Date) 2016.09.30

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சுகாதார,போசணைமற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition& Indigenous Medicine

General Circular No : 01-51/2016

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

Programme for Ending AIDS by 2025 in Sri Lanka

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

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

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

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

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

iii. The screening test positive patient need to be referred to the STD clinic for confirmatory testing. Confirmatory test positive patients will be registered as a person living with HIV (PLHIV) at the STD clinic for further management.

iv. It is the policy of the ministry of health that all PLHIV requiring institutional care be managed at general wards. Based on this policy decision the following procedures should be adopted. All PLHIV who need inward care facilities should be managed appropriately in the general wards (medical, surgical or any other speciality) in Colombo and in out-stations without stigma and descrimination. (General Circular No. 02/125/98)

v. All measures need to be taken to maintain confidentiality.

vi. Patients with infectious complications requiring barrier nursing may be transferred to the National Infectious Disease Hospiital, only if the facilities are not available to manage them at respective health institutions.

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

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

06. Ministry of Health seeks the commitment and cooperation of all hospital authorities to implement the programme for ending AIDS by 2025.

07. I reiterate the policy of the Government of Sri Lanka is to provide a comprehensive care services for PLHIV without stigma and discrimination. Your cooperation is earnestly requested.

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

Cc
1. Director, Private Health sector, MOH.

Annexure 2- Circular on Ending AIDS by 2025 in Sri Lanka (Sinhala)

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சுகாதார,போசணைமற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition& Indigenous Medicine

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වසර 2025 වන විට ශ්‍රී ලංකාවෙන් ඒඩිස් තුරන් කිරීමේ වැඩසටහන.

ඒඩිස් රෝගය වසර 2025 වන විට ශ්‍රී ලංකාවෙන් තුරන් කිරීම සඳහා මේ දිනවල කටයුතු කරමින් පවතී. සෞඛ්‍ය අමාත්‍යාංශය, සාකච්ඡා වට කිහිපයකින් පසු ලෝක සෞඛ්‍ය සංවිධානයේ නිර්දේශ අනුව සියලුම HIV ආසාදිත පුද්ගලයන්ට ප්‍රතිවෛරස ඖෂධ ලබාදීමට තීරණය කරන ලදි. මේ කාර්ය පහසු කිරීම සඳහා ප්‍රතිවෛරස ඖෂධ මිලදී ගැනීම රජයේ මුදල් ප්‍රතිපාදන මත සෞඛ්‍ය අමාත්‍යාංශය මගින් වසර 2016 සිට සිදු කරනු ලැබේ. සුදුසු සේවාවන් සමඟ ART ප්‍රතිකාර ආරම්භ කිරීම මගින් HIV ආසාදිත පුද්ගලයන් බහුතරයකගේ වෛරස් ප්‍රමාණය මාස කිහිපයක් තුල නොගිනිය හැකි තරම් අඩු කරගත හැකි අතර එමගින් රෝගය තවදුරටත් ව්‍යාප්තවීම අවම කරගත හැකිය. ප්‍රතිවෛරස ඖෂධ ආරම්භ කිරීම මගින් HIV ආසාදිත පුද්ගලයන්ගේ ජීවන තත්ත්වය ඉහළ නැංවෙන අතර අපේක්ෂිත ආයු කාලයද වැඩි වේ. නිසි පරිදි ප්‍රතිකාර ගැනීමෙන් HIV ආසාදිත පුද්ගලයන් ඒඩිස් තත්ත්වයට පත්නොවී දිගු කාලයක් ජීවත්විය හැකි අතර එය රජයට, සමාජයට සහ පවුලේ අභිවෘධිය සඳහා ඉතා වැදගත් වේ.

02. පුද්ගලයෙකු HIV ආසාදිත බව හඳුනාගැනීමෙන් එම පුද්ගලයාට ශාරීරික, මානසික සහ සමාජීය වශයෙන් විවිධ බලපෑම් ඇති කරනු ලැබේ. කොන්කිරීමෙන් සහ පහත්කොට සැලකීමෙන් තොරව සෞඛ්‍ය සේවකයන් විසින් HIV ආසාදිත පුද්ගලයන්ට අවශ්‍ය සේවාවන් සහ පහසුකම් සැපයීම මගින් ඔවුන්ට එම රෝගය සමඟ ජීවත් වීම සඳහා අනුගතවීමට පිටිවහලක් වේ. රෝග පරීක්ෂාව මගින් HIV ආසාදනය කලින්ම හඳුනා ගැනීම සියලුම ආසාදිත පුද්ගලයන්ට පරිපූර්ණ සේවාවක් ලබාදීමට උපකාරීවේ. HIV ආසාදිත පුද්ගලයන් සඳහා අවශ්‍ය සේවාවන් සහ ප්‍රතිවෛරස ඖෂධ ලිංගාශ්‍රිත රෝග සායනවලින් සහ බෝවන රෝග රෝහලෙන් (IDH) ලබාගත හැක.

03. HIV ආසාදිත පුද්ගලයන් සඳහා පරිපූර්ණ සේවාවක් ලබා දීම සඳහා පහත සඳහන් මාර්ගෝපදේශ අනුව ක්‍රියාමාර්ග ගැනීම අවශ්‍ය වේ.

i. රෝගියාගේ රෝග ලක්ෂණ අනුව හෝ ඔහුගේ/ඇයගේ අවදානම් චර්යාවන් අනුව වෛද්‍යවරයා විසින් HIV පරීක්ෂණය යෝජනා කල යුතුය. ඒ සඳහා රෝහල් සායනය / වාට්ටුව මගින් රුධිරය 3cc ක් වැකුයුටේනර් නලයකට ගෙන ළඟම ඇති ලිංගාශ්‍රිත රෝග සායනයට යැවීමට කටයුතු කළ යුතුය.

ii. ලිංගාශ්‍රිත රෝග සායන වලට ලැබෙන රුධිර සාම්පල HIV සඳහා මූලික පරීක්ෂණය සිදුකර ප්‍රතිඵලය නිකුත් කල යුතුය. HIV ආසාදිත රෝගීන් ලෙස හඳුනා ගන්නා රුධිර සාම්පල පිළිබඳ විස්තර අදාළ වෛද්‍යවරයාට හෝ විශේෂඥ වෛද්‍යවරයාට වහාම දැන්විය යුතු අතර මෙහිදී රෝගියාගේ පුද්ගලිකත්වය ආරක්ෂා කිරීමට වගබලා ගත යුතුය.

iii. HIV මූලික පරීක්ෂණය මගින් හඳුනා ගන්නා රෝගීන් තහවුරු කිරීමේ පරීක්ෂාව සඳහා ලිංගාශ්‍රිත රෝග සායනයකට යොමු කළ යුතුය. එමගින් HIV ආසාදිත බවට තහවුරු වන පුද්ගලයන් ලිංගාශ්‍රිත රෝග සායනය තුළ ලියාපදිංචිකර අවශ්‍ය සේවාවන් සපයනු ලැබේ.

iv. ආයතනික සත්කාර අවශ්‍යවන සියලුම HIV ආසාදිත පුද්ගලයන්ට අදාල සත්කාර සාමාන්‍ය වාට්ටු තුළ ලබාදිය යුතු බව සෞඛ්‍ය අමාත්‍යාංශයේ ප්‍රතිපත්තිය වේ. ඒ අනුව පහත සඳහන් ක්‍රියාමාර්ග අනුගමනය කළ යුතුය. රෝහල්ගතව ප්‍රතිකාර ලබා ගතයුතු HIV ආසාදිත පුද්ගලයන් සාමාන්‍ය වාට්ටු (සර්වාංග රෝග, ශල්‍ය වෛද්‍ය හෝ අනෙකුත් විශේෂඥ සේවාවන්) තුල සහ අනෙකුත් සෞඛ්‍ය ආයතන තුල කිසිදු කොන්කිරීමකින් තොරව ප්‍රතිකාර ලබා දිය යුතුය. (පොදු චක්‍ර ලේඛන අංක 02/125/98)

v. රෝගියාගේ රහස්‍යභාවය ආරක්ෂා කිරීමට අවශ්‍ය සියලුම ක්‍රියාමාර්ග ගත යුතුය.

vi. අනෙකුත් රෝගීන්ගෙන් වෙන්කර ප්‍රතිකාර කිරීමට අවශ්‍ය බෝවන රෝග සහිත පුද්ගලයන් IDH රෝහලට මාරුකර යැවිය හැක්කේ එම රෝගීන්ට ප්‍රතිකාර කිරීමට අවශ්‍ය පහසුකම් අදාළ ආයතනයේ නැතිනම් පමණි.

04. ශ්‍රී ලංකාවේ HIV පිළිබඳ ජාතික ප්‍රතිපත්තියෙහි **"HIV ආසාදිත පුද්ගලයන්ට කොන්කිරීමකින් හෝ වෙනස්කොට සැලකීමකින් තොරව ප්‍රතිකාර ලබාගැනීමට ඇති අයිතිය ශ්‍රී ලංකා ආණ්ඩුව විසින් පිළිගෙන ඇති බව"** සඳහන් වේ. දැනට ක්‍රියාත්මක ජාතික සෞඛ්‍ය ප්‍රතිපත්තිය සහ ජාතික මාර්ගෝපදේශ අනුව HIV ආසාදිත පුද්ගලයන්ට ප්‍රතිරෙට්‍රෝවයිරස ඖෂධ ලබා දීම සහ ඔවුන්ට වැළඳෙන අනෙකුත් ආසාදන සඳහා ප්‍රතිකාර ලබාදීම රාජ්‍ය අංශය විසින් සිදු කරයි. (3.8 පිටුව 22)

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

06. වසර 2025 වන විට එඩ්ස් රෝගය ශ්‍රී ලංකාවෙන් තුරන් කිරීමේ වැඩසටහන ක්‍රියාත්මක කිරීම සඳහා සෞඛ්‍ය අමාත්‍යාංශය සියලුම රෝහල් බලධාරීන්ගේ කැපවීම සහ සහයෝගය අපේක්ෂා කර සිටී.

07. HIV ආසාදිත පුද්ගලයන් කොන් කිරීමෙන් තොරව පරිපූර්ණ සේවාවක් සැපයීම ශ්‍රී ලංකා රජයේ ප්‍රතිපත්තිය බව මම නැවතත් ප්‍රකාශ කරන අතර මේ කාර්යය සාර්ථකකර ගැනීමට ඔබගේ අවංක සහයෝගය බලාපොරොත්තු වෙමි.

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

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

පිටපත්:-

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

Annexure 3- Circular on Programme for EMTCT of syphilis and HIV in Sri Lanka (English)

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e-mail)

වෙබ්අඩවිය) www.health.gov.lk
இணையத்தளம்)
website)

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

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

ඔබේඅංකය)
உமது இல)
Your No. :)

දිනය)
திகதி)
Date) 2016.10.27

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

General Circular No : 01 – 59/2016

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

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 by end 2017.

2. To achieve the elimination status, effective universal coverage of screening for syphilis and HIV during pregnancy need to be established. In Sri Lanka, by the end of 2015 screening for syphilis during pregnancy has achieved almost universal coverage (98%).

3. 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. Screening of pregnant mothers for HIV was scaled up from 2013 and HIV screening coverage has increased from 5.6% in 2012 to 71.2% in 2015. To achieve elimination status Sri Lanka needs to reach 95% of HIV screening coverage target by the end of 2016.

4. Ministry of Health seeks the commitment and cooperation of consultant obstetricians in public and private sector 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 institution as per the guidelines given below.

(A) Public sector

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

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

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

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

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

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

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

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

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

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

(B) Private sector

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

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

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

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

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

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

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

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

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

Dr. P. G. Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine
"Suwasiripaya",
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

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

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

Annexure 4- Antenatal 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 5- Pregnancy Record (H512)

සායනික සංරක්ෂණය/பிணியாய்வு நிலைய பராமரிப்பு / Clinic care

Date of Visit										
POA										
Urine: Sugar / Albumin										
Pallor										
Oedema: Ankle										
Oedema: Facial										
BP (160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50)										
Fundal Height										
Foetal Lie										
Presentation										
Engagement of the presenting part										
FM / FHS										
Iron / Folate / Vitamin C										
Calcium / Antimalarial Drugs										
Food Supplementation										
Signature of the officer examined										
Designation										

Auscultation	
First trimester	
Second trimester	
Third trimester	

Respiratory System	
Breast Examination	

Investigations

	POA	Result
Blood Sugar		
Haemoglobin		

Other Investigations

Antihelminthic Drugs	
Date of issuing kick count chart	

Syphilis Screening

POA of blood sampling		
Date of blood sampling		
Date of result received		
Result	NR	R
If (R) Date of referral		

HIV Blood Sample taken for the HIV Screening	YES	No

Tetanus Toxoid Immunization

Tetanus Toxoid	1	2	3	4	5	NE
Date						
Batch No.						

3

Annexure 6 -EMTCT STD clinic supervision check list

EMTCT HIV AND SYPHILIS - STD CLINIC SUPERVISION CHECK LIST

Treatment and care - Syphilis

STD clinic: …… File Number: …….

Date of supervision:…… Supervised by: …….

Follow up of pregnant women with positive TPPA report	Yes/No/NA	Responsible officer
1. Mother attended STD clinic within 2 weeks of testing date of ANC blood sample		CV/MO/PHNS/MLT
2. Mother registered at STD clinic		CV/MO
3. Age of the patient available		CV/MO/PHNS
4. Place of residence mentioned		PHNS
5. Nationality of the patient mentioned		PHNS
6. Assessed for risk and vulnerability factors		CV/MO
7. Mothers blood sample sent for retesting of VDRL and TPPA		CV/MO
8. Mother screened for other STI		CV/MO
9. Partner/partners registered at STD clinic		CV/MO
10. Infant's file No mentioned in mother's file		CV/MO
11. MP/RP's file number mentioned		CV/MO

Management of mother		
Records	**Yes/No /NA**	**Responsibility**
1. Copy of H 512A available in the STD file		PHNS/NO/MO
2. LMP available		CV/MO
3. EDD available		CV/MO
4. POA at registering ANC clinic mentioned (H512A)		CV/MO
5. POA at ANC blood testing mentioned (H512A)		CV/MOIC/MO
6. POA at registering for EMTCT care mentioned		CV/MOIC/MO
7. Details about past obstetric history available in the file		CV/MOIC/MO
8. Initial VDRL with titer mentioned		CV/MO
9. TPPA report available		CV/MO
10. Stage of syphilis mentioned		CV/MOIC/MO
11. POA at initiation of treatment mentioned		CV/MOIC/MO
12. Mother treated with penicillin		
13. Penicillin adequate dosage given according national Guideline		CV/MOIC/MO
14. POA at completion of treatment available		CV/MOIC/MO

15. Mother's treatment completed 4 weeks prior to delivery		
16. Mother's monthly VDRL done until the delivery		CV/MOIC/MO
17. Defaulter tracing arranged if necessary		CV/MOIC/PHNS /PHI
18. VOG referral done		CV/MOIC/MO
19. Delivery details recorded		CV/MOIC/MO
A. Delivery date B. POA at delivery C. Pregnancy outcome D. Mode of delivery		
20. Mother reviewed at STD clinic after delivery (before discharge)		CV/MOIC/MO
21. Mother's VDRL available at delivery		CV/MOIC/MO
22. Mother followed up according to national guideline after delivery		CV/MOIC/MO
Management of infant (from infant's file)		
1. Infant reviewed at STD clinic before discharge		CV/MO
2. Date of birth available		CV/MO
3. Place of birth available		CV/MO
4. MOD available		CV/MO
5. Birth weight mentioned		CV/MO
6. Infant's VDRL with titer available at birth		CV/MO
7. Infant's Syphilis IgM testing arranged		CV/MO
8. Additional tests to exclude congenital syphilis done where indicated		CV/MO
9. Prophylactic penicillin given according to National Guideline.		CV/MO
10. Congenital syphilis diagnosis made or excluded based on national guideline		CV/MO
11. If congenital syphilis diagnosed IV penicillin treatment given based on national guideline		CV/MO
12. TPPA test arranged around 6 months of age		CV/MO

EMTCT Congenital Syphilis: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health

CS_V 1.10.2024

Name of the STD clinic:_____ Pregnant woman's file number & PHN no: _____

Baby's file number & PHN no: _____ Pregnant woman's date of registration:_____

Filled by (name/ designation) _____ Pregnant woman referred from:_____

Note: Fill this form for all pregnant women with positive TPPA results, (including previously treated inactive syphilis) and for children diagnosed with congenital syphilis.

Details of the pregnant woman with syphilis			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc.)		6. KP Status	
7. Parity		8. Obstetric history	
9. Date and Stage of syphilis diagnosis			
Details of the current pregnancy			
10. LRMP		11..EDD	
12. POA at ANC registration			
13. POA at VDRL testing		14. POA when registering for EMTCT services	
15. VDRL result & date (initial)		16. VDRL result & date (closest to delivery)	
17. TPPA result		18. Results of additional syphilis tests	
19. Treatment (date /medication/dose/route):			
20. POA at treatment (weeks)		21. Gestational age at delivery (weeks)	
22. Pregnancy outcome		23. Mother's HIV test result	
Details of the sexual partner/s			
24. Partner's file no. & PHN no.		25. KP Status	
26. VDRL/TPPA of the partner		27. Stage of Syphilis	
28. Partner treated and date:	1. Yes 2. No	Date:	
Details of the baby			
29. Date of birth		30. Facility/Place of birth	
31. Mode of delivery, If LSCS – indication		32.Birth weight	
33. Date of first VDRL		34. Titre of first VDRL	
35. Management(prophylaxis or treatment details.)			
36. If treated as congenital syphilis, state reasons (clinical, Inadequate/non penicillin treatment of mother etc.)			
37. Date, type and results of additional tests (DG, IgM, CSF VDRL, X-Ray etc.)			
38. Baby's VDRL result at 3 months		Date	
39. Baby's VDRL result at 6 months		Date	
40. Further management of baby if VDRL positive at 6 months (Investigations & treatment)			
41. Baby's last available VDRL result		Date	
42. Baby's final diagnosis		Date	
43. If miscarriage, date & POA of miscarriage			
Remarks			

Annexure 7 -EMTCT Congenital syphilis: Case investigation report

Annexure 8 -EMTCT Congenital syphilis case report format

Congenital syphilis case report format

Details of the baby

- Baby's file number :
- Date of Birth :
- Place of Birth :
- Mode Of delivery :
- History of presentation :
- Investigations :
- Treatment :

Details of the mother - before delivery

- Mothers file number :
- Age :
- Parity :
- LRMP :
- EDD:
- District :
- MOH:
- ANC Clinic :
- PHM :

- MOH Blood collection date for syphilis /HIV screening :
- Syphilis & HIV results :
- Date of syphilis tests done at STD lab :
- Date which mother informed about the results :
- Comment on follow up at ANC/STD clinic
- Any other relevant information

Details of the mother - after delivery

- VDRL
- TPPA
- Treatment

Details of the partner before delivery

- File Number
- VDRL
- TPPA
- Treatment

- Any other relevant information