The strategy for elimination of mother to child transmission of HIV and syphilis in Sri Lanka

Second Edition
2018

National STD and AIDS Control Programme

Ministry of Health Sri Lanka

unicef

THE STRATEGY FOR ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV AND SYPHILIS IN SRI LANKA 2018

Contributors:

Dr. L.I.Rajapaksa	Consultant Venereologist, EMTCT and HIV care, NSACP
Dr. K.A.M.Ariyaratne	Consultant Venereologist, SIM unit, NSACP
Dr. G. Weerasinghe	Consultant Venereologist, STI care and HIV testing, NSACP
Dr. J. Elvitigala	Consultant Microbiologist, NRL, NSACP
Dr. Himali Perera	Consultant Venereologist, Training, NSACP
Dr. Chandrika Jayakody	Consultant Venereologist, IEC, NSACP
Dr. Sriyakanthi Beneregama	Consultant epidemiologist, NSACP
Dr. Irsoha Nilaweera	Consultant Community Physician, Maternal care, FHB
Dr. Kaushalya Kasthuriarachchi	Consultant Community Physician, Monitoring & Evaluation, FHB
Dr. Sanjeewa Godakanda	Consultant Community Physician, Family planning, FHB
Dr. Loshan Munasinghe	Consultant Community Physician,Womens health,Women & GBV, FHB
Dr. Nimali Jayasuriya	Consultant Venereologist, Matara
Dr. S. Somawardna	Consultant Venereologist, Kurunegala
Dr. Priyantha Weerasinghe	Consultant Venereologist, Gampaha
Dr. Indika Malwatta	Assistant Venereologist, NSACP
Dr. Dulari Liyanage	Assistant Venereologist, NSACP
Dr. Waruni Pannala	Assistant Venereologist, NSACP
Dr. Anuruddha Karunaratne	Senior Registrar, NSACP
Dr. Vindya Perera	Senior Registrar, NSACP
Dr. W. S. C. Dileka	Senior registrar, NSACP

The support extended by the following are acknowledged...

Dr. Susie Perera	DDG PHS 2, Ministry of Health
Dr. Nethanjalie Mapitigama	Director (Acting), FHB
Dr. U. Rathnasiri	Consultant Obstetrician, CSHW
Dr. Nalin Gammethige	Consultant neonatologist, DMH
Dr. N. Janakan	National Professional Officer, Communicable diseases, WHO
Dr. Dhammica Rowel	Consultant Community Physician, UNICEF

Coordinated by;

Dr. L.I. Rajapaksa, National Coordinator EMTCT of HIV and syphilis programme
National STD/AIDS control Programme,
Sri Lanka.

1st Edition -December 2014

2nd Edition -August 2018

Published by:

National STD/AIDS Control Programme

Ministry of Health

Colombo, Sri Lanka

Funded by UNICEF, Sri Lanka

Contents

List of annexures

List of Figures

List of tables

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 STIs which cause increased mortality and morbidity in children due to mother to child transmission.

1.1. Global and Regional situation of HIV and syphilis 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.

In 2012, WHO estimated that over 900 000 pregnant women were infected with syphilis. These maternal infections resulted in more than 350 000 estimated adverse pregnancy outcomes, over 200 000 of which were stillbirths or neonatal deaths (4). 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%.

The human immunodeficiency virus pandemic has caused serious social health and developmental challenges to many countries in the world. There are estimated 36.9 million of people living with HIV by end of 2017 and out of which 1.8 million were children <15 years of age. Nearly all HIV infections among children are acquired from infected mothers during pregnancy, delivery or while breast feeding. An estimated 5.2 million people living with HIV are in the Asia Pacific region and among pregnant women with HIV only 53% has access to ART services.

1.2. How EMTCT of syphilis and HIV contributes to achieving Sustainable Development Goals

Dual elimination serves to improve a broad range of maternal and child health (MCH) services and outcomes. This achievement directly contributes to Sustainable Development Goals (SDGs) 3, 5 and 10 which aspire to ensure health and well-being for all, achieve gender equality and empower women and girls, and reduce inequalities in access to services and commodities. Additionally, the similarity of the control interventions necessary to prevent transmission of HIV and syphilis in pregnancy adds to the feasibility and benefit of such an integrated approach to the elimination of MTCT (EMTCT) of both infections.

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. The estimated number of persons living with HIV in 2017 is 3500 (3000 – 4200). In the year 2017, 285 adult new infections have been identified including 62 females with HIV infection. Majority of these females are in the reproductive age group (82%), increasing the risk of transmission from mother to child. Eighty four paediatric HIV infections have been detected by 2017. Though the numbers are small, it is obvious that the numbers are increasing gradually over the years.

Figure 1: Reported number of HIV cases, 1987 - 2017

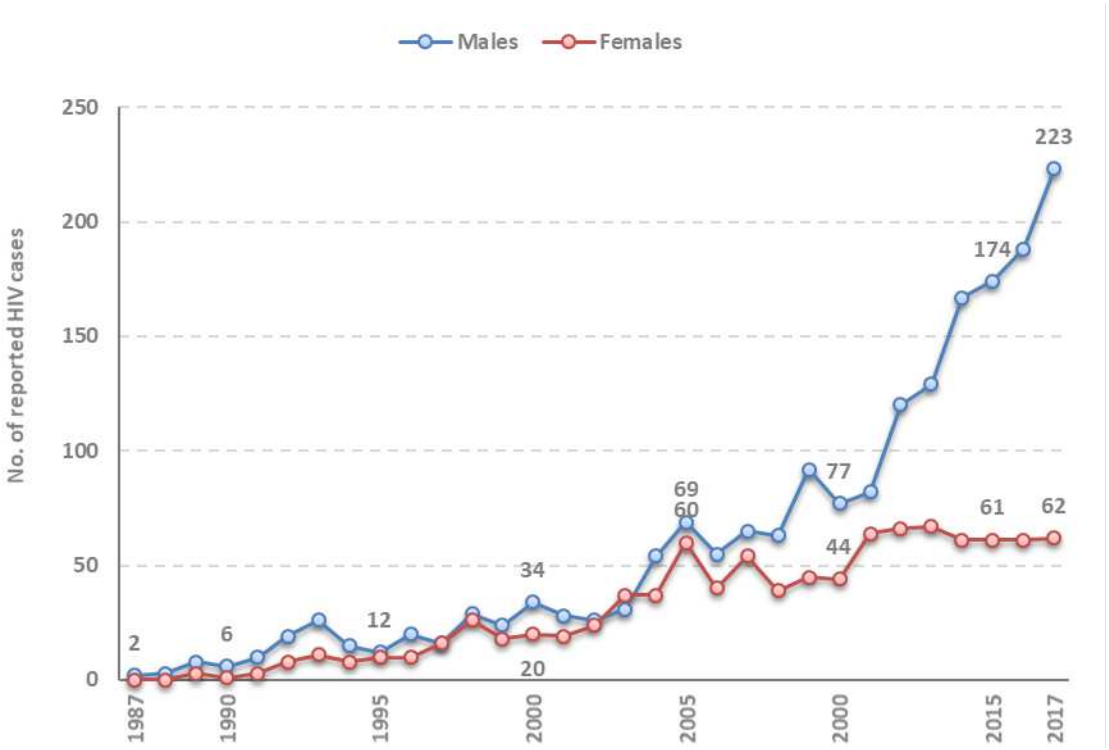


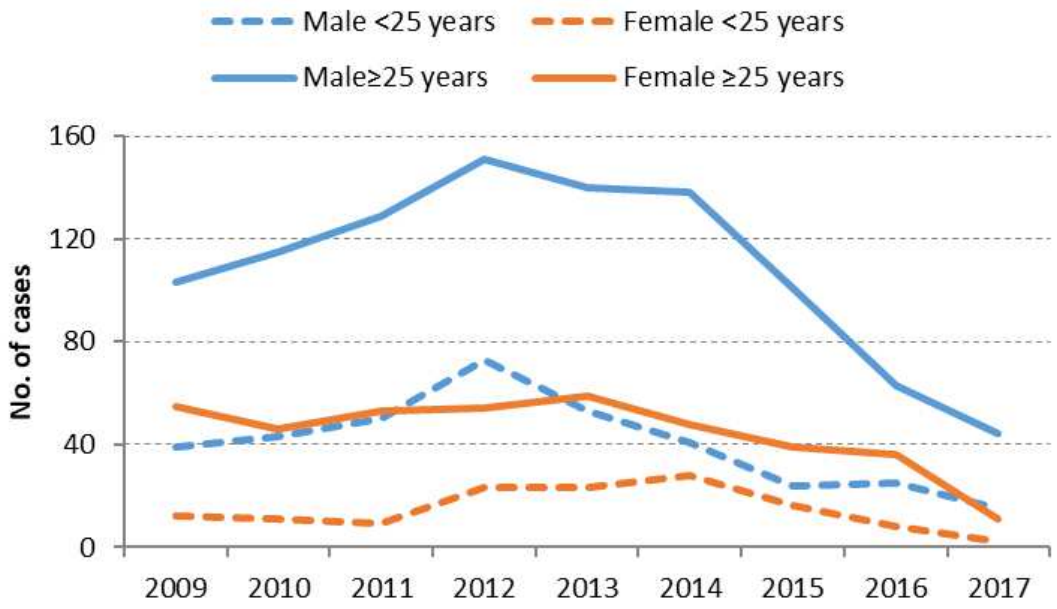
Table 1: Age and Sex distribution of cumulative HIV Cases

Age	Male	Female	Total	%
<15	50	34	84	3%
15-24	155	74	229	8%
25-49	1422	729	2151	76%
50 +	210	111	321	11%
Total	1837	948	2785	98%
Unknown	26	31	57	2%
Total	1863	979	2842	100%

Seroprevalence 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 up to 2013. However, there is a marked drop of number of infectious syphilis cases since 2013 and this has continued till 2017.

Figure 2: Reported early (infectious) syphilis cases, 2009- 2017



2. Mother to child transmission of HIV and congenital syphilis

2.1. MTCT of HIV

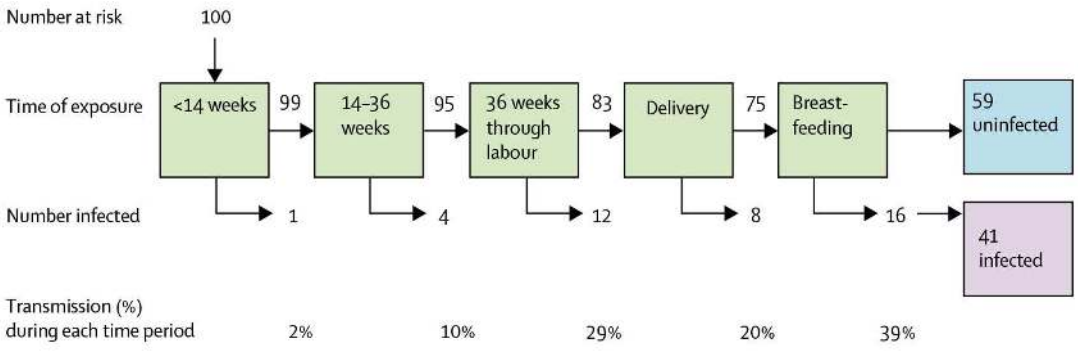
HIV among children is a growing problem. Majority of infected children acquire the infection through mother to child transmission. In the absence of any intervention, rates of mother-to child transmission of HIV remains high in developing country settings.

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 positive 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



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

Source- Athena PK-et al. Mother to child transmission of HIV-1. Timing and implications for prevention. Lancet infectious diseases. 2006; 6 726-32

2.2. 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% 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

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

Source - Global elimination of congenital syphilis, WHO

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.

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 women 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, 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**

3.3. National HIV policy

National HIV policy covers the areas such as testing, counselling, care and treatment services and prevention of HIV and STI.

National HIV AIDS policy of Sri Lanka clearly states that prevention of mother to child transmission of HIV should cover the four prongs identified by UNAIDS. Prevention of infection among men and women in the reproductive age and promoting voluntary counseling and testing for HIV in this age group is the primary strategy. Prevention of unplanned pregnancies among HIV infected women, provision of antiretroviral therapy, safer delivery practices and safer feeding practices will also be provided as per standard guidelines.

The Government of Sri Lanka promotes voluntary confidential counseling and testing, recognizing that mandatory testing would drive those at high risk of HIV infection beyond reach and prevent their access to public health preventive activities and other health services. Testing will be carried out according to accepted international guidelines. The screening of donated blood, donors of tissue and organs will be according to the recommendations of national policies. Testing for research and surveillance purposes will be according to current international guidelines.

Counseling is recognized as an integral part of all programs related to HIV/AIDS prevention, care and treatment. It is important that these services are provided by persons who are adequately trained in HIV/AIDS counseling.

The Government of Sri Lanka accepts the rights 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 national guidelines and prevailing National health policy.

Prevention and management of sexually transmitted infections are considered a priority in the control of HIV transmission. In this regard the services for STI prevention and care will be further strengthened and sustained. Screening for syphilis among all ante-natal mothers should be ensured. Preventive, educational, and clinical services will be provided to those believed to be at high risk, including sex workers, men having sex with men and injecting drug users.

The Government of Sri Lanka will ensure that the human rights of people living with HIV/AIDS are promoted, protected and respected and measures taken to eliminate discrimination and combat stigma which will provide an enabling environment to seek relevant services. These include the rights of everyone to life, liberty and security of person, freedom from inhuman or degrading treatment or punishment, equality before law, absence of discrimination, freedom from arbitrary interference with privacy or family life, freedom of movement, the right to work (rights of the people living with HIV in the work places) and to a standard of living adequate for health and wellbeing including housing, food and clothing, the right to the highest attainable standard of physical and mental health, the right to education, the right to information which includes the right to knowledge about

HIV/AIDS/STI related issues and safer sexual practices, the right to capacity building of the individual in dealing with this condition, the right to participate in the cultural life of the community and to share in scientific advancement and it's safety in health care settings. However, steps shall be taken to prevent persons from willfully and knowingly infecting HIV to other persons. The responsibility and behavior of the media as stated in Article 28 of the constitution of Sri Lanka which casts a duty to respect the rights of others on reporting on matters related to HIV/AIDS are emphasized.

3.4. Instructions to MCH service providers

The General Circular No: 01/59 - 2016 released by ministry of Health in 2016 highlights the important aspects to be considered in service provision by MCH service providers for elimination of mother to child transmission of HIV and syphilis as given below.

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.

Public sector

- Pregnant 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.
- Review syphilis and HIV test results at subsequent visits. Syphilis and HIV test reports need to be entered in the antenatal record appropriately.
- 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.
- All the pregnant women with positive screening test need to be referred to STD clinic for further management.
- 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.
- 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, VOG and RDHS.
- Women reporting abortions, still births, adverse pregnancy outcomes may need to undergo VDRL and HIV tests if not done in early pregnancy.

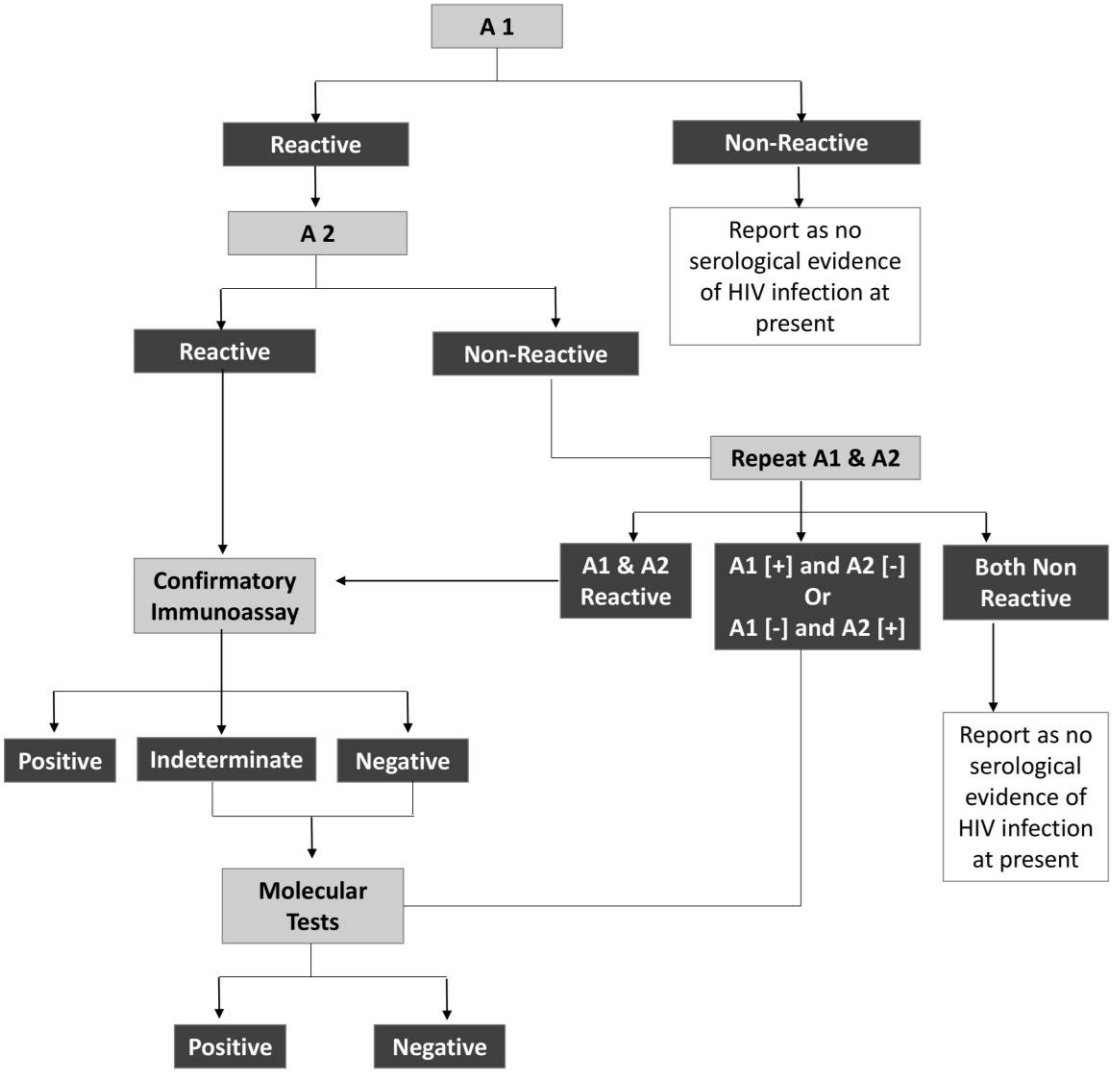
Private sector

- Pregnant mothers are to be screened before 12 weeks of gestation for Syphilis and HIV (preferably at the first visit).
- Syphilis and HIV tests need to be done from recognized laboratories maintaining quality standards.
- Syphilis and HIV test details need to be entered in the antenatal record appropriately.
- Women with positive syphilis or HIV test results should be managed according to the national guidelines by referring to venereologist/ STD clinic.
- All pregnant women with Syphilis or HIV should be provided appropriate services including institutional care, without stigma or discrimination.
- Data on pregnant women with syphilis or HIV should be informed to the NSACP in relevant formats.

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)

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)

Figure 4. Testing strategy for HIV diagnosis in adults



A1 - A 4th Generation Immunoassay in laboratory settings
A2 – A 2nd Immunoassay Test with different method

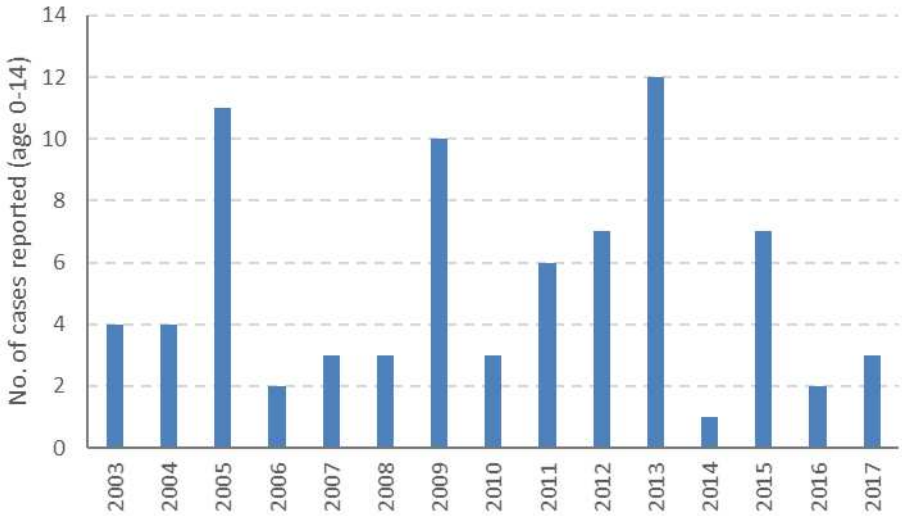
4. Elimination of MTCT of HIV programme in Sri Lanka

The elimination of mother to child transmission of HIV is 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.

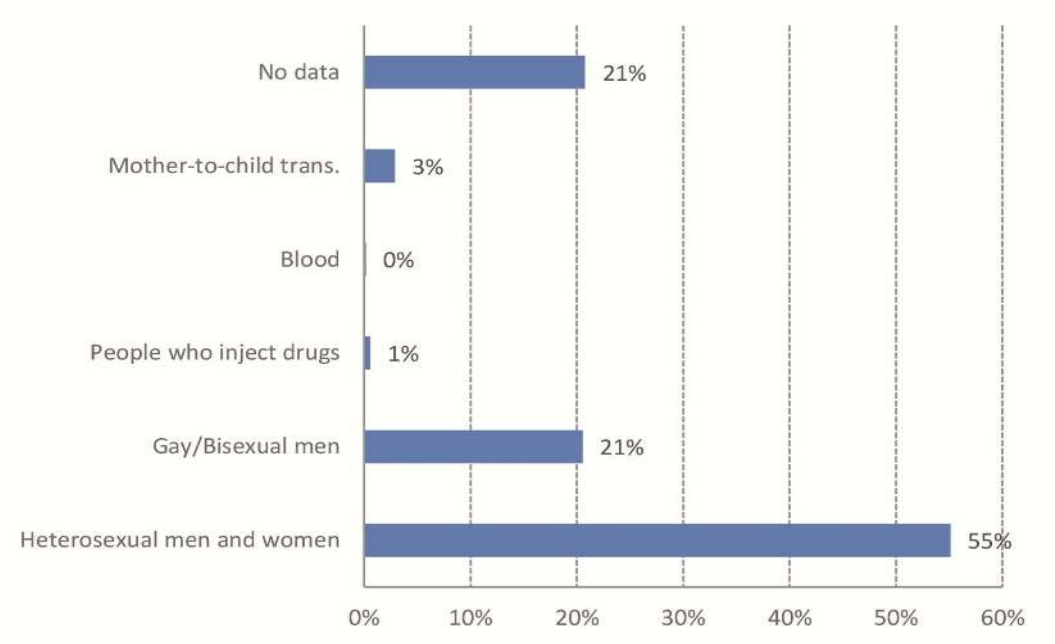
WHO recommends provider initiated testing and counseling (PITC) for HIV in pregnant mothers in low prevalent countries. Until the year 2012 the screening services to detect HIV among pregnant women in Sri Lanka was limited to few centers with coverage of 5.6%.

Figure 5. Reported paediatric HIV cases (age 0-14 years) 2003-2017



In the year 2013, out of total diagnosed PLHIV 5% were children. While most of PLHIV diagnosed in 2013 contracted infection due to unprotected sexual exposures, mother to child transmission was the second important mode of transmission. Though Sri Lanka is a country with low prevalence of HIV infection these statistics indicate the importance of preventing mother to child transmission of HIV.

Figure.6 Mode of transmission of HIV Cases reported up to end of 2017 (N= 2841)



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

4.1. Management of pregnant women with HIV

When screening test becomes reactive, Consultant/MO of the STD clinic will inform the relevant officers of the ANC clinic requesting to refer the pregnant mother to the STD clinic for further testing. All screening positive mothers will be counselled, and confirmatory tests will be arranged at the STD clinic.

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 pediatrician. Babies are given ART from birth to 6 weeks and mothers are counseled on appropriate feeding practices.

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

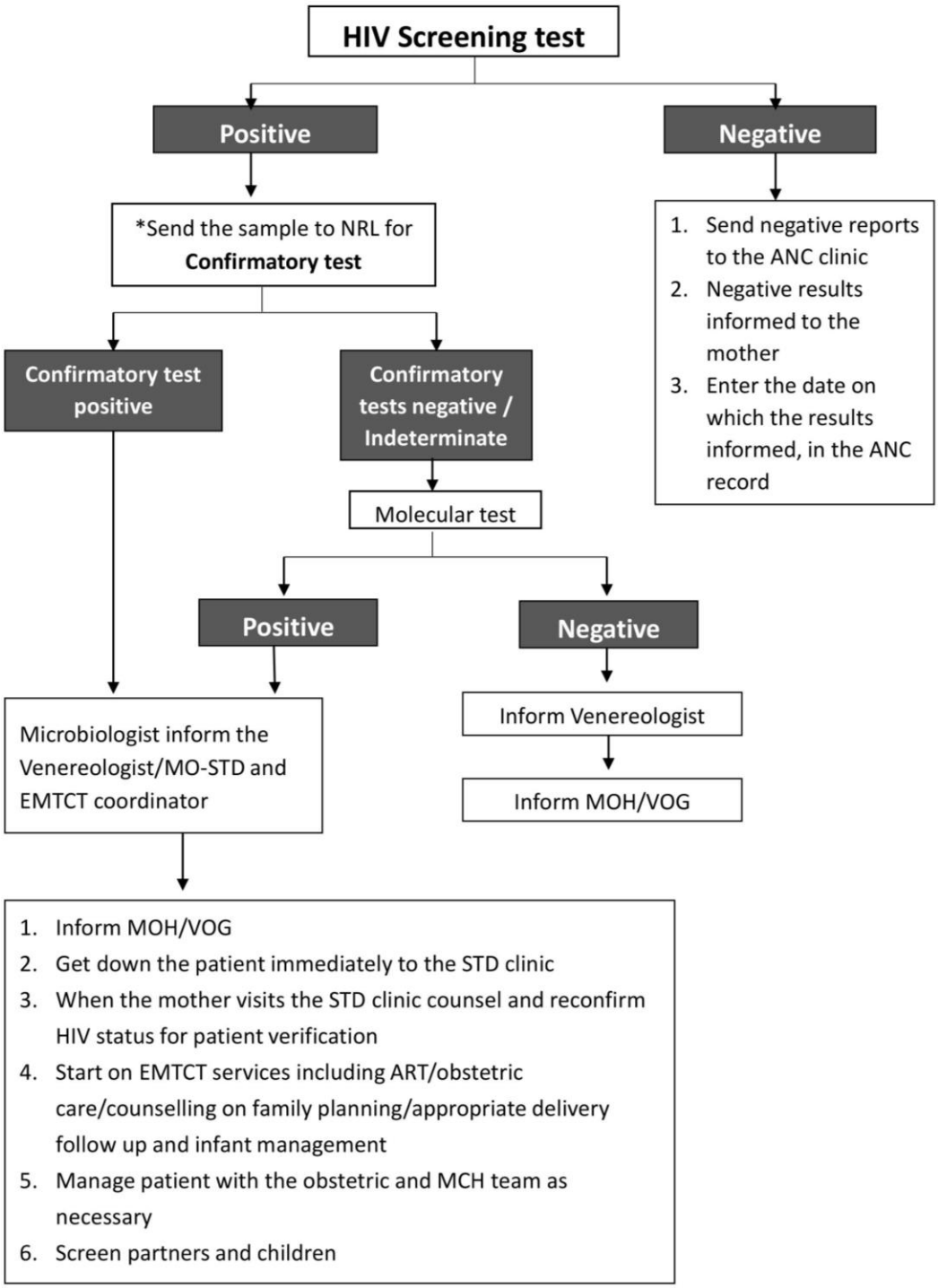
1. Improving mother's health
2. Preventing mother to child transmission of HIV
3. Preventing transmission of HIV from mother to sexual partner

ART should be initiated in all pregnant and breastfeeding women living with HIV regardless of WHO clinical stage and at any CD4 cell count and should be continued lifelong. ART should be initiated as early as 14 weeks of gestation or as soon as possible thereafter during pregnancy. However, even if they are identified late in pregnancy or postpartum, ART should be initiated immediately as it is the most effective way to prevent mother-to-child HIV transmission.

Option B+ is considered to be of the greatest benefit in which initiating ART in all pregnant and breastfeeding women with three drugs and continuing ART lifetime, would reduce HIV viral load and prevent HIV transmission in both current and future pregnancies.

First-line ART for adults should consist of two nucleoside reverse-transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse-transcriptase inhibitor (NNRTI). TDF + FTC (or 3TC) + EFV as a fixed-dose combination is recommended as the preferred option to initiate ART in pregnant women.

Figure 7. Protocol to inform HIV test results and management of pregnant women with HIV



*In the event of a screening test positive mother with a late pregnancy or in areas of difficult accessibility to health care the initial sample can be sent to NRL for further HIV testing thereby preventing the delay in providing EMTCT services.

4.2. Management of infant exposed to HIV

Infant post-exposure prophylaxis (PEP)
Neonatal PEP should be commenced soon after birth, certainly within 4 hours.
Infants receiving replacement feeding should be given 4–6 weeks of infant prophylaxis with daily NVP (or twice-daily AZT).
Infants born to mothers with HIV who are at high risk* of acquiring HIV should receive dual prophylaxis with AZT (twice daily) and NVP (once daily) for the first 6 weeks of life, whether they are breastfed or formula fed.
Breastfed infants who are at high risk* of acquiring HIV, including those first identified as exposed to HIV during the postpartum period, should continue infant PEP for an additional 6 weeks (total of 12 weeks of infant prophylaxis) using either AZT (twice daily) and NVP (once daily) or NVP alone.
Infants of mothers who are receiving ART and are breastfeeding should receive 6 weeks of infant prophylaxis with daily NVP.

4.3. HIV diagnosis in infants and children

4.3.1. Exclusively non-breastfed infants

Molecular diagnostics (HIV RNA and HIV DNA nucleic acid tests) for HIV infection should be performed on the following occasions:

- At Birth (During the first 48 hours)
- At 8 weeks of age (2 weeks post cessation of infant prophylaxis)
- At 4 – 6 months of age (This test is mainly for exclusion of HIV)
- On other occasions if there is an additional risk

HIV antibody testing for sero-reversion should be performed at age 9 and 18 months to exclude HIV infection. (If HIV antibody test is negative, the test should be repeated immediately with a separate blood sample to confirm HIV negative status).

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

Definitive exclusion of HIV infection in non-breastfed infants, is based on 2 or more negative virological tests, with one obtained at age ≥1 month and one at age ≥4 months, or 2 negative HIV antibody tests from separate specimens obtained at age ≥6 months.

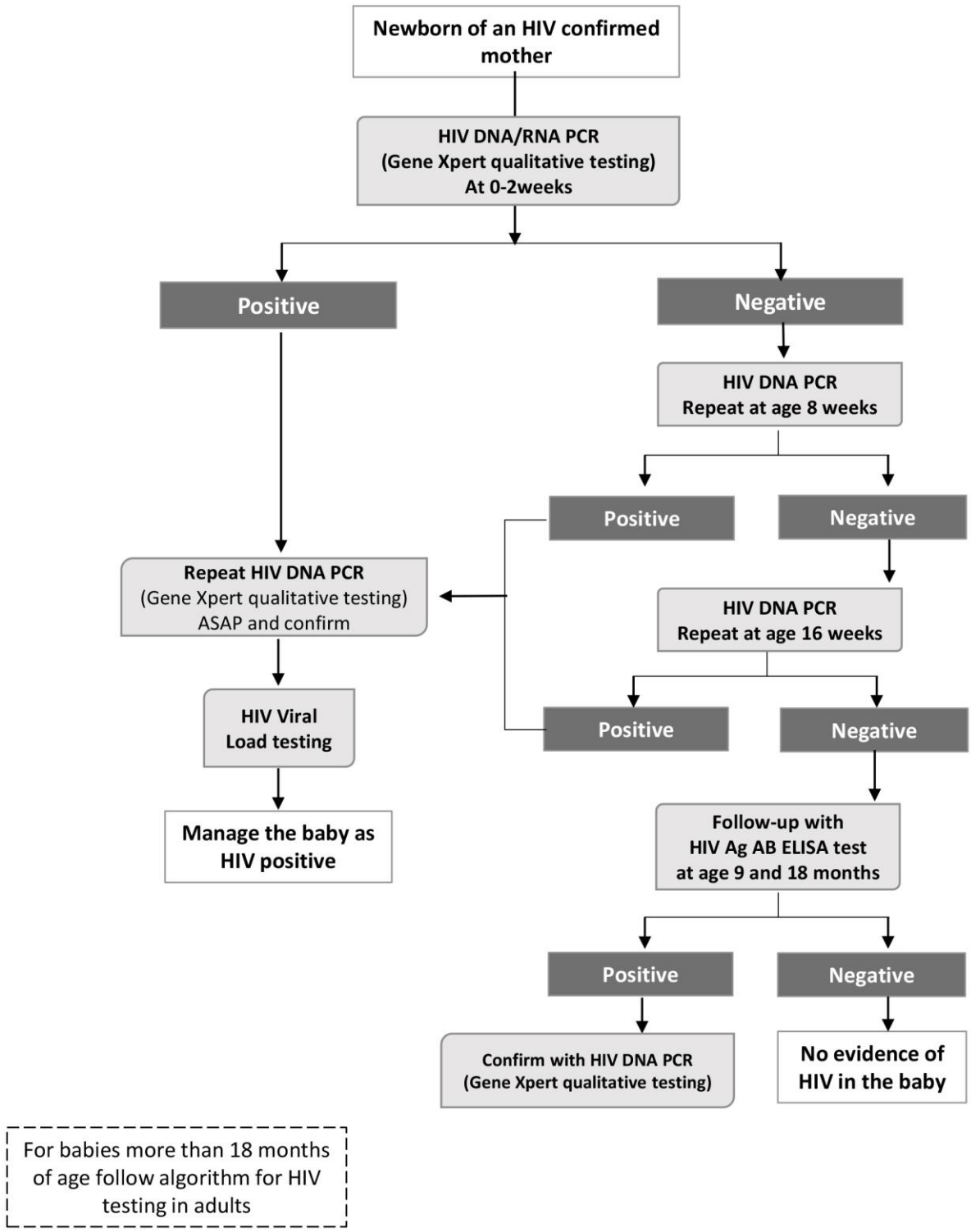
Some experts confirm the absence of HIV infection at 12 to 18 months of age in children with prior negative virological tests by performing an antibody test to document loss of maternal HIV antibodies.

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

4.3.2. Breastfed infants

Additional monthly testing of infant is recommended.

Figure 8. Algorithm for infant diagnosis of HIV



Source: Adopted from Anteretroviral therapy for HIV infection in infants and children: towards universal access. Recommendations for a public health approach. 2010 revision. Geneva, WHO 2010

5. 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 syphilis screening services for pregnant mothers have been offered since early 1950s.

Maternal and child health delivery system in Sri Lanka is considered to be one of the best in the South East Asian region. When the anti VD campaign was formally established in 1952 screening of pregnant mothers for syphilis was identified as one of the specific objectives of the campaign. Based on the success of the prevention of MTCT of syphilis programme, in 2009 the programme was revived as Elimination of congenital syphilis (ECS) programme. "Elimination of congenital syphilis strategy" was published based on the global strategy to facilitate this programme. By end 2017 countrywide syphilis testing coverage was 98%.

In the year 2013 both ECS programme and PMTCT of HIV programmes were combined to a single programme under the name "Elimination of MTCT of HIV and syphilis programme". The links between MCH services and STD services have been strengthened over the years which facilitates smooth functioning of the programme.

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 district team which consist of district authorities, including medical officer of maternal and child health. At the grass root level medical officer of health works closely with the area STD clinic to provide EMTCT of syphilis and HIV services to the community.

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 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.

5.1. Management of pregnant woman with syphilis

Public health team provides antenatal care services in the community which includes awareness on STI and HIV and collection of blood for VDRL and HIV testing. All pregnant women should be screened for syphilis at the first antenatal visit preferably before 12 weeks of gestation to prevent congenital syphilis.

When the pregnant woman gets registered for antenatal care services in the community clinic of MOH, VDRL testing is offered as a routine screening test. Blood samples are collected and transported to the closest STD clinic laboratory. 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 with penicillin injections. The objective is to complete treatment in early pregnancy, latest by 24 weeks of POA. 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. Irrespective of mothers treatment all babies born to mothers with syphilis 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.

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) to confirm the presence of treponemal infection.

When treponemal test (TPPA) becomes positive the reports will be informed by the Consultant/MO of the STD clinic to the relevant officers of the ANC clinic, requesting to refer the pregnant mother to STD clinic as early as possible for further management.

MOH will organize to trace the mother with the assistance of the staff while maintaining confidentiality. Mother will be appropriately counseled and reassured by the MOH before referring to STD clinic. MCH staff should ensure that the pregnant woman attended the STD clinic without delay. Date of referral should be documented in the ANC record relevant cage, “If (R) date of referral”.

If the treponemal test is positive the pregnant woman should be treated with penicillin injections according to the stage of infection.

Biological False Positive (BFP) reaction

When the VDRL test is positive and the treponemal test is negative it is known as a “biological false positive (BFP) reaction”.

BFP reactions for VDRL are common in pregnancy. The titre of the nonspecific test is usually low, rarely more than 1:8.

Figure 9: Protocol to inform VDRL test results of ANC mothers in peripheral setting

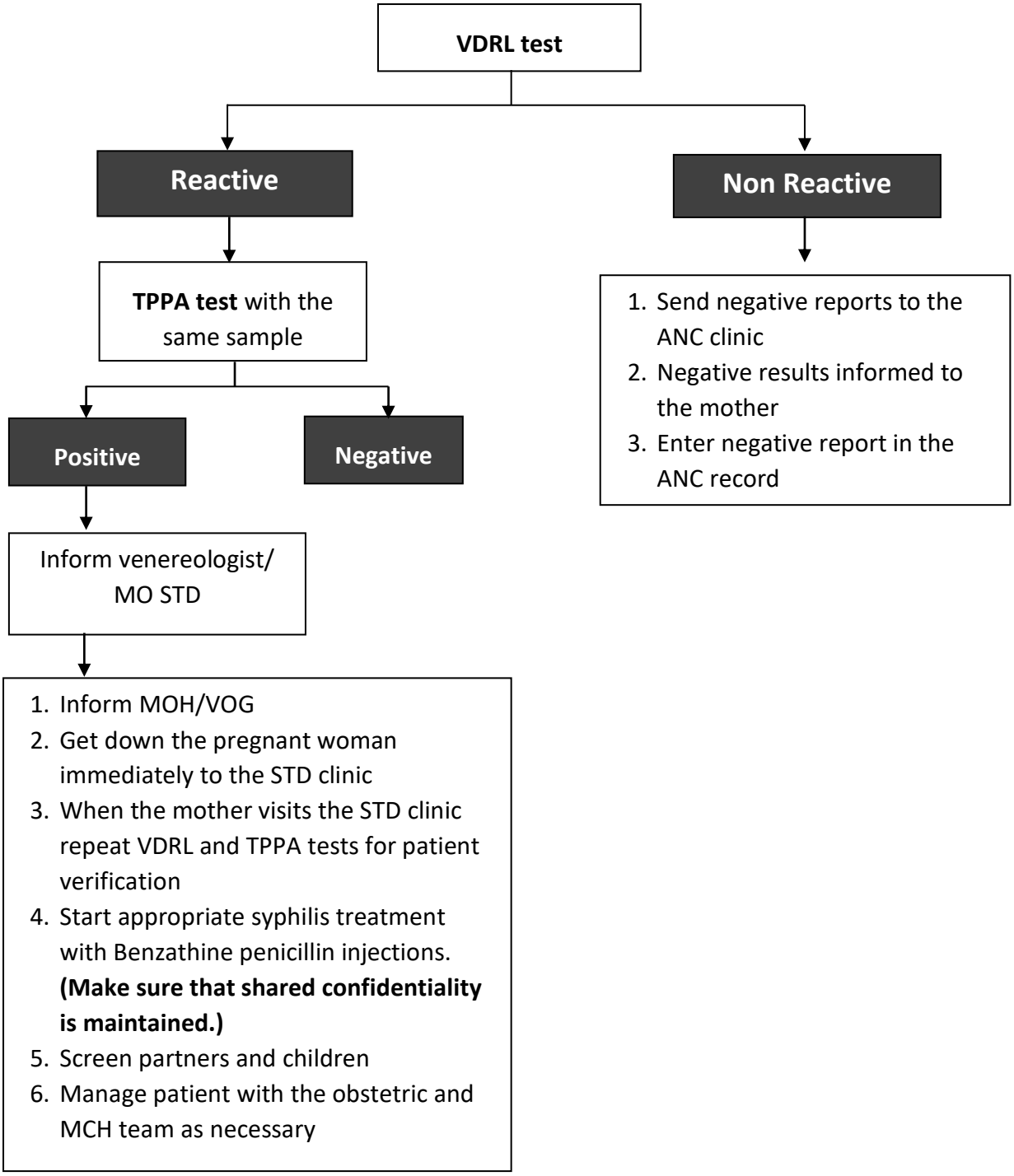
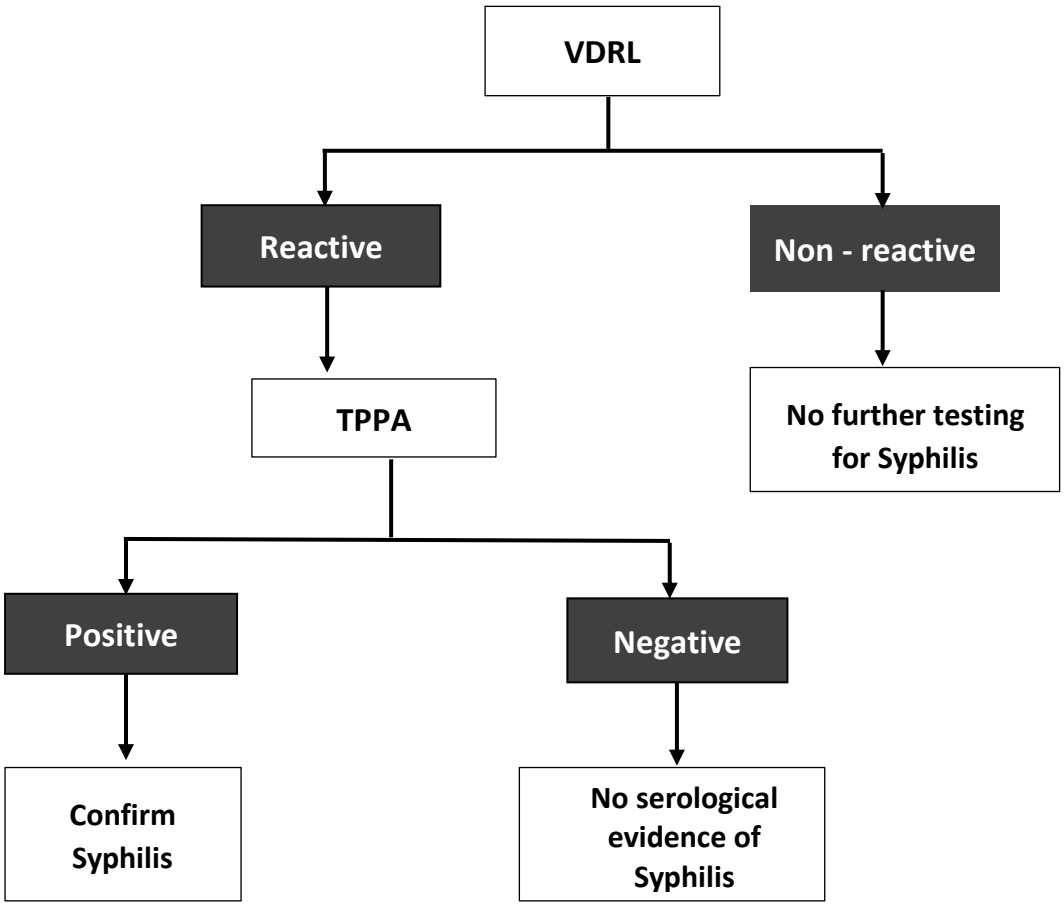


Figure 10: Testing Strategy of Syphilis for Antenatal mothers



5.2. Treatment of the pregnant women

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

5.2.1. 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).

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

5.2.2. 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)

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

5.2.3. Penicillin Allergy

No proven alternatives to penicillin are available for treatment of syphilis during pregnancy. It is recommended desensitization is the best option if it is feasible. There is no proven data for use of ceftriaxone.

Alternatively, Erythromycin can be used when penicillin is contraindicated. Recommended dose is Erythromycin 500mg 6 hourly/PO for 14 days in early syphilis and for 28 days in late syphilis. (In pregnancy doxycycline is contraindicated).

If the mother was treated with non-penicillin treatment, the baby should be treated as having congenital syphilis. The pregnant woman should be managed in coordination with the MCH care services and/or obstetrician in a tertiary care unit.

5.2.4. Pregnant mothers with syphilis and HIV infection

Evidence suggests that treatment and follow-up for syphilis in pregnant women who are HIV positive should be similar to that is given to HIV negative pregnant women

5.3. Follow up

Serological (VDRL) follow-up should be done monthly during pregnancy and thereafter according to national guideline.

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

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

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

5.4. 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 mothers 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 - Please refer guidelines for the management of maternal syphilis and congenital syphilis)

Table 3. Antenatal syphilis screening done at NSACP - 2012-2017 and number of pregnant women with positive TPHA

Year	No. tested	No. positive	Prevalence %
2012	204947	45	0.02%
2013	230882	98	0.04%
2014	289190	115	0.04%
2015	329184	87	0.03%
2016	341952	80	0.02%
2017	333102	43	0.01%

**Source -SIM unit, NSACP*

Global surveillance case definition for congenital syphilis

The global surveillance case definition for congenital syphilis is given below

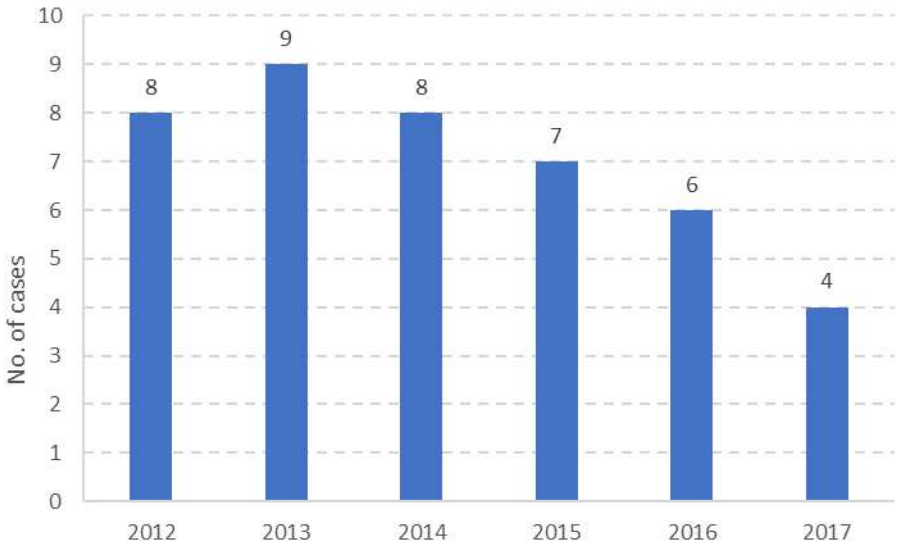
1. **a live birth or fetal death at >20 weeks of gestation or >500 g (including stillbirth) born to a woman with positive syphilis serology and without adequate syphilis treatment***

   * 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.2,3

   OR

2. **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).**

Figure 11. Congenital syphilis cases reported to NSACP - 2012-2017



**Source SIM unit, NSACP*

In Sri Lanka the rate of CS is around 1 per 100,000 live births which is much lower than the target for ECS (50 per 100,000 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

Figure 12. Organization of RMNCAYH Programme at Different Levels of Health System

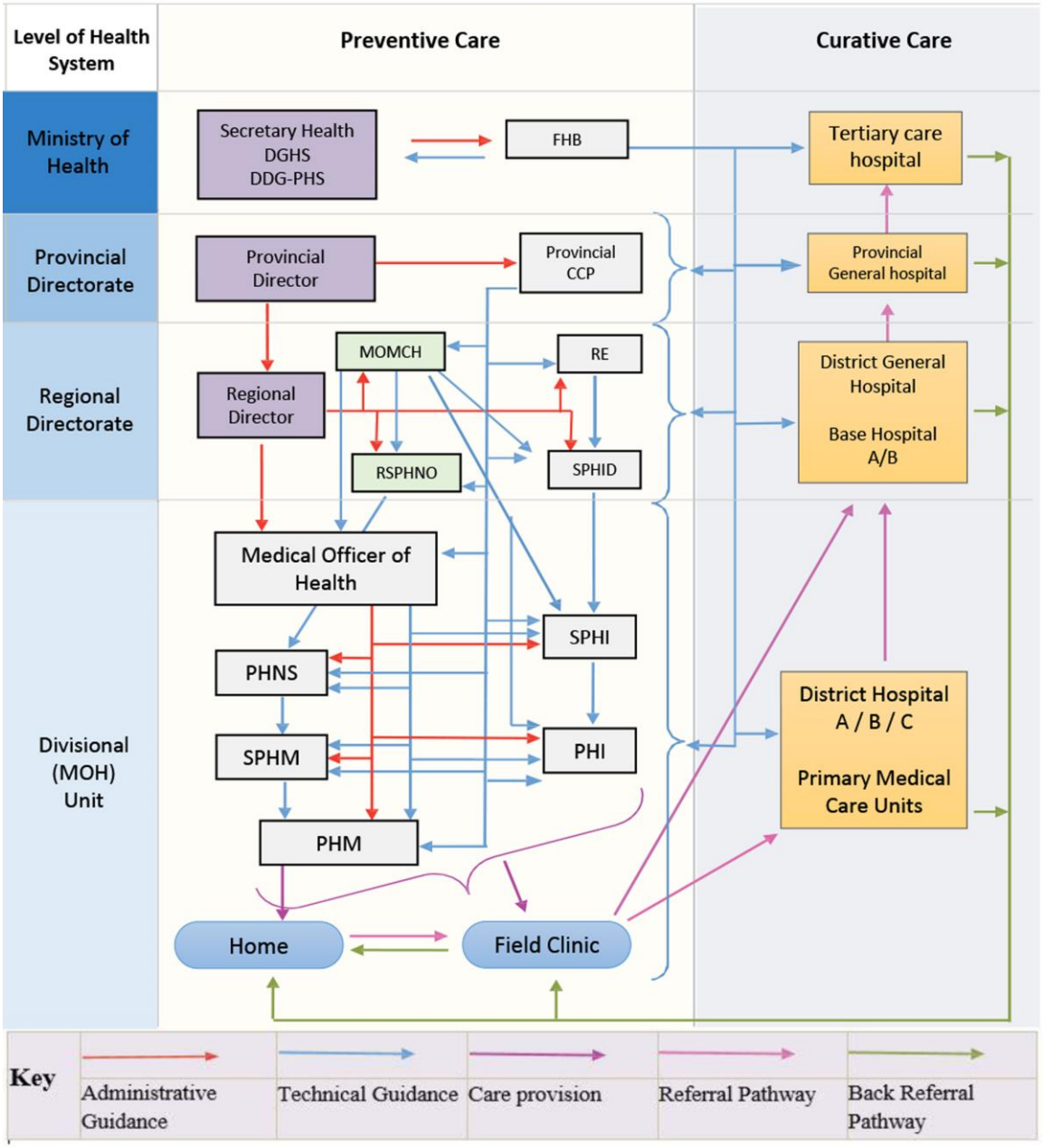
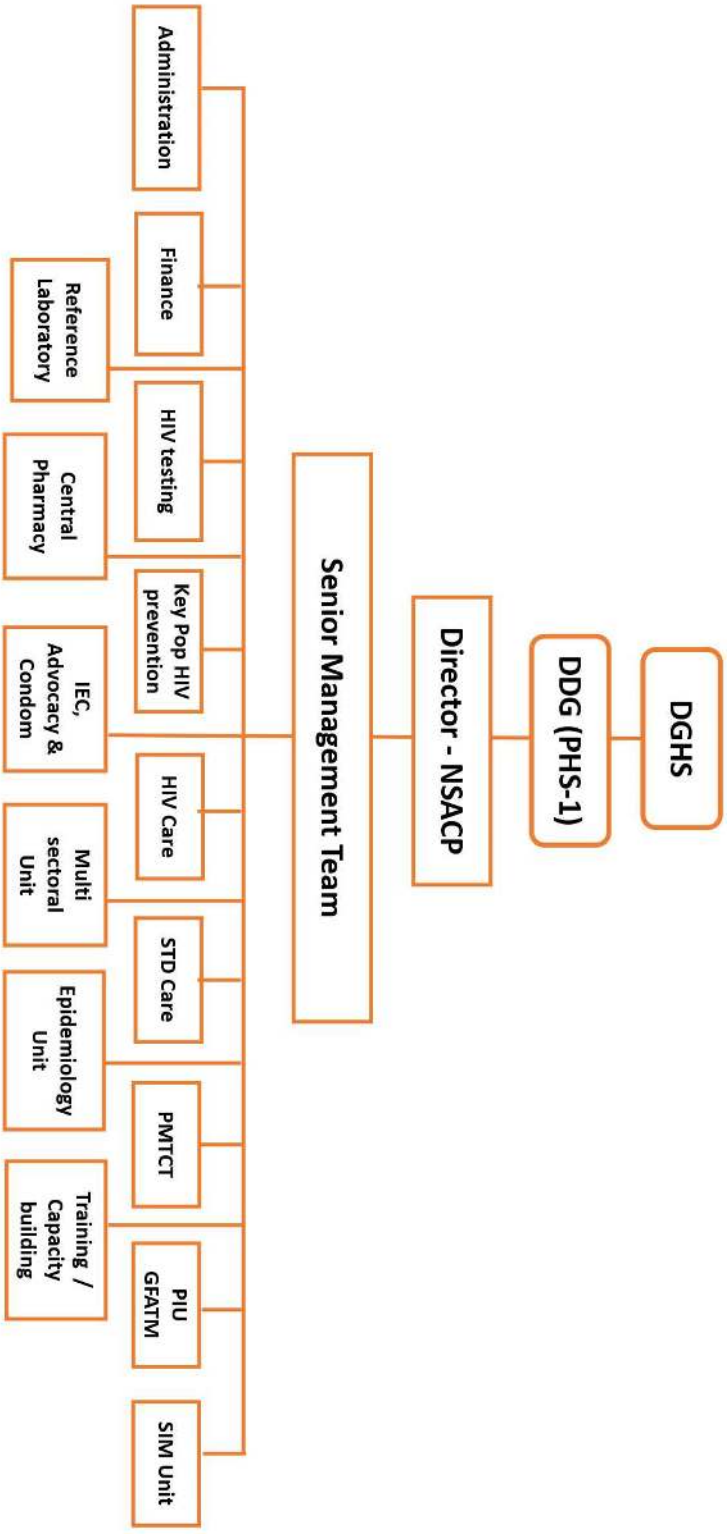


Figure 13. NSACP Organogram

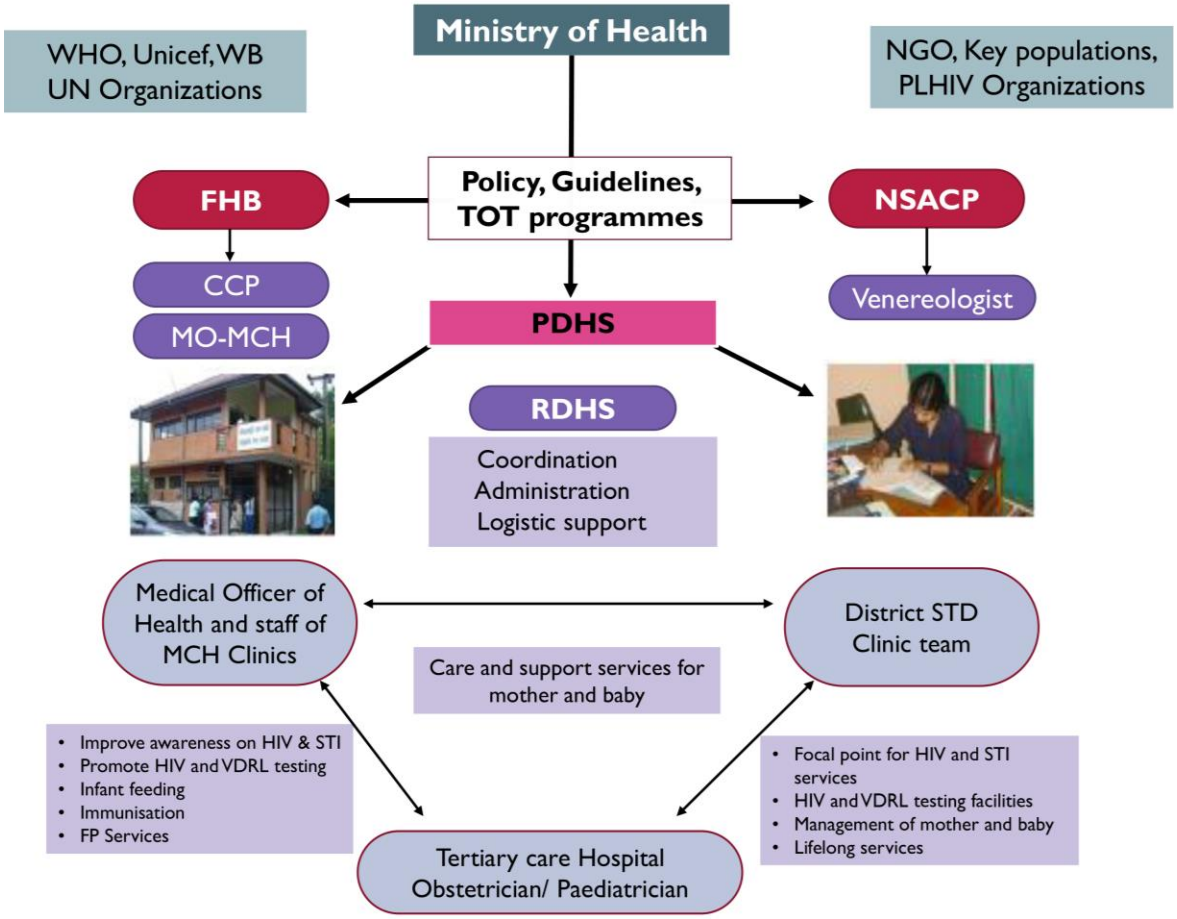


6. Stakeholders in EMTCT of syphilis and HIV programme

Under the ministry of health there are many institutions providing EMTCT services and facilitating the EMTCT of the syphilis and HIV 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 Director General of Health Services and Deputy Director General of Public Health Services (DDG PHS 1 and 2) of ministry of health.

The link developed at the national level extends to the district level through the district STD clinics and district team responsible for MCH services. At the district level the district team comprising of district authorities, maternal and child health services and STD services complement the services in addressing the reproductive health needs of the population. At the grass root level Medical officer of Health (MOH) provides services to the community through the public health staff including public health nursing sisters, supervising public health midwives and public health midwives. The strong link between the national STD AIDS Control Programme and Family Health Bureau (FHB) has strengthened over the years and the link extends to the district level and through that to the community level. Close coordination of relevant institutions, keen interest shown by provincial and district authorities as well as involvement of tertiary care institutions through multidisciplinary approach are the reasons for success of EMTCT of syphilis and HIV programme

Figure 14. Stakeholders in EMTCT of HIV and syphilis programmes



EMTCT of syphilis and HIV programme is fully funded by the government of Sri Lanka. This ensured sustainability of the programme. WHO and UNICEF supported the EMTCT of syphilis and HIV programme providing technical support as well as funding and logistics. UNICEF was instrumental in improving quality of laboratory services while supporting monitoring of the activities. World Bank and other UN partners supported the programme when necessary. The involvement of key population organizations and PLHIV organizations facilitated to take services to difficult to reach.

7. Criteria and process for Validation

Before applying for validation of EMTCT of HIV and/or syphilis, countries must meet the following global minimum criteria:

1. National-level evidence of achievement of the EMTCT validation process indicator targets for two years and achievement of validation impact indicator targets for one year.
2. Evidence that EMTCT of HIV and/or syphilis has been adequately addressed in the lowest-performing subnational administrative units.
3. Existence of an adequate "validation standard" national monitoring and surveillance system that can capture process data from both the public and private health sectors, and detect the great majority of cases of MTCT of HIV and/or syphilis.
4. Validation criteria must have been met in a manner consistent with basic human rights considerations.

7.1. Targets for validation of EMTCT of syphilis and HIV programme of Sri Lanka

HIV
Impact indicators for one year
• a population case rate of new paediatric HIV infections due to MTCT of ≤50 per 100 000 live births and • an HIV MTCT rate of <5% (breastfeeding countries) OR <2% (non-breastfeeding countries).
Process indicators for two years
• Population-level ANC coverage (at least one visit) of ≥95% • Coverage of HIV testing of pregnant women of ≥95% • Antiretroviral therapy (ART) coverage of HIV-positive pregnant women of ≥95%
Syphilis
Impact indicators for one year
• a case rate of congenital syphilis of ≤50 per 100 000 live births
Process indicators for two years
• Population-level ANC coverage (at least one visit) of ≥95% • Coverage of syphilis testing of pregnant women of ≥95% • Treatment coverage of syphilis-seropositive pregnant women of ≥95%

7.2. Validation process

Country validation

- MOH submits a validation request to the regional secretariat.
- MOH and the RVC jointly establish an NVC.
- NVC and NVT 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 GVAC.
- GVAC reviews regional validation report for compliance with minimum global criteria.
- GVAC 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 by 2018

Targets

Maintain the incidence of congenital syphilis to <50 cases/100,000 live births

Maintain mother to child transmission of HIV to <50 cases/100,000 live births

Objectives of EMTCT of syphilis and HIV programme

EMTCT of HIV

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

EMTCT of Syphilis

- **>95% of ANC attendees tested for syphilis**
- **>95% syphilis sero-positive mothers receive effective treatment**
- **>95% 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 child 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 child health care services at all levels have helped Sri Lanka to 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 are 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;

1. Primary prevention of HIV and syphilis transmission among women in childbearing age
2. Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices
3. Ensure high level commitment and advocacy to eliminate the incidence of congenital syphilis and transmission of HIV from mother to child
4. Increase access to and quality of syphilis and HIV services at maternal and child health services
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
6. 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. Awarenes programmes for PLHIV on MTCT

Strategy 3 - Ensuring advocacy and sustained political commitment for a successful EMTCT programme

Major activities

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

Strategy 4 - Increasing access to and improve the quality of maternal and newborn health services

Major activities

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

Strategy 5- Prevention of HIV and syphilis transmission from women living with HIV/ syphilis to their children by promotion and integration/linkage of PMTCT with related services

Major activities

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

Strategy 6 - Strengthen surveillance, monitoring and evaluation of EMTCT programmes of syphilis and HIV

Major activities

1. Strengthen data collection systems in relation to maternal syphilis and HIV
2. Develop data collection formats where necessary
3. Develop indicators to monitor the EMTCT programme (input, process, output and outcome)
4. Establish performance review in relation to EMTCT at each level
5. Monthly MOH review meetings
6. Quarterly review by RDHS
7. Annual review by NSACP and FHB
8. Promote operational research
9. Review and revise the existing information systems to fulfill the EMTCT requirements

Table 4. Major activities conducted from 2013

Activity	Time	Details
Revive PMTCT programme to work towards elimination	January 2013	Strengthen the links between FHB and NSACP
Decision taken on universal screening of pregnant women	May 2013	Meeting with stakeholders
Advocacy Advocacy meeting - country programme to introduce EMTCT services	From January 2013	Meeting with DMH, CSHW, Director, FHB Meeting on EMTCT at Taj Samudra Hotel organized by UNICEF September 2013 – with participation of all provincial MCH staff and STD staff
National level steering committee	2013	Quarterly meeting
Circular issued by the MOH	2014	To inform relevant authorities regarding decisions taken
Commence ANC HIV testing	December 2013	Year 2013 – cover Colombo, Gampaha, Galle, Matara, Hambantota and Kandy districts
Training programmes for health care workers	2013/2014	MCH staff and Institutional staff from selected areas
Improvement of laboratory	2013/2014	Responsibility – National Coordinator Laboratories NRL • Procure test kits • ELISA machines • Vacutainer tubes • Protective gear kits carrier boxes
Other improvements for data collection	2014	Computers, multimedia projectors, printers
IEC material	2014	Posters, leaflets, EMTCT strategy, CD for ANC health talk

Figure 15. Scaling up of EMTCT programme since 2013 to 2016

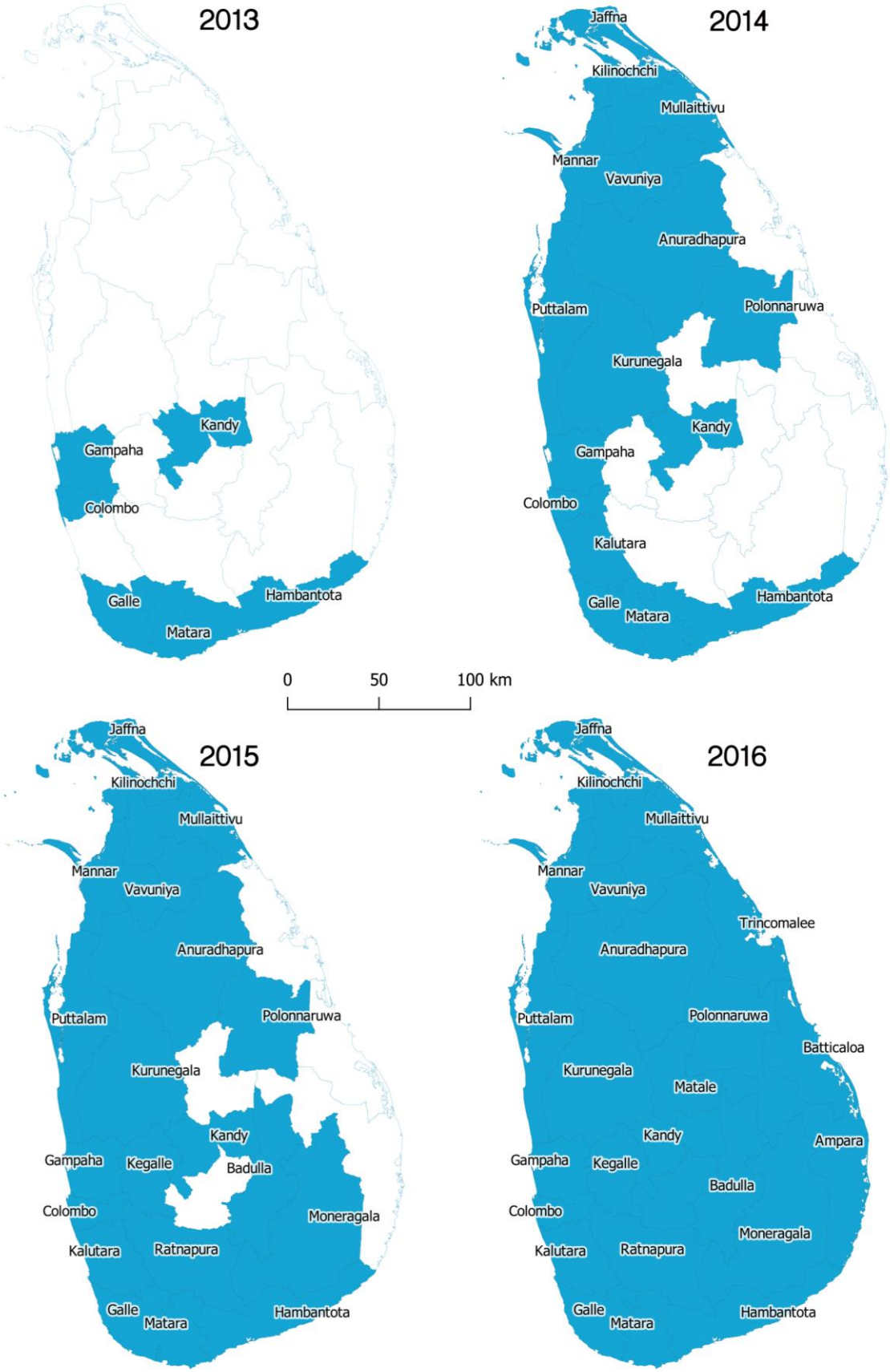


Table 5. Detailed activity plan for EMTCT of HIV and syphilis 2017/ 2018

Activity	**Timeline**	**Details**
Advisory meeting headed by the minister of health	June 2017	Decision taken to work towards validation of EMTCT programme
EMTCT steering committee meeting	2017/ 2018	Once in 3 months
Appoint local consultant to review EMTCT programme and submit the report	July 2017	Dr. Iyanthi Abeywickreme Prof. A. Pathmeshwaran Funnded by WHO
Teams for four main domains established	April 2017	Coordinators of four main domains Care – Dr. L Rajapaksa/ Dr. I Nilaweera Laboratory – Dr. J Elwitigala/ Dr. L Munasinghe Data – Dr. K A M Ariyaratne/ Dr. Kaushalya Human rights – Dr. G Weerainsghe/ Dr. S Dhanapala (UNICEF)
Launch of validation process	June 2017	Meeting with 150 participants countrywide- MOMCH and venereologists, obstetricians and paediatrician (UNICEF)
Continue Training of all MOH, institutional staff and STD clinic staff	2017/2018	For refresher training and to train new appointees
Introduce the whole concept to all key populations and PLHIV groups	July 2017/ 2018	Organized with the help of FPA
Development of MCH guide for MCH staff	June 2017	Distributed to all MOH offices (UNICEF)
Update guidelines on • Management of pregnant woman with HIV • Management of pregnant woman with syphilis • Antiretroviral Treatment	September 2016	Updated guidelines were distributed to all PDHS, RDHS, MO MCH and STD clinics
Reprinting of posters and leaflets	June 2017	Distributed among 365 MOH offices and ANC clinics of institutions

Activity	Timeline	Details
Provincial review meetings (9)	August - September 2017 October-November 2018	Completed all nine provinces.
Laboratory development	2017/2018	Working towards applying for accreditation of national reference laboratory with ISO 15189 standard and improving the STI clinic laboratories to reach the requirements of the standard.
Data verification process 1. Private hospital survey 2. Postnatal unit survey to check VDRL and HIV data	2017/2018	All major hospitals in the country covered in postnatal survey. Main 10 private hospitals in Colombo covered in private hospital survey
Supervisory visits to ANC clinics	July – September 2017/2018	Supervise ANC clinic services by district team
Each domain to submit the relevant material for chapters	August 2018	Coordinators of four main domains Care – Dr. L Rajapaksa/ Dr. I Nilaweera Laboratory – Dr. J Elwitigala/ Dr. L Munasinghe Data – Dr. K A M Ariyaratne/ Dr. Kaushalya Human rights – Dr. G Weerasinghe/ Dr. S Dhanapala
Mass media campaign (TV,Radio)	September-October 2017/2018	TV and radio programmes (UNICEF)
Formation of District committees	September 2017	Regular District reviews (UNICEF)
Visit of the consultant to review readiness for validation and prepare draft report	May 16 – 25th 2018	WHO consultant Dr. Richard Stein's visit (WHO and GF)
Introduce final steps to reach elimination targets symposium	September 2018	Meeting with 150 participants countrywide to assess readiness. (UNICEF)

Activity	Timeline	Details
Supervisory visits to STD clinics,	2018/2019	Supervising team– STD clinics
Annual review Meeting to finalize data for the report (2 day)	November 2017/2018	Review of country programme (UNICEF)

Table 6. Major activities conducted in laboratory sector

Activity area	Time	Details
1. Testing Assessment of the laboratory sector for capacity to undertake testing & activities to fill the gaps	2013	• Situational analysis for human resource, equipment and test kits • Meeting with the laboratory staff to arrange the testing with available staff until the vacancies are filled. Agreed for testing at piece rate per sample. • Request made to MoH for appointing MLTs for all the district STI/HIV clinic laboratories • Obtaining funding for test kits from WHO to initiate expanding the testing in western province, kandy & Galle. • Cluster testing arranged for districts where there are no MLTs • Arranged uniformity in sample collection, by introducing new request forms for ANC specimens and uniformity in transportation with training workshops.
Capacity building for HIV Screening country wide • making facilities available • Initiate Data management • Streamline EID testing for babies	2014/15	• Obtained funding for test kits from world bank to expand testing to the whole country for 2014 (20 M) and 2015. (40 M) • Introduced the ELISA technique as the screening test for HIV as the main stream with PA & RDT supporting the system. • Procured ELISA machines to new stations through UNICEF funding • Train the MLTs for ELISA technique- by in service training at NRL • Introduced data management for laboratories with data formats given by NRL and monthly collection of data • Arranged HIV DNA PCR by out sourcing as the facility is not available onsite •
Streamlining the sample collection& transport, IQC and EQA concentrating mainly on improving the quality management system	2016/17	• Distribution of guideline for sample collection at MOHs • Circulation of guideline for STD laboratories for reagent transport, storage and usage • Streamlining of IQC and EQA for Syphilis and HIV screening through workshops to all central and peripheral lab staff. • Guided all the STI clinic laboratories to improve the infrastructure as per quality requirements • Procured ELISA machines to new stations (to raise from 12 stations in 2013 to 26 in 2017) • Improve documentation in all the network laboratories

continuous quality improvement Review testing algorithms Establishing EID in country Decentralization of testing for patient management	2018/19	• Establishment of EID testing at NRL • Testing algorithms reviewed. • Preparation of sample collection manual as a booklet to be used by all ANC sample collection centres • Decentralization of testing facilities –CD_4 testing and HIV Viral load to 2 main peripheral stations • Improving the sample collection, transport of specimens by introducing cold boxes, improving IQC ,data management. • Arranging the IQC for CD_4 testing • Arranging the EQA for Viral load testing
2. Quality of tests Strengthen the national planning for procurement and distribution of HIV & Syphilis tests by strengthening the supply chain management	2014	• Developed the guidelines for selection of test kits and procured the test kits through MSD of MoH with World bank funds
	2015	• Developed the guide lines for assurance of the quality of kits after arrival- test kit verification and periodic checking for performance.
	2016	• Attended to streamlining the forecasting & making the request to MoH to include the test kit requirement in government annual estimates • Started regular meetings with MSD and SPC with a view to avoid stock outs by having a smooth continuous dialogue on requests and orders. • Discussions with NRL technical staff for reviewing stock balances regularly • Guided the peripheral and central level to monitor the stock balances, reorder levels and periodic stock verifications
	2017	• Development of formats for ordering reagents and monitoring stocks in a uniform manner • Circulation of guideline to peripheral STI laboratories for stock management for Syphilis and HIV test kits and reagents
	2018	• Refresher training for the laboratory staff on proper estimation and re order levels • Stock management workshop for all laboratory staff
3. Equipment management	2013/14	• Initial assessment of the availability of equipment in laboratories and procurement of possible as per the available funding.

Surveying Procurement Calibration Maintenance		• 2014 -2017- Procurement of ELISA machines fill the gap- (to improve ELISA facility from 6 stations to 28 stations island wide)
	2015/16	• Distribution of equipment management guideline among the STD clinic laboratories and introduce equipment management for all the laboratories with training workshops • Equipment survey-2016,2017,2018 to complete the equipment gaps
	2017/18	• Calibration of laboratory equipment-NRL& Peripheral STD lab • Arranging equipment maintenance with service agrrements
	2019	• Request to automate NRL • Continue calibration and maintenance in all laboratories
4. Laboratory Quality Management Capacity building activities- Technical	2014	• Participation in the workshop conducted by Sri Lanka Accreditation Board (SLAB) by 4 senior medical laboratory technologists & 2 Medical staff
	2015	• Accreditation awareness work shop on site for all NRL lab staff by experienced staff from of an external lab which underwent accreditation and with a SLAB assessor. • Introduction of medical laboratory accreditation to all peripheral laboratories in their refresher training courses to familiarize the medical laboratory standards
	2016/17	• Participation by one senior MLT from NRL & the Microbiologist in the Asian workshop in Indonesia for quality improvement conducted by NRL, Australia • Conducted a series of workshops for laboratory quality management for all peripheral consultant Venerelogists/MOICs,MLTs,PHLTs by local expertise under CDC/CMAI project ,Training of senior medical laboratory technologists of NRL and few peripheral STD clinics as trainers on QMS –CMC,Vellore • Two workshops by CDC/CMAI project, for all laboratory staff& consultants on quality management system by regional experts
	2018/19	• Participation of quality management workshops conducted by SLAB by 3 MLTs & 2 MOs of NRL • 2018 – training of senior MLT staff & medical staff of NRL in New Deldhi , India on EQA • Webinars from CMC Vellore for improving the knowledge

Obtaining support for working towards accreditation - NRL is applying for accreditation and the peripheral laboratories are build up to the Iso 15189 standards Support extended from CDC/India for quality improvement of the laboratory system for EMTCT through PEPFAR funding -(partnered in a project from 2016-2019.) Implementing partner of the project- CMAI-India		• Main Activities – technical assistance • 2016- Initial assessment by two external assessors from India to see the preparedness for accreditation - to identify the main gaps and prioritize the needs. • 2017 –capacity building training on QMS at CMC,Vellore • Capacity building workshops conducted in country by regional experts for all STI lab staff on quality management system. • Support in improving documentation for accreditation of NRL • 2018- Mid-term assessment • 2018- provision of technical assistance through a technical officer for documentation support for accreditation • Arranging webinars to improve knowledge base • 2019- Data management workshop for NRL technical staff by regional experts • 2019-supporting the internal audit and application for accreditation
Quality improvement guidance and activities conducted	2013-2018	• Guided all the STI clinic laboratories to improve - the infrastructure as per quality requirements - documentation and document control - test kit quality verification - IQC& EQA - equipment management - stock management for test kits and reagents - bio safety, waste management & infection control (all lab was given Hep B vaccine and checked for antibodies) - Data management • Provided on site supervision to peripheral laboratories by NRL • Capacity building for laboratory technical staff and relevant medical staff
5. Data management	2014	• Introduction of data collecting formats to all the labs to streamline the data management
	2015/16	• Distribution of formats for laboratory records in testing, QA, stock management etc…
	2017-2019	• Continuous improvement in data related documents • Support developing the laboratory information management system under EIMS
6. Familiarization for the EMTCT validation	2018	• Refresher training on laboratory validation tool for laboratory staff of NRL and peripheral STD laboratories

11. References

1. National STD/AIDS control programme. *Guidelines for the Management of HIV infection in Pregnancy in Sri Lanka*. 1st ed. Sri Lanka. National STD/AIDS control programme; 2008
2. UNAIDS. *HIV in Asia and the Pacific UNAIDS report 2013*. 1st ed ; 2013
3. WHO. *HIV/AIDS in the South-East Asia Region Progress towards MDG 6A, 2012*. 1st ed. World Health Organization, Regional office for South East Asia. WHO; 2012
4. Ministry of Healthcare and Nutrition, Colombo, Sri Lanka. National STD/AIDS control programme. *National HIV/AIDS strategic plan 2007-2011*. Democratic Socialist Republic of Sri Lanka; 2007
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
6. Ministry of Health and Social Welfare Tanzania Mainland. *Tanzania elimination of mother to child transmission of HIV plan, 2012-2015*. The United Republic of Tanzania; 2012
7. UNAIDS. *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, 2011-2015*. UNAIDS; 2011.
8. National STD/AIDS control programme. Ministry of Healthcare and Nutrition, Sri Lanka. *Guidelines on Management of HIV infection in Pregnancy in Sri Lanka*. 2nd ed. Sri Lanka. National STD/AIDS control programme; 2008.
9. WHO. *Preventing HIV and unintended pregnancies: Strategic Framework 2011-2015.*WHO; 2011.
10. CDC, WHO. *Methods for surveillance and monitoring of congenital syphilis elimination within existing systems*. Geneva, Switzerland. Initiative for the global elimination of congenital syphilis; 2011.
11. National STD/AIDS control programme, Sri Lanka *Guidelines for the Management of Maternal Syphilis and Congenital Syphilis*. 1st ed. National STD/AIDS control programme; 2011.
12. WHO. *Regional strategy for the elimination of congenital syphilis.* Regional office for South East Asia. WHO; 2009.
13. Strategic Information Management Unit, National STD/AIDS control programme. *Annual Report 2013*. 1st ed. Sri Lanka. National STD/AIDS control programme, Ministry of Health Sri Lanka; 2013
14. National STD/AIDS control programme. *National HIV/AIDS Policy: Sri Lanka*. 1st ed. Sri Lanka. National STD/AIDS control programme, Ministry of Health Sri Lanka; 2012.
15. World Health Organization, Global guidance on Criteria and processes for validation: Elimination of mother to child transmission of HIV and syphilis, WHO, Geneva
16. WHO, Investment case for eliminating mother to child transmission of syphilis, Inititative for the global elimination of congenital syphilis, , Geneva 2012
17. WHO, Guideline on syphilis screening and treatment for pregnant women, WHO, Geneva 2017
18. National STD AIDS Control Programme, Annual report 2017; 2018
19. National STD AIDS Control Programme, Guidelines on Management of Pregnant women with syphilis; second edition; 2016
20. National STD AIDS Control Programme, Guidelines for management of pregnant women with HIV infection; 3rd edition; 2016

12. Annexures

දුරකථන) 0112669192 , 0112675011
தொலைபேசி) 0112698507 , 0112694033
Telephone) 0112675449 , 0112675280

ෆැක්ස්) 0112693866
பெக்ஸ்) 0112693869
Fax)0112692913

විද්‍යුත් තැපෑල)postmaster@health.gov.lk
மின்னஞ்சல் முகவரி)
e-mail)

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

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

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

ඔබේ අංකය)
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

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

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.

දුරකථන) 0112669192 , 0112675011
தொலைபேசி) 0112698507 , 0112694033
Telephone) 0112675449 , 0112675280

ෆැක්ස්) 0112693866
பெக்ஸ்) 0112693869
Fax)0112692913

විද්‍යුත් තැපෑල)postmaster@health.gov.lk
மின்னஞ்சல் முகவரி)
e-mail)

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

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

මගේඅංකය)DDG/(PHS-1)/NSACP/201
எனது இல)
My No.)

ඔබේඅංකය)
உமது இல)
Your No.)

දිනය)2016.10. 27
திகதி)
Date)

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

පොදු චක්‍රලේඛ අංක: 01-59 /2016

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

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

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

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

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

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

(අ) රාජ්‍ය අංශය

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

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

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

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

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

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

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

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

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

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

(ආ) පුද්ගලික අංශය

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

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

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

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

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

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

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

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

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

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

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

පිටපත්:-

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

දුරකථන) 0112669192 , 0112675011
தொலைபேசி) 0112698507 , 0112694033
Telephone) 0112675449 , 0112675280

ෆැක්ස්) 0112693866
பெக்ஸ்) 0112693869
Fax)0112692913

විද්‍යුත් තැපෑල)postmaster@health.gov.lk
மின்னஞ்சல் முகவரி)
e-mail)

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

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

මගේ අංකය)
எனது இல)DDG/(PHS-1)/NSACP/201/
My No.)

ඔබේ අංකය)
உமது இல)
Your No. :)

දිනය)
திகதி) 2016.10. 27
Date)

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

பொது சுற்றறிக்கை இல:- 01 -59 /2016

அனைத்து மாகாண/பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்கள்,
அனைத்து போதனா வைத்தியசாலைகள் பணிப்பாளர்கள்,
அனைத்து விசேட செயற் திட்டங்களின் தலைவர்கள்,
அனைத்து நிறுவனங்களின் தலைவர்கள்,
அனைத்து மகப்பேற்று வைத்திய நிபுணர்கள்,

இலங்கையில் தாயிலிருந்து மகவுக்கான சிபிலிஸ் மற்றும் எச்.ஐ.வி தொற்றினை முற்றாக ஒழிப்பதற்கான செயற்திட்டம் (EMTCT of Syphilis and HIV)

2017ஆம் ஆண்டின் முடிவில், தாயிலிருந்து மகவுக்கான பிறப்பு மூலமான சிபிலிஸ் மற்றும் எச்.ஐ.வி தொற்றினை முற்றாக ஒழிப்பதற்கு ஏதான நாடாக இலங்கை அடையாளம் காணப்பட்டுள்ளது.

2. இந்த முற்றுமுழுதான நீக்குதல் நிலையை அடைவதற்கு, நாடளாவிய அனைத்து கர்ப்பிணிகளுக்குமான சிபிலிஸ் மற்றும் எச்.ஐ.வி பரிசோதனைகள் பயனுள்ள வகையில் முன்னெடுக்கப்படுதல் வேண்டும். இலங்கையில் 2015 ஆம் ஆண்டின் முடிவில் கர்ப்பிணிகளுக்கான சிபிலிஸ் பரிசோதனைகள் கிட்டத்தட்ட நாடளாவிய அளவில் (98%) மேற்கொள்ளப்பட்டுள்ளது.

3. பல்வேறு ஆலோசனைத் தொடர்களின் பின்னரான முடிவுகளின்படி, கர்ப்பிணிகளுக்கான எச்.ஐ.வி பரிசோதனைக்கான கொள்கைத் தீர்மானம், தற்போது நடைமுறையிலிருக்கும் சிபிலிஸ் பரிசோதனைகளுடன் ஒன்றிணைக்கப்படல் அவசியம் என்ற முடிவினை சுகாதார அமைச்சு எடுத்துள்ளது. 2013 ஆம் ஆண்டிலிருந்து அதிகரிக்கப்பட்டதன்படி, கர்ப்பிணிகளுக்கான எச்.ஐ.வி பரிசோதனைகள் 2012 ஆம் ஆண்டில் 5.6% இலிருந்து 2015 ஆம் ஆண்டில் 71.2% ஆக அதிகரிக்கப்பட்டுள்ளது. இலங்கை 2016 ஆம் ஆண்டின் முடிவில் இந்த முற்றுமுழுதான நீக்குதல் நிலையை அடைவதற்கு எச்.ஐ.வி பரிசோதனையின் முழு இலக்கினை 95 சதவீதமாக அதிகரிக்க வேண்டியுள்ளது.

1

4. தாயிலிருந்து மகவுக்கான சிபிலிஸ் மற்றும் எச்.ஐ.வி. தொற்றினை முற்றாக நீக்குவதற்கான திட்டத்தினை நடைமுறைப்படுத்துவதற்காக சுகாதார அமைச்சு, பொது மற்றும் தனியார் சேவையிலுள்ள மகப்பேற்று வைத்திய நிபுணர்களின் அர்ப்பணிப்புடனான ஒத்துழைப்பை நாடுகின்றது. கீழே தரப்பட்டுள்ள வழிகாட்டுதலுக்கு அமைவாக, உங்களது நிறுவனத்திலும் கர்ப்பிணிகளுக்கான கர்ப்பகால சிபிலிஸ் மற்றும் எச்.ஐ.வி. தொற்றினைக் கண்டறிவதற்கான பரிசோதனைகளை அதிகரிப்பதற்காக நடவடிக்கைகளை மேற்க்கொள்ள வேண்டியது அவசியம் ஆகும்.

(அ) <u>பொதுத்துறை</u>

i. சகல கர்ப்பிணித் தாய்மார்களும் 12 கிழமைகளுக்கு முன்னரான கர்ப்பகாலத்தில் (<12 weeks of POA) சிபிலிஸ் மற்றும் எச்.ஐ.விக்கான பரிசோதனைகளுக்கு உட்படுத்தப்படல் வேண்டும். (முன்னுரிமையாக முதலாவது வருகையின்போது)

ii. கற்பகால மருத்துவ கிளினிக்கில் (MOH Clinics, ANC Clinics) இருந்து சிபிலிஸ் மற்றும் எச்.ஐ.வி. பரிசோதனைக்கான 5 cc குருதி மாதிரிகள், ஒரு வெற்றிடமாக்கிய குழாயினுள் (vacutainer tube) சேகரிக்கப்பட்டு, பாலியல் நோய் சிகிச்சை நிலையத்திற்கு (STD Clinics) அனுப்பப்படுதல் வேண்டும். பரிசோதனைக்கான குருதியை எடுத்துச் செல்வதற்கான வழிமுறைகளை உங்கள் பிராந்திய சுகாதார வைத்திய சேவைகள் பணிப்பாளர், தாய் சேய்நல சுகாதார வைத்திய அதிகாரி, பாலியல் நோய் சுகாதார வைத்திய அதிகாரி, மற்றும் சுகாதார வைத்திய அதிகாரி ஆகியோருடன் கலந்து ஆலோசித்து அதன்படி பின்பற்றப்பட வேண்டியது அவசியமாகும்.

iii. அடுத்தடுத்த வருகையின் போது, சிபிலிஸ் மற்றும் எச்.ஐ.வி க்கான பரிசோதனை முடிவுகளைப் பார்வையிடவும். இந்த பரிசோதனை முடிவுகளை கற்பகால அறிக்கையில் (ANC record) தகுந்த முறையில் குறிப்பிடவும்.

iv. கற்பகால மருத்துவ சேவை கிளினிக்கிலிருந்து (ANC Clinics), பாலியல் நோய் சேவை நிலையங்களுக்கு (STD Clinics) எடுத்துச் செல்லப்படும் குருதியினை சிபிலிஸ் மற்றும் எச்.ஐ.வி. தொற்றினைக் கண்டறிவதற்கான பரிசோதனைகளை மேற்கொள்வதுடன், அவ் அறிக்கைகள் தொடர்புடைய அதிகாரிகளுக்கு அனுப்பப்படல் வேண்டும்.

v. சிபிலிஸ் மற்றும் எச்.ஐ.வி. தொற்று கண்டறியப்படின் அவ்வறிக்கை தொடர்பான தகவல்கள் வைத்திய அதிகாரி, சுகாதாரமருத்துவ அதிகாரி அல்லது மகப்பேற்று வைத்திய நிபுணருக்கு அறிவிக்கப்படுவதுடன், இத்தகவல்களின் இரகசியத்தன்மை பேணப்படுவதற்கான நடைமுறைகள் கண்டிப்பாகப் பின்பற்றப்படுதல் வேண்டும்.

vi. தொற்றுள்ளவர் எனக் கண்டறியப்பட்ட சகல கர்ப்பிணித் தாய்மார்களும் மேலதிக சிகிச்சைக்காக பாலியல் நோய் சிகிச்சை நிலையங்களுக்கு அனுப்பப்படுதல் அவசியம்.

vii. கர்ப்பிணித்தாய் ஒருவர் கர்ப்பகாலத்தில் பரீட்சிக்கப்படாமல் இருந்தால், மகப் பேற்றுக்காலத்தில் மருத்துவமனையில் இருந்து விடுவிக்கப்படுவதற்கு முன்னர் சிபிலிஸ் மற்றும் எச்.ஐ.வி. க்கான பரிசோதனைகள் மேற்கொள்ளப்படுதல் வேண்டும்.

viii. சிபிலிஸ் அல்லது எச்.ஐ.வி. தொற்றுள்ள சகல கர்ப்பிணித் தாய்மார்களுக்கும், களங்கம் மற்றும் பாகுபாடு இன்றிய, நிறுவன ரீதியான பராமரிப்பு உள்ளடங்கலாக தகுந்த சேவைகள் வழங்கப்படல் வேண்டும்.

ix. தாயிலிருந்து மகவுக்கான சிபிலிஸ் மற்றும் எச்.ஐ.வி. தொற்றினை முற்றாக நீக்குவதற்கான திட்டத்தினை மாவட்ட அளவில் ஆறுமாதங்களுக்கு ஒரு முறை, பாலியல் நோய் சுகாதாரமையம், சுகாதாரவைத்திய அதிகாரி காரியாலயம், பிராந்திய சுகாதார சேவைகள் பணிப்பாளர் காரியாலயம், தாய்சேய் நல சுகாதார நிலையம் சார்ந்த ஊழியர்கள் மற்றும் மகப்பேற்று வைத்திய நிபுணர் ஆகியோர் பங்குபற்றிக் கலந்து ஆலோசித்து மீளாய்வுக்கு உட்படுத்தல் வேண்டும்.

x. ஆரம்ப கற்பகாலத்தில் VDRL மற்றும் எச்.ஐ.வி.க்கான பரிசோதனைகள் செய்யப்படாதிருப்பின், கருக்கலைதலுக்கு உட்பட்ட மற்றும் சிசு இறந்து பிறத்தல் மற்றும் பாதகமான கர்ப்ப விளைவுகளை சந்தித்த பெண்களும் மேற்குறிப்பிட்ட பரிசோதனைகளுக்கு உட்பட வேண்டிய தேவை உள்ளது.

(ஆ) <u>தனியார்துறை</u>

i. சகல கர்ப்பிணித் தாய்மார்களும் 12 கிழமைகளுக்கு முன்னரான கர்ப்பகாலத்தில் (<12 weeks of POA), சிபிலிஸ் மற்றும் எச்.ஐ.விக்கான பரிசோதனைகளுக்கு உட்படுத்தப்படல் வேண்டும். (முன்னுரிமையாக முதலாவது வருகையின்போது).

ii. சிபிலிஸ் மற்றும் எச்.ஐ.வி.க்கான பரிசோதனைகள் அங்கீகாரம் பெற்ற மற்றும் தரநிர்ணயத்தைப் பேணும் ஆய்வகங்களில் மேற்கொள்ளப்படுதல் வேண்டும்.

iii. சிபிலிஸ் மற்றும் எச்.ஐ.வி.க்கான பரிசோதனை விபரங்கள் தகுந்த முறையில் கற்பகால மருத்துவப் பதிவேட்டில் பதியப்படல் வேண்டும்.

iv. சிபிலிஸ் அல்லது எச்.ஐ.வி. தொற்றுள்ள கர்ப்பிணிகள், பாலியல் நோய் சுகாதார மையத்திற்கு (STD Clinics) அனுப்பப்பட்டு, தேசிய வழிகாட்டிக்கமைய பலியல் சுகாதார வைத்திய நிபுணரின் ஆலோசனையின்படி சிகிச்சை மற்றும் பராமரிப்பிற்க்கு உட்படுத்தப்படுதல் வேண்டும்.

v. சிபிலிஸ் அல்லது எச்.ஐ.வி. தொற்றுள்ள சகல கர்ப்பிணித் தாய்மார்களுக்கும், களங்கம் மற்றும் பாகுபாடு இன்றிய நிறுவன ரீதியான பராமரிப்பு சேவைகள் உட்பட தகுந்த சேவைகள் வழங்கப்படல் வேண்டும்.

vi. சிபிலிஸ் அல்லது எச்.ஐ.வி. தொற்றுள்ள கர்ப்பிணித் தாய்மார்களின் தகவல்கள் தேசிய பாலியல் நோய் மற்றும் எய்ட்ஸ் கட்டுப்பட்டு திட்டத்திற்கு (NSACP), தகுந்த முறையில் தெரிவிக்கப்படல் வேண்டும்.

5. இலங்கையின் தேசிய எச்.ஐ.வி. கொள்கைக்கமைய, "எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்கள், களங்கம் மற்றும் பாகுபாடு இன்றிய நிறுவன ரீதியான பராமரிப்பு சேவைகளைப் பெற்றுக் கொள்வதற்கான உரிமையை இலங்கை அரசாங்கம் ஏற்றுக் கொள்கின்றது. எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்களுக்குத் தேவையான மனித நிர்ப்பீடன எதிர்ப்பு வைரசுக்கான மருந்துவகைகளும், சந்தர்ப்பவாதத் தொற்று நோய்களுக்கான சிகிச்சையும் தேசிய வழிகாட்டிக்கமையவும், நடைமுறையிலுள்ள சுகாதார கொள்கையின்படியும், அரசினால் வழங்கப்படும்." (3.8 பக்கம் 22)

6. மேலும், 2016.03.14 அன்று SC.FR.No.77/2016 க்கு அமைய வழங்கப்பட்ட தீர்ப்பின் பிரகாரம் "எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்களின் மனித உரிமைகள் மேம்படுத்தப்பட்டு, அவை பாதுகாப்படுவதுடன் அவற்றை மதிக்கத் தகுந்த நடைமுறைகளை செயற்படுத்துவதன் மூலம் அவர்கள் வேறுபடுத்தப்படுவதனை ஒழிப்பதற்கான நடவடிக்கைகள் மேற்கொள்ளப்படுமென அரசு உத்தரவாதமளிக்க வேண்டும் என்பதை நீதிமன்றமும் பதிவேட்டில் பதிவு செய்ய விரும்புகின்றது".(பக்கம் 4)

7. கர்ப்பிணித் தாய்மார்களுக்கான வெற்றிகரமான மகப்பேற்று வெளிக்கொணர்வுக்கும் அத்துடன் அவர்கள் எல்லோருக்குமான சிபிலிஸ் மற்றும் எச்.ஐ.வி.க்கான பரிசோதனையை வழங்குவதற்குமான, இலங்கை அரசின் விசாலமான, கற்பகால மருத்துவ சேவைத் தொகுப்பிற்கான கொள்கையை நான் மீண்டும் வலியுறுத்துகின்றேன். உங்களது ஒத்துழைப்பு மிகவும் வேண்டப்படுகிறது.

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

வைத்தியர்.பி.ஜி.மஹிபால
சுகாதார சேவைகள் பணிப்பாளர் நாயகம்

பிரதிகள்

i. **பணிப்பாளர்**, தனியார் சுகாதாரத்துறை, சுகாதார வைத்திய அதிகாரி
ii. தலைவர், இலங்கை மகப்பேற்று நிபுணர் சங்கம்
iii. தலைவர், சுயாதீன மருத்துவ உத்தியோகத்தர்கள் சங்கம்
iv. தலைவர், இலங்கை மருத்துவர்கள் கல்லூரி
v. தலைவர், இலங்கை பொது மருத்துவ சங்கம்

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.

Instructions on sample collection and handling for HIV and VDRL in antenatal clinics

Introduction

The quality of results of blood testing is dependent on the sample quality. Therefore, it is very necessary to ensure that blood specimens received to the laboratories of National STD/AIDS Control Programme are of good quality. Good quality samples lead to accurate reliable results while the poor-quality samples may give rise to erroneous results.

Objectives of this document

To make the staff aware about

Good quality sample emphasizing the facts required for good quality.

Sample collection

Sample transport

Sample storage

Bio safety and infection control measures in collecting and handling samples

Samples collection

Equipment needed	Procedure
Preparation -Hand hygiene materials (soap and water or alcohol rub) -Well-fitting gloves -Tourniquet	Select an appropriate quite clean and well-lit area Let the mother sit comfortably. Perform hand hygiene. Check that the request form matches the mother's identity and identification number. Verbally inform and obtain consent from the mother to collect blood. Apply the tourniquet above the site to be punctured. Put on well-fitting gloves. Disinfect the collection site with a 70% alcohol swab for 30 seconds and allow to dry completely.
Blood drawing when Single-use disposable needles, syringes and plain tubes are used	Puncture the skin 3–5 mm away from the vein at 300angle. Gently draw the syringe plunger back. Once the blood flow begins, the tourniquet should be loosened. Gently draw the syringe plunger back until the syringe is filled with the required volume of blood. Required volume is 4 ml blood in a single tube (2 ml per each test)
when Plastic needle holder (Vacutainer barrel) vacutainer needles and	Insert the specimen tube into the plastic needle holder (vacutainer barrel) Puncture the skin 3-5mm away from the vein 300 angle. Once the blood flow begins, the tourniquet should be loosened.

plain vacutainer tubes are used	After the tube is filled with required volume, remove the tourniquet.
After blood drawing -Gauze /cotton -Sharp bin -Tube rack	Apply a cotton swab/dry gauze to the site and slowly withdraw the needle. Inject the blood sample extremely slowly into the tube minimizing the pressure and velocity. Discard the needle and syringe together into the sharp bin. Do not remove or recap the needle. Apply digital pressure to puncture site for 2-3 minutes.

Sample transport

Keep the samples in the tube rack for 30 mins for clot formation

Transport samples to the laboratory as soon as possible.

Use a leak proof container with upright tube rack inside.

Do not keep the request forms in contact with samples.

Sample storage

Samples should be refrigerated at 4°C after collection. Send the sample to the laboratory within 24 hrs. If not send them at least within 3 days and take necessary measures to minimize the storage time.

<u>Factors influencing a good outcome of laboratory results during collection and transport include,</u>

Carrying out phlebotomy by properly trained staff in phlebotomy.

Not allowing alcohol to remain in the puncture site as it may cause haemolysis.

Use of the correct gauge of hypodermic needle (preferably 21G) to prevent haemolysis.

Drawing blood slowly and steadily.

- Avoiding vigorous suction on the tube which causes haemolysis.
- Injecting the blood sample extremely slowly into the tube minimizing the pressure and velocity to prevent haemolysis.
- Labeling immediately all specimen tubes by the collector and ensure they are accurately labelled.
- Keeping the samples in room temperature and allowing to clot before refrigerating.
- Transporting samples to the laboratory as soon as possible. (The longer you keep samples in the refrigerator, the chance of haemolysis and decomposition will increase)

An incident reporting system

A system is required for reporting all adverse events. A log book or register should be established with accurate details of the incident, possible causes and management of adverse events.

National STD/HIV Reference Laboratory
No.29, De Saram Place, Colombo 10, Sri Lanka
Tel: 0112667163, Tel/Fax: 0115336873

NSACP/10/ANC/2

REQUEST FOR SYPHILIS / HIV TESTING IN ANTENATAL MOTHERS

Institution / Clinic ……

MOH Area ……

Date of Sample Collection ……

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

…… …… ……
Name of Collecting Officer Designation Signature

…… …… ……
Name of Medical Officer Designation Signature

REPORT (Laboratory use only)
Date/Time of Receipt of Samples :…… ……am/pm
MLT: …… Consultant Microbiologist: ……
Date: …… Date :……..

EMTCT Congenital Syphilis: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health CS_V 11.10.2018

Name of the STD clinic:_____ Mother's file number :_____

Baby's file number :_____

Completed by (name & designation): _____ Date :_____

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

A. 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. Past obstetric history (parity, miscarriages, still births etc.			
7. Date and Stage of syphilis diagnosis			
Details of the current pregnancy			
8. LRMP		9. POA of pregnancy at registration	
10. POA at VDRL testing		11. POA at registering for EMTCT services	
12. VDRL result (initial)		13. VDRL result (closest to delivery)	
14. TPPA result		15. Results of additional syphilis tests	
16. Treatment (date /medication/dose/route):			
17. POA at treatment (weeks)		18. Gestational age at delivery (weeks)	
19. Pregnancy outcome		20. Mother's HIV test result	
Details of the sexual partner/s			
21. File number/s of the partner/s			
22. VDRL/TPPA and syphilis stage of the partner/s			
23. Partner/s' treated and date:	1. Yes 2. No	Date:	
B. Details of the baby			
24. Date of birth		25. Facility/Place of birth	
26. Mode of delivery		27. Birth weight	
28. Date of first VDRL		29. Titre of first VDRL	
30. Management of the baby (prophylaxis or treatment details.)			
31. If treated as congenital syphilis, reasons for diagnosis? (clinical, inadequate/non-penicillin treatment of mother etc.)			
32. Date, type and results of additional tests (DG, IgM, CSF VDRL, X-Ray etc.)			
33. Baby's VDRL & TPPA result around 18 month		Date	
34. Baby's last available VDRL & TPPA result		Date	
35. Baby's final diagnosis		Date	
Other relevant information (Describe attempts to follow-up, if available):			

EMTCT HIV: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health HIV_V 11.10.2018

Name of the STD clinic:_____ Mother's file number :_____

Baby's file number :_____

Completed by (name & designation): _____ Date :_____

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

A. Details of the pregnant woman with HIV			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc.)			
6. Past obstetric history (parity, miscarriages, still births etc.			
7. Date of HIV confirmation			
Details of the current pregnancy			
8. LRMP		9. EDD	
10. POA of pregnancy at registration		11. POA at registering for EMTCT services	
12. 1st CD4 count during this pregnancy & date		13. 1st VL during this pregnancy & date	
14. Other relevant diagnosis (TB/Syphilis/other)		15. Date of ART initiation	
16. ART regimen during this pregnancy			
17. Adherence (>95%, 80-95%, <80%)		18. CD4 count at third trimester	
19. Viral load closest to 36 weeks of POA		20. Number of ANC visits	
21. Post-partum family planning method			
Details of the sexual partner/s			
22. Partners HIV status		23. If positive file no.	
24. Partners ART regimen			
B. Details of the baby			
25. Date of birth		26. Facility/Place of birth	
27. Mode of delivery		28. Gestational age at delivery	
29. Baby's birth weight		30. Infant feeding (exclusive formula/ breast feeding)	
31. ARV prophylaxis for baby (Type/dose/duration)			
32. HIV PCR at birth (result/not done)			
33. 1st DNA PCR of the baby		Date	
34. 2nd DNA PCR of the baby		Date	
35. Baby's HIV ELISA around 18 months		Date	
36. Baby's final diagnosis			

Other relevant information (Describe attempts to follow-up, adherence if available):

Blue - Primi
Red - At Risk

ගර්භණී සටහන් පත
கர்ப்பவதியின் பதிவேடு
PREGNANCY RECORD

සෞ. 512 ඒ
சு 512 ஏ
H 512 A

Revised 2016

රුධිර කනය இரத்தப் பிரிவு Blood Group		ශරීර ස්කන්ධ දර්ශකය உடற் திணிவுச் சுட்டி BMI		උස (සෙ.මී) உயரம் (செ.மீ) Height (cm)		අසාත්මිකතා ஒவ்வாமை Allergies	

කරුණාකර මෙම කාඩ්පත සේවාවන් ලබාගැනීම සඳහා සායනයට/රෝහලට යනවිට රැගෙන යන්න

இவ் அட்டையை கர்ப்பவதிகள் சிகிச்சை நிலையத்திற்கு அல்லது வைத்தியசாலைக்குப் போகும் போது எடுத்துச் செல்லவேண்டும்.

Please take this card to clinic / hospital when seeking services

මවගේ නම
தாயின் முழுப் பெயர்.....
Name of the mother

වයස
வயது .....
Age

සෞ. වෛ. නි. කොට්ඨාශය
சு. வை. அ. பிரிவு .....
MOH area

පවුල් සෞඛ්‍ය සේවා නිලධාරි කොට්ඨාශය
கு. சு. உ. பிரிவு .....
PHM area

ක්ෂේත්‍ර සායනයේ නම
பிணியாய்வு நிலையத்தின் பெயர் .....
Name of the Field Clinic

ග්‍රාම නිලධාරි කොට්ඨාශය
கிராம அலுவலர் பிரிவு .....
Grama Niladari Division

රෝහල් සායනයේ නම
பிணியாய்வு நிலையத்தின் பெயர் .....
Name of the Hospital Clinic

ප්‍රසව හා කාර්වේද විශේෂඥ වෛද්‍යවරයාගේ නම
பெண்நோயியல் மற்றும் பிரசவ.....
வைத்திய நிபுணரின் பெயர
Name of the Consultant Obstetrician

ඇඳුනාගත් පූර්ව ප්‍රසව අවදානම් තත්ව / රෝගී තත්ව அடையாளம் காணப்பட்ட அபாய நிலைமைகள் / பிணிகள் **Identified antenatal risk conditions & morbidities**

ලියාපදිංචි අංකය හා දිනය
பதிவு இலக்கமும் திகதியும்
Registration No and date

සෞඛ්‍යසේවා පවුල් ලේඛනය தகுதி வாய்ந்த குடும்ப பதிவேடு Eligible Family Register	ගර්භණී මවගේ ලේඛනය கர்ப்பவதிகள் பதிவேடு Pregnant mother's Register

වර්තමාන ගර්භ ඉතිහාසය
தற்போதைய கர்ப்பகால சரிதை
Present obstetric History

කීවෙනි ගර්භයද எத்தனையாவது கர்ப்பம் Gravidity	G	P	C

බාලම ළමයාගේ වයස கடைசி பிள்ளையின் வயது Age of Youngest child	
අන්තිමට ක්‍රමවත්ව ඔසප් වූ දිනය கிரமமாக கடைசி மாதவிடாய் ஏற்பட்ட திகதி /LRMP	DD MM YYYY
බලාපොරොත්තු වූ ප්‍රසව දිනය பிரசவத்தை எதிர்பார்க்கும் திகதி /EDD (සති 40 සම්පූර්ණ වන දිනය) (40 கிழமைகள் நிறைவாகும் நாள்) (40 Week Completed)	DD MM YYYY
US නිවැරදි කළ බලාපොරොත්තු ප්‍රසව දිනය ஸ்காளினால் திருத்தப்பட்ட பிரசவத்தை எதிர்பார்க்கும் திகதி US corrected EDD (To be filled by VOG/MO).	DD MM YYYY
POA at dating scan	Signature
භ්‍රෑණ චලන පළමුවෙන් දැණුනු දිනය பிள்ளைத் துடிப்பு முதன்முதலில் ஏற்பட்ட திகதி/Date of Quickening	
ලියාපදිංචි කරන විට ගර්භයට සති ගණන பதிவு செய்தபோது கர்ப்பகாலம் வாரங்களில் POA at registration	

ලේ ඥාතීන් අතර විවාහය நெருங்கிய உறவு முறைத் திருமணம் Consanguinity	
රුබෙල්ලා ප්‍රතිශක්තීකරණය ரூபெல்லா நிர்பீடனம் Rubella Immunization	
පෙර ගර්භ සුව පිරික්සුම කළේද යන වග கர்ப்பம் அடையும் முன்பு திடநலப் பரிசீலனை Pre-pregancy screening done	
ගර්භණී බව දැනගැනීමට පෙර ෆෝලික් අම්ලය ගැනීම ආරම්භ කළේද යන වග கருத்தரிக்கும் முன்னதாக போலிக்கமில மாத்திரை பயன்பாடு Preconceptional Folic acid	
ඖදසරුභාවය පිළිබඳ ඉතිහාසය கர்ப்பம் தரிப்பதில் தாமதம் ஏற்பட்ட சரிதை History of subfertility	
සැලසුම් කල ගර්භනීභාවයක්ද යනවග திட்டமிடப்பட்ட கர்ப்பம் Planned Pregnancy or not	
අවසාන වරට භාවිතා කළ පවුල් සැලසුම් ක්‍රමය கடைசியாக பாவித்த குடும்ப திட்டமிடல் முறை Family Planning method last used	

පෞද්ගලික තොරතුරු /பிரத்தியேக தகவல் / Personal Information

	භාර්යාව மனைவி/Wife	ස්වාමිපුරුෂයා கணவன்/Husband
වයස/வயது Age		
අධ්‍යාපන මට්ටම கல்வித்தகமை Highest Level of Education		
රැකියාව தொழில் Occupation		

පවුලේ රෝග ඉතිහාසය / குடும்ப சரிதை/Family History

රෝග තත්වය /பிணிகள்/Condition	
දියවැඩියාව நீரிழிவு Diabetes Mellitus	
අධි රුධිර පීඩනය உயர் குருதி அமுக்கம் Hypertension	
රුධිරය ආශ්‍රිත රෝග තත්ව குருதி சம்பந்தமான நோய்கள் Haematological diseases	
බහු දරු උපත් இரட்டை/ பல கர்ப்பகிலை Twin / Multiple Pregnancies	
වෙනත් (සඳහන් කරන්න) ஏனையவை (குறிப்பிடுக) Others (specify)	

කායික /ශල්‍ය රෝග ඉතිහාසය /மருத்துவ /சத்திர சிகிச்சை சரிதை / Medical / Surgical History

රෝග තත්වය பிணிகள்/Condition	
දියවැඩියාව/நீரிழிவு Diabetes	
අධි රුධිර පීඩනය உயர்குருதி அமுக்கம் Hypertension	
හෘද රෝග තත්ව இருதய நோய்கள் Cardiac Diseases	
වකුගඩු රෝග තත්ව சிறுநீரக நோய்கள் Renal Diseases	
අක්මා රෝග තත්ව ஈரல் நோய்கள் Hepatic Diseases	
මානසික රෝග තත්ව மன நோய்கள் Psychiatric Illnesses	

රෝග තත්වය பிணிகள்/Condition	
අපස්මාරය /வலிப்பு/Epilepsy	
පිළිකා රෝග තත්ව/புற்றுநோய்கள் Malignancies	
රුධිරය ආශ්‍රිත රෝග තත්ව குருதி சம்பந்தமான நோய்கள் Haematological diseases	
ක්ෂය රෝගය/காசநோய் Tuberculosis	
තයිරොයිඩ් ග්‍රන්ථිය ආශ්‍රිත රෝග තත්ව தைரொயிட் நோய்கள் Thyroid diseases	
ඇදුම இளைப்பு Bronchial Asthma	

රෝග තත්වය பிணிகள்/Condition	
පෙර ගැඹුරු සිර මාවත් තත්ව முன்னதாக ஆழ்நாளங்களில் குருதி உறைதல் Previous DVT	
සිසේරියන් සැත්කම හැරුණු විට කර ඇති අනෙක් සැත්කම් சிசேரியன் தவிர்ந்த வேறு சத்திர சிகிச்சைகள் Surgeries other than LSCS	
වෙනත් (සඳහන් කරන්න) ஏனையவை (குறிப்பிடுக) Other (Specify)	
සමාජීය සේත අංකය சமூக அபாய நிலை Social Z Score	

පෙර ගර්භ ඉතිහාසය / முந்திய கர்ப்பங்களில் சரிதை / Past obstetric History.

ගර්භණී භාවය கர்ப்பம் Pregnancy	පූර්ව ප්‍රසව සංකූලතා கர்ப்பகால சிக்கல்கள் Antenatal complications	ප්‍රසූතිය සිදුවූ ස්ථානය සහ ආකාරය பிரசவித்த முறையும் இடமும் Place & Mode of Delivery	ප්‍රතිඵලය பெறுபேறு Outcome	උපත් බර (ග්‍රෑම්) பிறப்பு நிறை (கி) Birth weight(g)	පසු ප්‍රසව සංකූලතා பிரசவத்திற்கு பின்பான சிக்கல்கள் Postnatal complication (Specify)	ස්ත්‍රී/පුරුෂ භාවය සහ වයස பால் மற்றும் வயது Sex and Age
G1						
G2						
G3						
G4						
G5						
G6						

සායනික සංරක්ෂණය/பிணியாய்வு நிலைய பராமரிப்பு / Clinic care

සායනයට පැමිණි දිනය/ வருகை தந்த திகதி/ Date of Visit										
ගර්භයට සති / கர்ப்ப வாரங்களின் எண்ணிக்கை / POA										
මූත්‍ර/சிறுநீர் Urine — සීනි/சீனி / Sugar										
ඇල්බියුමින්/அல்புமின் / Albumin										
සුදුමැලි බව / வெளிறல் / Pallor										
ඉදිමුම වීක්ගම් Oedema — වළලුකර / கணுக்கால் Ankle										
මුහුණ/முகம்/Facial										
රුධිර පීඩනය/இரத்த அமுக்கம் /BP 160										
150										
140										
130										
120										
110										
100										
90										
80										
70										
60										
50										
ගුඩිනයේ උස කරුப்பையின் உயரம் Fundal Height										
හුණයේ ලීලාව சிசு அமைந்திருக்கும் பாங்கு Foetal Lie										
හුණයේ පිහිටීම சிசுவின் அமைந்திருக்கும் பாங்கு Presentation										
ප්‍රමුඛ කොටස ශ්‍රෝණි කුහරය තුළ පිහිටීම வெளிப்படும் பகுதி இடுப்புக்குழியில் இறங்கியிருக்கும் அளவு Engagement of the presenting part										
හුණ චලන சிசுவின் அசைவு FM / හෘද ශබ්ද சிசுவின் இதயத்துடிப்பு FHS										
යකඩ இரும்பு Iron / ෆෝලේට් போலேட் Folate										
කැල්සියම් கல்சியம் Calcium / විටමින් සී விட்டமின் C Vitamin C										
පෝෂක අතිරේක குறை நிரப்பு உணவுகள் Food Supplementation										
පරීක්ෂා කරන ලද නිලධාරියාගේ අත්සන பரிசோதித்தஉத்தியோகத்தரின் கையொப்பம் Signature of the officer examined										
තිල තාමය / பதவி / Designation										

හෘද පරීක්ෂාව இருதய பரிசோதனை Auscultation		මානසික සෞඛ්‍ය පරීක්ෂාව உளஆரோக்கியம் Mental Health
T1		
T2		
T3		

ශ්වසන පද්ධතිය சுவாசத்தொகுதி Respiratory System	
පියයුරු පරීක්ෂාව மார்பகப் பரிசோதனை Breast Examination	

දන්ත සංරක්ෂණය/பற்சுகாதாரம் Dental Care

යොමුකළ දිනය தவணைப் வைக்கப்பட்ட திகதி Referred Date	පරීක්ෂා කළ දිනය பரிசீலிக்கப்பட்ட திகதி Date of examination
ප්‍රතිකාර/சிகிச்சை / Treatment	

පරීක්ෂණ/ பரிசோதனைகள் Investigations

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

වෙනත් පරීක්ෂණ ஏனைய பரிசோதனைகள் Other Investigations	
පණු ප්‍රතිකාර பூச்சித் தடுப்பு மருந்துகள் Antihelminthic Drugs	
හුණ චලන සටහන්පත ලබා දුන් දිනය குழந்தை நகர்வுப் பட்டியல் வழங்கிய நாள் Date of issuing kick count chart	

උපදංශය සඳහා පූර්ව පරීක්ෂාව/ சிபிலிசுக்கான முற்பரிசோதனை / Syphilis Screening

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

HIV පූර්ව පරීක්ෂාව සඳහා රුධිර සාම්පලය ලබාගත් දිනය HIV சோதனைக்காக குருதி மாதிரி எடுக்கப்பட்ட திகதி Date of taking blood sample for the HIV screening	
ප්‍රතිඵලය මවට දැනුම්දුන් දිනය பெறுபேற்றை தாய்க்கு அறிவித்த திகதி Date of Result Infomed to Mother	

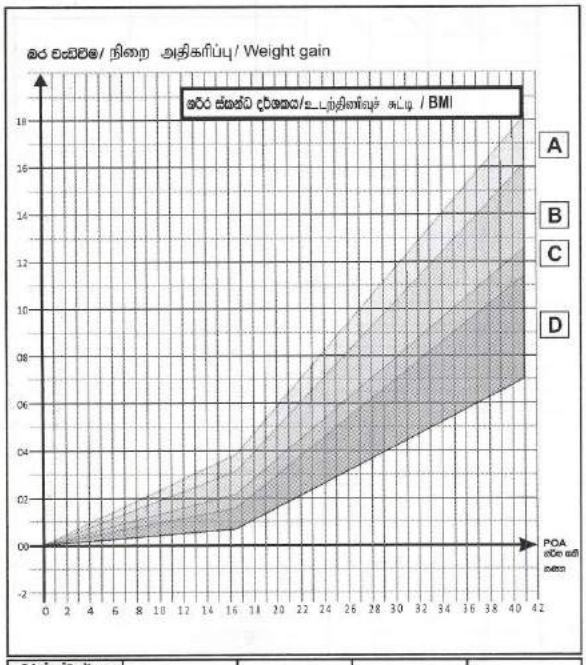
පිටගැස්ම ධූලකාහ ප්‍රතිශක්තිකරණය /ஏற்பு நோய் தடுப்பு மருந்து வழங்குதல்/ Tetanus Toxoid Immunization

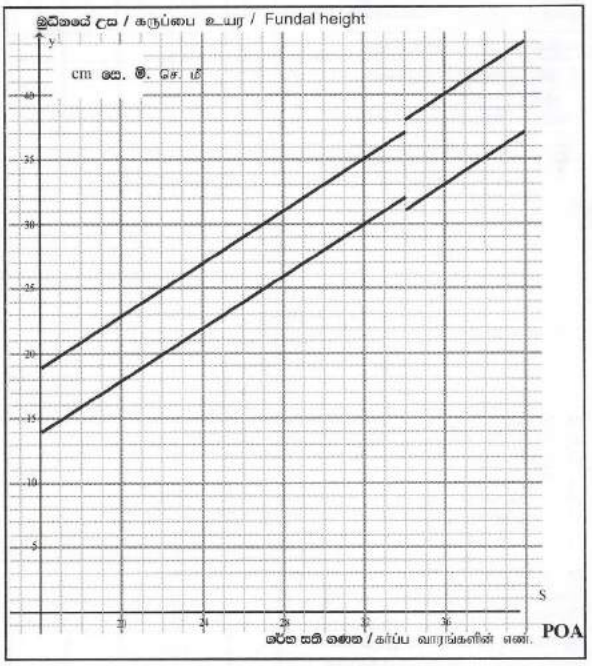
මාත්‍රාව/ அளவு / Dose	1	2	3	4	5	NE
දිනය / திகதி / Date						
බාච් අංකය குழு இலக்கம் Batch No.						

බර වැඩිවීමේ සටහන/ உடல் நிறை அதிகரிப்பிற்கான அட்டவணை/ Weight Gain Chart

ගර්භ සති ගණන/கர்ப்பவாரங்களின் எண்ணிக்கை / POA									
බර/நிறை/ Weight									
බරෙහි වැඩිවීම/ நிறை அதிகரிப்பு Weight Gain									

ගුඩියේ උස සටහන
கருப்பை உயர அட்டவணை / SFH Chart





ශරීර ස්කන්ධ දර්ශකය உடற்திணிவுச் சுட்டி BMI	< 18.5	18.5 - 24.9	25 -29.9	> 30
කලාපය வலயம் Zone	A & B	B & C	C & D	Below D

ප්‍රසූත සහායිකාව පිළිබඳ දැනුවත් කිරීම மகப்பேற்று உதவியாளரை அறிவுறுத்தல் Companion of Choice at Labour Discussed	

උපත සහ හදිසි අවස්ථාවන් සඳහා සූදානම්වීමේ සැළැස්ම பிரசவம் மற்றும் அவசரநிலைமைகளுக்கு தயாராகும் திட்டம் Birth and emergency Preparedness Plan	ප්‍රසූතියේදී பிரசவத்திற்கு Delivery	හදිසි අවස්ථාවකදී அவசரநிலைமையில் In an emergency
යෙමිට විලාසිතාවෙන්තු වන රෝහල பரிந்துரைக்கப்பட்ட வைத்தியசாலை / Intended Hospital		
ප්‍රවාහන ආකාරය பிரயாண ஒழுங்கு முறை / Mode of Transport		
ඒ සඳහා දළ වියදම அண்ணளவான செலவு மதிப்பீடு / Average cost		
නිවසේ සිට ඇති දුර வீட்டிலிருந்து அமைந்திருக்கும் தூரம் / Distance from Home		
ළඟා වීමට ගතවන කාලය சென்றடைவதற்கான நேரம் / Time taken to reach		

පූර්ව ප්‍රසව සැසි සඳහා පැමිණීම /கர்ப்பகால வகுப்புகளுக்கு வருகை / Attendance at antenatal classes

සැසිය / வகுப்பு Session	දිනය / திகதி Date	ස්වාමිපුරුෂය / கணவன் Husband	භාර්යාව / மனைவி Wife	වෙනත් / பிறர் Other	අත්සන/ கையொப்பம் Signature
1st T					
2nd T					
3rd T					

තොරතුරු අධ්‍යාපනය සහ සන්නිවේදනය සඳහා වූ පොත්
தகவல், கல்வி மற்றும் தொடர்பாடல் சம்பந்தமானவை / IEC Material

පූර්ව ප්‍රසව සමය පිළිබඳ පොත கர்ப்பகாலம் சம்பந்தமான புத்தகம்	
මව්කිරි දීම පිළිබඳ පොත් தாய்பாலூட்டல் சம்பந்தமான புத்தகம்	
මුල් ළමාවිය සංවර්ධනය පිළිබඳ පොත් ஆரம்ப பிள்ளைப்பருவ அபிவிருத்தி புத்தகம் பெறப்பட்டது	
පවුල් සැලසුම් ක්‍රම පිළිබඳ පත්‍රිකාව குடும்பத்திட்டமிடல் கையேடு	

පවුල් සෞඛ්‍ය සේවා නිලධාරිණිය පැමිණෙන දිනය கு. சு. சே. உ ஆல் வீட்டுத் தரிப்பு மேற்பட்ட திகதிகள்					

සායනයට පැමිණිය යුතු දිනය கு. சு. சே. உ. ஆல் வீட்டுத் தரிப்பு மேற்பட்ட திகதிகள்					

පවුල් සැලසුම් /குடும்பத்திட்டம்/ Family Planning

උපදේශනය ලබා දුන් දිනය ஆலோசனை பெற்ற தினம் Date of Counselling							
තෝරාගත් ක්‍රමය தெரிவு Chosen Method	T	PL	L	IP	N	P	C
නොගැනීම හේතුව மறுப்பதற்கான காரணம் Reason for not using a Method							
කැමැත්ත දැනුම් පත්‍රිකාව අත්සන් කළ දිනය சம்மதம் தெரிவித்த தினம் Consent form Signed Date							

යොමු කිරීම/ பரிந்துரை/ Referral

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

රෝහල් සායනික සංරක්ෂණය
வைத்தியசாலை பிணியாய்வு நிலைய பராமரிப்பு
Hospital Clinic Care

Clinic No/ Bar Code

Date							
POA							
Weight							
Urine							
Oedema							
BP							
Fundal Height							
Lie							
Presentation							
FM/FHS							
Signature							
Designation							
Date of next visit							

Heart	Lungs

Risk Factors Identified

Plan of Management

US scan

Date							
POA							
EBW							
CRL							
Gest.Sac							
BPD							
HC							
AC							
FL							
Liqour							
Placenta							
Average POA							
Any other							
Signature							
Designation							

Clinic Notes:

ප්‍රසව සහ පසුප්‍රසව සංරක්ෂණය / பிரசவம், பிரசவத்திற்கு பின்னான பாராமரிப்பு
Delivery & Postnatal Care

රෝහල வைத்தியசாலை Hospital	

හෙද නිලධාරිනිය / පවුල් සෞඛ්‍ය සේවා නිලධාරිනිය විසින් රෝහලින් මුදාහරින අවස්ථාවේදී සම්පූර්ණ කළ යුතුය.
வைத்தியசாலையிலிருந்து வெளியேறும் போது தாதிப் பணியினரினால்/ மருத்துவ மாதினால் நிரப்பப்பட வேண்டியவை
To be filled by the nursing officer or midwife at the discharge

උපත් බර பிறப்பு நிறை Birth weight		ගර්භ සති ගණන கர்ப்பவாரங்களின் எண்ணிக்கை POA		සජීව උපත් உயிருடன் பிறந்த சிசு Live Birth		මළ දරු උපත් இறந்த பிறந்த சிசு Stillbirth	
දරුවාගේ හඳුනාගත් අසාමාන්‍යතා குழந்தையில் இனங்காணப்பட்ட அசாதாரணங்கள் Abnormalities detected in baby							

ප්‍රසූතිය සිදු කළ දිනය பிரசவித்த திகதி Date of delivery		ස්ත්‍රී / பெண் / Female		රෝහලෙන් මුදාහරින විට රුධිර පීඩනය லைத்தியசாலையில் இருந்து லிலகும் போது இரத்த அழுத்தம் Blood pressure at the time of discharge	
		පුරුෂ / ஆண் / Male			
ප්‍රසූතිය සිදු කළ ආකාරය பிரசவித்த முறை Mode of delivery	සාමාන්‍ය යෝනි ප්‍රසූතිය/யோனிவழிப் பிரசவம் VD අඳු භාවිතය/போர்செப்/Forceps වැකියුම් භාවිතය/வக்யும்/Vacuum සිසේරියන් ශල්‍යකර්ම/ சிசேரியன் சிகிச்சை/ LSCS			විටමින් ඒ අධිමාත්‍රාව දුන්නේද விட்டமின் A மெகா டோஸ் கொடுக்கப்பட்டது Vit.A Megadose given	ඔව්/නැත ஆம்/இல்லை Yes/No
විටපිය කැපුම எபிஸ் வெட்டு Episiotomy		ඔව්/නැත ஆம்/இல்லை Yes/No		රුබෙල්ලා ප්‍රතිශක්තිකරණය ලබා දුන්නේද ருபெல்லா தடுப்பு மருந்து கொடுக்கப்பட்டது Rubella Immunization given	ඔව්/නැත ஆம்/இல்லை Yes/No
පසුගිය දින දෙක ඇතුලත ශරීර උෂ්ණත්වය සාමාන්‍යව පැවතියේද යන්න உடல்வெப்பநிலை 2 நாட்களுக்கு சாதாரணமாகக் காணப்படுதல் Body Temperature normal for last 2 Days		ඔව්/නැත ஆம்/இல்லை Yes/No		Anti-D එන්නත දුන්නේද Anti-D ஊசி கொடுக்கப்பட்டது Anti-D antibodies given	ඔව්/නැත ஆம்/இல்லை Yes/No
සැරහුම් ද්‍රව්‍ය සඳහා යෝනි පරීක්ෂාව සිදුකළේද යන්න ஏதும் துணித்துண்டுகள் உள்ளனவா என்பதற்கு யோனிவழி பரிசோதிக்கப்பட்டது. Vaginal examination done to check packs		ඔව්/නැත ஆம்/இல்லை Yes/No		රෝග විනිශ්චය කාඩ්පතක් දුන්නේද (අවශ්‍ය අවස්ථා වලදී) தேவை ஏற்படின் நோயறிக்கை அட்டை வழங்கப்பட்டது Diagnosis card given if indicated	ඔව්/නැත ஆம்/இல்லை Yes/No
මිනෙම මාතෘ සංකූලතාවයක් තිබුණේ නම් සඳහන් කරන්න தாயில் ஏதும் சிக்கல் எற்பட்டிருப்பின் குறிப்பிடவும் Any maternal complications. if yes Specify				ළමා සෞඛ්‍ය වර්ධන සටහන් පත සම්පූර්ණ කර මවට ලබා දුන්නේද යන්න சிறுவர் சுகாதார அறிக்கை பூர்த்தி செய்யப்பட்டு வழங்கப்பட்டுள்ளது CHDR completed and handed over	ඔව්/නැත ஆம்/இல்லை Yes/No
විටපිය කැපුම/ඉරිම/සිසේරියන් තුවාලයේ ආසාදන யோவாய் தையலில் / கிழிவில்/சிசேரியன் காயத்தில் கிருமித்தொற்று ஏற்படுதல் Epis/Tear/LSCS infection		ඔව්/නැත ஆம்/இல்லை Yes/No		අවශ්‍ය නම් ප්‍රතිකාර සටහනක් දුන්නේද යන්න தேவை ஏற்படின் மருந்து சீட்டு வழங்கப்பட்டது. Prescription given if needed	ඔව්/නැත ஆம்/இல்லை Yes/No
පවුල් සැලසුම් குடும்பத்திட்டம் Family Planning	ලබා දුන් பெற்ற தினம் Method given		T	PL	
තෝරාගත් தெரிவு Chosen method	T L IP N V C				ඉහළ පවුල් සෞඛ්‍ය සේවා නිලධාරිනියට යොමු කළේද යන්න கள சு.சு.உ. க்குப் பரிந்துரைக்கப்பட்டது. Referred to the field public health midwife ඔව්/නැත ஆம்/இல்லை Yes/No
නැතිනම් හේතුව மறுப்பதற்கான காரணம் If not, Reason					
පසු ප්‍රසව අහතුරු සංඥා පහදා දුන්නේද යන්න பிரசவத்திற்கு பின்பான ஆபத்து அறிகுறிகள் பற்றி விபரித்தல் Post partum danger signals explained	ඔව්/නැත ஆம்/இல்லை Yes/No	වෙනත්/வேறு/Any other			
මවකිරි දම ස්ථාපිත කළේද යන්න. தாய்பாலூட்டல் ஸ்தாபிக்கப்பட்டது. Breast feeding established	ඔව්/නැත ஆம்/இல்லை Yes/No	මුදාහල දිනය வெளியேறிய திகதி Date of Discharge		අත්සන கையொப்பம் Signature	

විශේෂ සටහන් / விசேட குறிப்புக்கள் / Special Notes

පසු ප්‍රසව ක්ෂේත්‍ර සංරක්ෂණය / பிரசவத்திற்கு பின்பான வெளிக்களப் பராமரிப்பு /Post Partum Field Care

හඳුනාගත් පසුප්‍රසව රෝගී තත්ව සහ ගත් පියවර/பிரசவத்தின் பிற்பாடு கண்டுபிடிக்கப்பட்ட பிணிகள் மற்றும் எடுக்கப்பட்ட நடவடிக்கைகள். Identified post partum morbidities & Actions taken

Z Score	පවුල් සෞඛ්‍ය සේවා නිලධාරිනිය නිවසට පැමිණි දිනය/ கு. சு. சே. உ. ஆல் வீட்டுத் தரிசிப்பு செய்யப்பட்ட திகதி Date of home visit by PHM							

සහල් පෝෂක ලබාදුන් දිනය/நுண்போசணைகள் விநியோகம் செய்ததிகதி/ Date of Issuing Micronutrients							

පසු ප්‍රසව සායන දිනය සහ ස්ථානය/பிரசவத்தின் பிற்பாடு பிணியாய்வு நிலையத்தைத் தரிசிப்பதற்குரிய திகதியும் /அமைந்திருக்கும் இடமும்/Date for postpartum clinic & place	

පසු ප්‍රසව සායනික සංරක්ෂණය பிரசவத்தின் பின்பான பிணியாய்வு நிலையப் பராமரிப்பு /Postnatal clinic care

දිනය/திகதி/Date .....

පියයුරු ගැටළු/ மார்பகப் பிரச்சனைகள் Breast problems		පූර්ව පරීක්ෂණ මෙවලමට අනුව මානසික තත්වය (EPDS) අසවීට්ටු මුරා මූලම් කණික්කප්පට්ට තායින් මනනිලෙ Mental status according to the screening tool (EPDS)		පවුල් සැලසුම් ක්‍රමය தெரிவு செய்யப்பட்ட குடும்பத்திட்டமிடல் முறை Family Planning	
අසාමාන්‍ය යෝනි ස්‍රාව அசாதாரணமான யோனிவழிக் கசிவு Abnormal vaginal discharge				භාවිතා කරන ක්‍රම பெற்ற தினம் Method in use	T / PL
අධික ලෙස යෝනි රුධිර වහනය யோனிவழியினூடாக மிதமிஞ்சிய குருதிப்போக்கு Excessive Vaginal bleeding		වෙනත්/ஏனையவை/Other		තෝරාගත් ක්‍රම தெரிவு Chosen	T / L / IP / N / V / C
සුදුමැලි බව/வெளிறல்/Pallor		මවගේ හඳුනාගත් ගැටළු සහ ගත් පියවර அடையாளம் காணப்பட்ட தாயின் பிரச்சனைகளும் எடுக்கப்பட்ட நடவடிக்கைகளும் Identified problems in mother and actions taken		නැතිනම් භාවිතා නොවන හේතුව மறுப்பதற்கான காரணம் If not Reason	
කාමලාව/மஞ்சள் காமாலை/Icterus				පවුල් සැලසුම් සායනය/குடும்பத்திட்டமிடல் பிணியாய்வு நிலையம்/Family planning clinic	
ඉදිමුම් (අඟුලකර සහ / හෝ මුහුණ) வீக்கம் (கணுக்கால்/முகம்) Oedema (ankle and/or facial)				ස්ථානය இடம் Place	
රුධිර පීඩනය/குருதி அமுக்கம்/BP				දිනය திகதி Date	
රුධිර වාහිනී පද්ධතිය குருதிச் சுற்றோட்டத் தொகுதி Cardiovascular system				වේලාව நேரம் Time	
ශ්වසන පද්ධතිය/சுவாசத் தொகுதி Respiratory system				විශේෂ සටහන්/விசேட குறிப்புக்கள் Special Notes	
උදර පරීක්ෂාව/வயிற்று பரிசோதனை Abdominal Examination					
යෝනි පරීක්ෂාව අවශ්‍යනම් யோனி பரிசோதனை, தேவை எற்படின் Vaginal examination if needed					

පරීක්ෂා කරන ලද නිලධාරියාගේ අත්සන/ பரிசோதித்த உத்தியோகத்தரின் கையொப்பம் / Signature of the officer examined	
නිල නාමය/ பதவி / Designation	

හදිසි අවස්ථාවකදී දැනුම් දීම /அவசர தேவையில் அணுகவேண்டிய தொடர்பு / In an emergency contact

දැනුම් දියයුතු අයගේ නම සහ ලිපිනය
தொடர்பு கொள்ள வேண்டியவரின் பெயரும், முகவரியும்
Name and address of the contact person ....

දුරකථන අංකය
தொலைபேசி இலக்கம் .....
Telephone No

පවුල් සෞඛ්‍ය සේවා නිලධාරිනියගේ දුරකථන අංකය
கு.சு.சே.உ. தொலைபேசி இலக்கம்
Telephone No of PHM .....

සෞඛ්‍ය වෛද්‍ය නිලධාරී කාර්යාලයේ දුරකථන අංකය
க.வை.அ.காரியாலயத்தின் தொலைபேசி இலக்கம்
Telephone No of the MOH office .....


ඔබේ ආදරණීය බිළිඳාට
HIV ආසාදනයෙන් තොර සුරක්ෂිත හෙට දවසක්...
HIV වෛරසය කිසිදු රෝග ලක්ෂණයක් නොපෙන්වා ඔබ තුල සැඟවී සිටිය හැකිය.
එය දැන ගත හැකිවන්නේ රුධිර පරීක්ෂණයකින් පමණි.
උපදින බිළිඳා HIV ආසාදනයෙන් වලක්වා ගනිමු.
ඒ සඳහා අවශ්‍ය සියලුම සේවාවන් නොමිලේ ලබා ගත හැකිය.
ඔබගේ සියලු තොරතුරුවල රහස්‍යභාවය සම්පූර්ණයෙන්ම ආරක්ෂා කෙරේ.
ඔබත් අදම HIV රුධිර පරීක්ෂාවක් කර ගන්න.
NATIONAL STD AIDS CONTROL PROGRAMME
Family Health Bureau

உங்களது அன்பான சின்னஞ்சிறு குழந்தைக்கு, HIV தொற்று இல்லாத நாளைய தினம் .....

HIV வைரஸ் தொற்று உங்களது உடலில் எவ்வித அறிகுறிகளையும் காட்டாது இருக்கலாம்

இதனை இரத்தப்பரிசோதனை மூலமே அறிந்துகொள்ள முடியும்.

புதிதாகப்பிறந்த சிசுவை HIV தொற்று இல்லாமல் பெறுவோம்.

அனைத்து சேவைகளும் எந்தவித கட்டணமும் இன்றி இலவசமாக மேற்கொள்ளப்படும்.

உங்களது தகவல்களின் இரகசியத்தன்மை பேனப்படும்.

நீங்களும் இன்றே HIV இரத்தப்பரிசோதனையை செய்துகொள்ளுங்கள்

NATIONAL STD AIDS CONTROL PROGRAMME

Family Health Bureau

unicef


Be the best mother you can be
to your "bundle of Joy"
Let it be born free of HIV/AIDS
Protect our children
from HIV/AIDS
NATIONAL
STD/AIDS
CONTROL
PROGRAMME
ජාතික ලිංගාශ්‍රිත රෝග/
ඒඩ්ස් මර්දන වැඩසටහන
Effective treatments are available
For more details
contact your nearest STD clinic
Inquiries: National STD/AIDS Control Programme, No. 29, De Soram Place, Colombo 10. Tel: 011 2667163 Fax: 011 5336873, 2682859 E-mail: info@aidscontrol.gov.lk Web: www.aidscontrol.gov.lk
Coordination: Multi-Sectorial Unit, National STD/AIDS Control Programme, Tel: 011 2697625 E-mail: multiunitnsacp@yahoo.com

Annexure 9- Leaflet For pregnant women on service package

සායනයේදී මුත්‍රා හා රුධිරය පරීක්ෂා කල යුත්තේ ඇයි ?

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

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

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

රුධිර වර්ගය හා ආර් එච් ඝනය(Grouping & Rh)

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

හිමොග්ලොබින්(Hb)

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

රුධිරයේ සීනි පරීක්ෂණය (Blood Sugar)

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

වී.ඩී.ආර්.එල් (VDRL)පරීක්ෂණය

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

එච්.අයි.වී (HIV) පරීක්ෂණය

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

- தகுந்த பரிசோதனையை செய்வதன்மூலமும்
- ஆலோசனையைப் பின்பற்றுவதன்மூலமும் ஆரோக்கியமான சிசுக்களை பெற்றுக் கொள்வதற்கான உங்கள் ஆசை நிறைவேறும்.

உங்களது பொறுப்பு என்னவென்றால்

நீங்கள் கருத்தரித்த நிலையை அறிந்த உடனேயே

- கிளினிக்கிற்கு வருகைதருதல்
- முதல் மூன்று மாதங்களுக்குள் அனைத்து பரிசோதனைகளையும் செய்தல்
- தகுந்தவாறு மருந்துகளை உட்கொள்ளல்
- ஆலோசனையைப் பின்பற்றுதல்

உங்களது உதவிக்காக எப்போதும்
சுகாதாரசேவை உங்களுடன்.....

வெளியீடு
தேசிய பாலியல் மற்றும் எச்.ஐ.வி/எயிட்ஸ் கட்டுப்பாட்டு நிலையம்
இல 25, தி சேரம் பிளேஸ்
கொழும்பு 10.
தொலைபேசி இல - 011-2667163

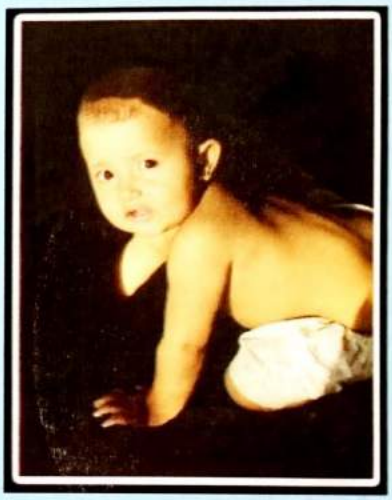
NATIONAL STD/AIDS CONTROL PROGRAMME

Ministry of Health

Family Health Bureau

unicef

உங்களது ஆசை நிறைவேற



ஆரோக்கியமான குழந்தையைப் பெற்றுக்கொள்வதற்கே ஒவ்வொரு பெண்ணும் விரும்புவர்.

அதற்காக நீங்கள் செய்யவேண்டியது என்னவெனில், மகப்பேற்று கிளினிக்கில் பரிந்துரைக்கப்படும் இரத்தப் பரிசோதனைகளை தவறாது செய்தல் ஆகும்

ஏன் இந்த சலம் மற்றும் இரத்தப் பரிசோதனைகள் கிளினிக்கில் மேற்கொள்ளப்படுகின்றன?

❖ சலத்திலுள்ள அல்புமின் புரதம் மற்றும் கர்ப்பகாலம் சம்பந்தப்பட்ட நோய்களை முன்னரே அறிந்துகொள்வதற்காக ஆகும்.

கிளினிக்கில் எடுக்கப்பட்ட இரத்தத்தில், கீழே தரப்பட்டுள்ள எல்லாப் பரிசோதனைகளையும் செய்துகொள்ளமுடியும்.

- இரத்தப்பிரிவும்,ஆர்.எச். (Grouping & Rh)
- ஹீமோக்ளோபின் (Hb)
- இரத்ததிலுள்ள சீனி அளவு (Blood Sugar)
- வி.டி.ஆர்.எல்.பரிசோதனை (VDRL)
- எச்.ஐ.வி. பரிசோதனை (HIV)

இரத்தப்பிரிவும்,ஆர்.எச். (Grouping & Rh)

மகப்பேற்றின்போது தேவையேற்படின் இரத்தம் வழங்கப்படுவது இலகுவாக்கப்படும்.

ஹீமோக்ளோபின் (Hb)

இரத்தசோகையால் ஏற்படக்கூடிய பாதிப்புக்களில் இருந்து நிவாரணம் பெறலாம்.

இரத்தத்திலுள்ள சீனி அளவு (Blood Sugar)

டயபெடிக் நோயைக் ஆரம்பத்திலேயே கண்டுபிடிப்பதற்கும், இதனால் ஏற்படக்கூடிய பாதிப்புக்களை தவிர்ப்பதற்காகவும் இந்தப் பரிசோதனை ஆரம்ப வருகையின்போதும் பின்னர் 24-28 கிழமைகளிலும் (6-7மாதங்கள்) செய்யப்படும்.

வி.டி.ஆர்.எல்.பரிசோதனை (VDRL)

இது சிபிலிஸ் நோய்க்கான ஆரம்ப இரத்தப்பரிசோதனை.தகுந்த சிகிச்சைமூலம் இதனை பூரணமாக குணப்படுத்தமுடியும்.

எச்.ஐ.வி. பரிசோதனை (HIV)

கர்ப்பிணி எச்.ஐ.வி. தொற்றுக்குட்பட்ட நிலை கண்டறியப்பட்டால்,அவரது நோய்நிலையை கட்டுப்படுத்த முடியும். அத்துடன் தாயிலிருந்து சிசுவிற்கான நோய்த்தொற்று கிட்டத்தட்ட பூரணமாக தடுக்கப்படும்.

Annexure 10 — Request for HIV antibody test

Confidential

National STD/AIDS Control Programme, Ministry of Health, Sri Lanka

STRATEGIC INFORMATION ON LABORATORY CONFIRMED HIV INFECTIONS

(VERSION: 06/07/2011/SIM)

Office use only

Serial No. ☐☐☐☐☐

SL No. ☐☐☐☐☐

Comments:----------

Instructions: 1. Complete for all new and old HIV infected persons
2. Circle correct answers
3. Send completed forms in a confidential cover to:
Coordinator, SIM Unit, through Director, *National STD/AIDS Control Programme, 29, De Saram Place, Colombo 10*

1. Identification information

1.2 FIRST NAME (last two letters only) ☐☐

1.2 LAST NAME (last two letters only) ☐☐

1.3 DATE OF BIRTH (dd/mm/yyyy) ------/---------/--------

1.4 HIV CLINIC NUMBER ☐☐☐☐☐☐

2. Socio-demographic information

2.1 SEX
I. Male
II. Female
III. Others (transgender/transvestite etc)

2.2 AGE AT DIAGNOSIS(years/months, if <1 year) ☐☐

2.3 DISTRICT OF RESIDENCE _____

2.4 COUNTRY OF BIRTH
I. Sri Lanka II. Other (specify)_____

2.5 MARITAL STATUS
I. Never married
II. Currently married/Living together
III. Separated/Divorced/Widowed

2.6 ETHNICITY
I. Sinhalese II. Tamil
III. Moore IV. Other

2.7 OCCUPATIONAL STATUS
I. Unemployed II. Student III. Retired
IV. Employed as_____

3. HIV Testing details

3.1 SAMPLE NUMBER _____

3.2 DATE OF LAB CONFIRMATION(dd/mm/yyyy) ------/-----/-----

3.3 EVER TESTED FOR HIV BEFORE?
I. Yes (date of last negative report)_____
II. Never
III. Not known

4. Reason for HIV testing *(More than one option possible)*
I. Voluntary testing
II. Provider initiated testing
III. Investigation of clinical symptoms suggestive of HIV
IV. Partner/spouse/parent/child, diagnosed with HIV infection
V. STD screening
VI. Blood donor screening
VII. Screening before medical/surgical procedure
VIII. Screening for Visa/Insurance/Legal / Foreign jobs
IX. ANC screening
X. Others (specify).....

5. Clinical status of the HIV infected person at the time of diagnosis
I. Asymptomatic II. Symptomatic HIV III.AIDS

6. Information on exposure to HIV

6.1 SEXUAL EXPOSURE(mark only one response)
I. Sexual contact with person of opposite sex
II. Sexual contact with both sexes
III. Sexual contact with person of same sex
IV. No sexual contact
V. No response

6.2 HISTORY OF BLOOD EXPOSURE
I. No
II. Injecting drug use
III. Receipt of blood/tissue, specify year ----------
IV. Needle stick injury/Mucosal splash, specify year ----------

6.3 ACQUIRED FROM MOTHER TO CHILD TRANSMISSION
I. Yes II. No III. Not known

6.4 Ever engaged in commercial sex work/Client of sex worker?
I. Yes II. No III. No response

6.5 Ever gone abroad?
I. Yes II. No III. No response
If yes, give details (countries, purpose and duration)
_____

6.6 Ever had sex with a foreigner?
I. Yes II. No III. Not known/No response

7. Information of spouse (or living-together partner)

7.1. HIV STATUS OF THE SPOUSE
I. Positive II. Negative
III. Not known IV. Not applicable

7.2 Has the spouse ever gone abroad?
I. Never II. Yes III. Not applicable
If yes, give details (countries and purpose)
_____

7.3 RISK FACTORS FOR HIV IN SPOUSE
I. None II. MSM III. Sex worker IV. Drug user
V. Other (specify)----------
VI. Not known VII. Not relevant

7.4 LIKELIHOOD OF GETTING INFECTED FROM THE SPOUSE?
(Doctor's opinion based on history and clinical picture)
I. Likely II. Unlikely
III. Not sure IV. Not applicable

8. Information of reporting doctor

8.1 NAME OF DOCTOR----------
8.2 DESIGNATION ----------
8.3 ADDRESS/PLACE OF WORK ----------
8.4 DATE OF REPORTING ----------