Guidelines for Management of Pregnant Women with HIV infection

2016

FAMILY HEALTH BUREAU

MINISTRY OF HEALTH SRI LANKA

NATIONAL STD/AIDS CONTROL PROGRAMME SRI LANKA

Guidelines for Management of Pregnant Women with HIV Infection

National STD/AIDS Control Programme
Ministry Of Health
Sri Lanka

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Published by

National STD/AIDS Control Programme

Ministry of Health

Colombo, Sri Lanka.

1st Edition 2008

2nd Edition 2011

3rd Edition 2016

The guidlines for management of pregnant women with HIV infection - 2016 was prepared to assist policymakers to plan PMTCT interventions and healthcare workers to provide optimal services to pregnant mothers

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1. Management of pregnant women with HIV

1.1 When to start ART in pregnant and breastfeeding women

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. All efforts should be made to identify HIV-infected pregnant women early enough to avoid the need for high-risk prophylaxis for infants.

1.2 What ART regimens to initiate (Refer Guidelines for use of ART)

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

1. If above preferred ART regimen is contraindicated or not available, alternative first-line ART for pregnant and breastfeeding women includes AZT in place of TDF or NVP or a boosted PI (Lopinavir/ritonavir-LPV/r or Atazanavir/ritonavir-ATV/r) in place of EFV.
2. DTG has not been sufficiently studied in pregnant women for it to be recommended as an alternative in this population, unless the perceived benefits outweigh the potential risks.
3. In addition, the efficacy of low-dose EFV (400 mg) in pregnancy has not been studied.
4. In the absence of specific contraindications it is recommended that the third agent in ART should be efavirenz or nevirapine* (*If the CD4 cell count is less than 250 cells/ L) or a boosted PI.
5. Fixed-dose combinations and once-daily regimens are preferred for antiretroviral therapy in pregnancy.

Using simplified, less toxic and more convenient regimens as fixed dose combinations (FDCs) and once daily regimens is recommended for first line ART.

Table1 - First-line ART regimens

First –line ART	Preferred first –line regimens	Alternative first –line regimens*
Adults* and Adolescents(10 to 19 years) **≥ 35 kg**	TDF + FTC + EFV	AZT + 3TC + EFV/NVP** TDF + FTC + NVP** TDF + FTC + ATV/r TDF + FTC + LPV/r AZT + 3TC + ATV/r AZT + 3TC + LPV/r ABC*** + 3TC + EFV(or NVP**) TDF + 3TC (or FTC) + DTG****

**Adults include pregnant and breastfeeding women*

*** NVP – Women with CD4 count > 250 cells /mm3 are at risk for NVP hypersensitivity with fatal hepatic toxicity.*

****ABC - Presence of HLA-B 5701 gene indicate higher risk for hypersensitivity. Viral load should be <100,000 copies/ml*

***** Safety and efficacy data on use of DTG in pregnant women and children younger than 12 years of age are not available.*

ABC or boosted PIs (ATV/r, DRV/r, LPV/r) can be used in special circumstances.

In addition to receiving ART, pregnant women living with HIV should be offered the recommended package of pregnancy care and additional interventions such as screening for STIs (e.g.: hepatitis B and syphilis), nutritional support, infant feeding counselling and family planning guidance. Careful monitoring for the development of pregnancy-induced hypertension and pre-eclampsia – especially for women on ART prior to conception – is advised.

1.3 Women with HIV conceiving on ART

It is recommended that women conceiving on an effective ART regimen should continue ART (Even if it contains Efavirenz)

1.4 Late-presenting woman not on treatment

A woman who presents after 28 weeks should commence ART without delay.
If the viral load is unknown or > 100,000 HIV RNA copies/mL, a three or four drug regimen that includes Raltegravir is suggested.

1.5 An untreated woman presenting in labour

An untreated woman presenting in labour at term should be given a stat dose of Nevirapine and commence fixed-dose Zidovudine +Lamivudine and Raltegravir.

2. Monitoring of pregnant women receiving ART

- Clinical and laboratory evaluation is as for non-pregnant women receiving ART.
- Haematological and biochemistry parameters should be monitored as appropriate to the ART regimen used.
- In women who commence ART in pregnancy, HIV viral load should be performed 4 weeks after commencing ART and at 36 weeks.
- In women commencing ART in pregnancy, liver function tests should be performed at initiation of ART and then at each antenatal visit.
- In the event that a woman who has initiated ART during pregnancy has not achieved a plasma viral load of < 50 HIV RNA copies/ml at 36 weeks, following interventions are recommended:
    - Review treatment adherence and concurrent use of other medication
    - Perform resistance testing if appropriate
    - Optimize to the best regimen
    - Consider intensification

3. Obstetric management

3.1 Antenatal care

Pregnant HIV positive women should receive optimal care by a team including an obstetrician, venereologist, paediatrician, anaesthetist, theatre sister, MOH and infection control nurse. Good coordination, confidential communication and shared responsibility are very important aspects in the management of a pregnant woman with HIV infection.

Health care providers should ensure that pregnant women with HIV are provided antenatal care, labour and delivery care and post-partum services in a user-friendly environment. The head of the institution and consultants should take all measures to prevent stigma and discrimination.

3.2 Management

- Ensure privacy and confidentiality during consultations and reassure the woman that her HIV status will be kept confidential.
- Explain to the woman who the information will be shared with.
- Explain to the woman that she will have to follow routine antenatal clinic visits and give her confidence by discussing the management plan with her.
- Foetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.
- Invasive prenatal diagnostic testing should not be performed until after the HIV status of the mother is known and should ideally be deferred until HIV viral load has been adequately suppressed.
- If the invasive diagnostic test procedure cannot be delayed until viral suppression is achieved, it is recommended that women should commence ART to include raltegravir and be given a single dose of nevirapine 2–4 hours prior to the procedure.
- Plan and discuss the mode of delivery with the pregnant woman during antenatal care. Give her clear instructions on when to get admitted for delivery and whom she should contact.
- External cephalic version (ECV) can be performed in women with HIV when the viral load is suppressed.
- Health care workers should practice universal infection control measures for all deliveries irrespective of the infection status of pregnant women.

4. Antenatal care at the primary health care ANC clinic

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

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

There are two possibilities;

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

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

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

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

Counselling

The following areas need to be covered in counseling.

- ART and adherence to treatment
- Choice of infant feeding
- Partner disclosure/screening
- HIV testing of other children
- 100% Condom use to prevent acquiring other STIs, entry of other strains of HIV and onward transmission to a negative partner
- Postpartum family planning

6. Management of delivery of pregnant mother with HIV

6.1. Plan for delivery

Plan and discuss the mode of delivery with the pregnant woman (and her partner if possible) during antenatal care.
Give her instructions on when to get admitted to the hospital for delivery and whom she should contact.
Explain the possibility of preterm labour and what to do in case of an emergency.

When admitted for delivery

- Check the expected date of delivery
- Confirm normal growth of the foetus
- Check which ART regimen have been prescribed and whether drugs have been taken as prescribed
- Check for recent viral load results
- Women with incomplete viral suppression (>50 copies/mL) at the time of delivery preferably should receive IV zidovudine (if available) along with their other ARVs orally.
- In situations where IV administration is not possible/not available, oral administration of zidovudine using a 600-mg loading dose and 400 mg every 3 hours can be considered.(CDC)
- Check for availability of antiretroviral treatment for infant prophylaxis.
- Check for infant feeding method and provide lactation suppression therapy if mother has decided on formula feeding.
- Check for availability of safe delivery kits and post exposure prophylaxis therapy in the tertiary care institution which is identified for delivery.
- Confirm that a post-partum family planning method is arranged and make arrangements for LRT if it is the acceptable agreed method.

6.2 . Pre labour caesarean section of a woman who is on ART

Planned caesarean section

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

Caesarean section Evidence

Caesarean section before labour begins and before membranes are ruptured allows the baby to avoid contact with the mother's blood and cervical secretions.

Recent studies indicate that there is no significant difference in mother to child transmission (MTCT) of HIV in women with an undetectable viral load when comparing those who have a planned vaginal delivery and those who have a planned LSCS.

6.3. <u>If vaginal delivery is considered or unavoidable</u>

Planned normal vaginal delivery

If HIV viral load is < 50 copies/mL at 36 weeks, the risk of MTCT of HIV is less in the absence of other obstetric contraindications.

- Minimize vaginal examinations to reduce the risks of infection to the mother. Maintain aseptic techniques throughout labour.
- ART should be continued according to the ART plan
- Amniotomy, fetal scalp electrodes and fetal blood sampling, instrumental delivery and episiotomy have been avoided in pregnant women with HIV infection because of theoretical transmission risks.
- Artificial rupture of membranes increases the risk of infection of the placental membranes.
- Avoid prolonged labor by monitoring labour carefully and intervening appropriately (i.e., augmentation of labour through oxytocin or delivery caesarean section).
- Head should be presenting and well engaged.
- Check whether the cervix is effaced and dilated and await spontaneous onset of labour

In women for whom a vaginal delivery has been recommended and labour has commenced, obstetric management should follow the same principles as for the uninfected population.

6.4. <u>Management of pre-labour spontaneous rupture of membranes</u>

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

- If maternal HIV viral load is < 50 RNA copies/mL immediate induction of labour is recommended, preferably under antibiotic cover.

- If maternal HIV viral load is ≥ 50 RNA copies/mL plasma, immediate caesarean section is recommended.

- If maternal HIV viral load is not available, immediate caesarean section is recommended.

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

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

6.5 .Women who have not received antepartum antiretroviral drugs/Women who present in labor without documentation of HIV status

Women presenting in labour/ROM/requiring delivery without a documented HIV result must be recommended to have a Rapid HIV Test. A reactive/positive result must be acted upon immediately with initiation of the interventions to PMTCT without waiting for further/formal serological confirmation.

Pregnant women with positive HIV antibody tests (screening test) should be presumed to be infected until standard HIV confirmatory testing clarifies their infection status. IV zidovudine/ oral ART should be started immediately in all women with positive expedited HIV tests in labour to prevent perinatal transmission of HIV.

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

A single dose of nevirapine (regardless of CD4 cell count even if available) should be given immediately to the pregnant woman as this rapidly crosses the placenta and within 2 hours achieves and maintains effective concentrations in the neonate for up to 10 days .

If delivery is not imminent, a caesarean section should be considered. If delivery occurs less than 2 hours post maternal nevirapine, the neonate should also be dosed with nevirapine immediately.

After partus, refer mother to the STD Clinic for clinical and immunological assessment.

Points for consideration

- All known HIV infected pregnant women should have an individualized, regularly updated, plan of care which summarizes mutually agreed obstetric/HIV management including the drug regimen and recommended mode of delivery.
- Universal Infection Control measures, properly applied, provide adequate protection for staff. Routine incorporation of universal precautions in service delivery is crucial to mitigate occupational risk and reduce fear of blood borne infections on the part of the health care workers.

All ward staff should be aware of the need for confidentiality in relation to the pregnant mother's HIV status. On the basis of shared confidentiality staff members could be informed of the HIV status of the woman on a "need to know" basis.

7 Post-partum Management

7.1 Care for the baby:

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

Minimize the risk of postpartum haemorrhage by:

- Actively managing the third stage of labor
- Using controlled cord traction
- Performing uterine massage
- Repair any genital tears
- Carefully removing all products of conception

7.2Post- partum care (Includes care in the institution and thefield)

- Physical assessment in the postpartum period should follow routine guidelines. Examine women within 24 hours following delivery.
- Be aware of signs of infection following delivery. Like uninfected women, HIV positive women are also vulnerable to infection following delivery and retained blood and placental tissues. Postpartum uterine infection is a common and potentially life-threatening condition, and early detection and effective treatment are important measures to prevent complications.
- Manage infected tears or episiotomy.
- Advice women to come back to the same institution if LSCS wound infection is observed.
- When they are discharged from the healthcare facility, women should be advised to return to the clinic or inform the PHM if they notice symptoms such as fever,lower abdominal pain, burning with urination, foul smelling discharge, abnormal bleeding, cough, shortness of breath, calf pain (increasing on walking), diarrhoea and unusual/abnormal behaviour
- Give information to the mother on care of the perineum and breasts. Women living with HIV require special care to reduce breast engorgement, mitigate pain and avoid mastitis.
- Women who choose to breast feed should be counselled to avoid breast engorgement which could lead to mastitis, since inflammation is associated with increased risk of HIV transmission. She should be advised to seek immediate medical care if breast engorgement is associated with fever and pain.
- Instruct her about the safe disposal of lochia and blood-stained sanitary wear or other potential infectious materials.
- If family planning has not been discussed before delivery it should be done during the early postpartum period.

8 Neonatal management

8.1 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.

**High-risk infants are defined as those who are:*

– born to women with established HIV infection who have received less than four weeks of ART at the time of delivery; OR

– born to women with established HIV infection with viral load >1000 copies/mL in the four weeks before delivery, if viral load measurement available; OR

– born to women with incident HIV infection during pregnancy or breastfeeding; (defined as new HIV diagnosis in a pregnant or breastfeeding woman with a prior negative HIV test during pregnancy) OR

– identified for the first time during the postpartum period, with or without a negative HIV test prenatally.

Factors such as prolonged rupture of membranes, preterm delivery and low birth weight are no longer associated with increased risk of transmission when mothers are receiving ART. The critical determinants of transmission risk in the ART era are maternal viral load and duration of maternal ART.

Three drug infant combination antiretroviral prophylaxis regimen (AZT + 3TC + NVP) is under investigation but is already used in clinical practice by some experts.

8.2 Infants, born to untreated HIV-positive mothers

Infants < 72 hours old, born to untreated HIV-positive mothers, should immediately initiate three-drug therapy or dual therapy for 4 weeks.

If initiating ART in an infant less than 2 weeks of age, a regimen of AZT + 3TC + NVP should be started and NVP be substituted with LPV/r at the earliest opportunity, preferably at 2 weeks of age. In settings where LPV/r syrup is not available, NVP should be continued until the age of 3 months, with close clinical monitoring for children considered to be at high risk for carrying NNRTI resistance as a result of prolonged NVP-based postnatal prophylaxis or documented NNRTI failure in the mother. Where it is available, Ralregravir could also be considered as an option in special circumstances, such as lack of LPV/r in any of the above formulations.

9 HIV diagnosis in infants and children

- Virological assays that directly detect HIV must be used to diagnose HIV infection in children younger than 18 months with perinatal HIV exposure; HIV antibody tests should not be used.
- All HIV exposed infants should undergo nucleic acid testing (NAT) at birth to identify HIV infection.
- It is strongly recommended that all HIV-exposed infants have HIV virological testing at 8 weeks of age (at least 2 weeks after cessation of PEP) or at the earliest opportunity thereafter.
- In infants with an initial positive virological test result, it is strongly recommended that Antiretroviral therapy (Not PEP) be started without delay and at the same time a second blood sample is collected to confirm the initial positive virological test result. Confirmation of HIV infection among infants less than 18 months should be based on two positive virologic tests from separate blood samples. **Do not delay ART for confirmatory test results.** Immediate initiation of ART saves lives and should not be delayed while waiting for the results of the confirmatory test.
- It is strongly recommended that test results from virological testing of infants be returned to the clinic as soon as possible, but at the very latest within four weeks of specimen collection. Positive test results should be fast-tracked to the mother as soon as possible to enable prompt initiation of ART.
- It is strongly recommended that HIV-exposed infants, who are well, undergo HIV serological testing at around 9 months of age. Infants who have reactive serological assays at 9 months should have a virological test to identify HIV infection and the need for ART.

<u>Timing of assessments</u>

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

Breastfed infants

Additional monthly testing of both mother and infant is recommended.

10. Co-trimoxazole prophylaxis

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

• All HIV-infected infants.

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

• Infants whose mother's viral load at 36 weeks' gestational age or at delivery is > 1000 HIV RNA copies/mL despite cART or unknown (and continued until HIV infection has been excluded)

11. Fertility options for PLHIV

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

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

The physician does need to ensure that the uninfected partner has a full understanding of the possibility of becoming infected through unprotected intercourse. More importantly, the need for ART adherence and regular attendance for STI screening in the couple and viral load checks in the infected partner should be stressed. Clinics should consider asking couples to sign confirming that they have received comprehensive pre-conceptual counselling covering all their options for conceiving, including natural conception, and that they fully understand the risks associated with each method.

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

- Infected partner/couple should be receiving combination antiretroviral therapy and demonstrate sustained viral suppression (two undetectable viral load over the period of six months) of plasma viral load below the limits of detection (at present <34 copies/ml)
- Both partners should be screened for genital tract infections. Treatment of such infections is important because genital tract inflammation is associated with genital tract shedding of HIV.
- Should undergo fertility screen where necessary

11.1 Sero-discordant Couples

Before conception is attempted, the HIV-infected partner should be receiving ART and demonstrate sustained suppression of plasma viral load below the limits of detection.

HIV infected partner- woman:

HIV-positive women planning to have children should receive pre-conception counselling on MTCT risks, their long-term health and the possible effects of ARV medication on the foetus.

For HIV sero-discordant couples where the woman is the HIV-infected partner, the safest form of conception is artificial insemination, including the option to self-inseminate with the partner's sperm during the peri-ovulatory period. Condom use should be advised at all times.

HIV infected partner –man:

For HIV-discordant couples where the man is the HIV-infected partner, the use of donor sperm from an HIV-uninfected man with artificial insemination is the safest option.

When the use of donor sperm is unacceptable, the use of sperm preparation techniques coupled with either intrauterine insemination or in vitro fertilization with intracytoplasmic sperm injection has been reported to be effective in avoiding seroconversion in uninfected women and offspring in several studies.

Sperm preparation should utilize optimal methods that can detect the presence of HIV. Couples should also consider the cost and other possible complications of in vitro fertilization. More data are needed to demonstrate the complete efficacy of these techniques, and couples should be cautioned that there may be a small risk of transmission of HIV to the uninfected partner and to their offspring.

Discordant couples who do not have access to these reproduction services and who still want to try to conceive:

Conceiving through timed unprotected intercourse and abandoning condom use has previously been contraindicated in couples where one or both partners are infected with HIV.

Couple should be advised that timed, peri-ovulatory unprotected intercourse after the infected partner has achieved a sustained undetectable plasma viral load (with use of condoms at all other times) may reduce but not completely eliminate the risk of sexual transmission.

The couple should have regular screening for STIs. The infected partner should also be advised on the importance of adherence to medication and regular checking of plasma viral load.

In order to reduce the risk of unnecessary exposure in couples experiencing fertility issues, the couple should be advised of the benefits of having a fertility screen prior to attempting to conceive naturally. This should include a semen analysis for the male partner and an endocrine profile and baseline pelvic scan in the early follicular phase of the cycle (day 2–5) for the female partner together with a mid-luteal progesterone to confirm whether ovulation is occurring and non-invasive test of tubal patency (e.g. hysterosalpingogram), unless there is a history of pelvic pain or infection (in which case, laparoscopy and dye should be used to assess tubal patency).

PrEP may offer an additional strategy for safer conception. The utility of daily oral PrEP when the HIV-infected partner is receiving ART has not been studied. If clinicians elect to use PrEP for HIV-uninfected women or men in serodiscordant couples, the couples should be educated about the potential risks and benefits and all available alternatives for safer conception. It is recommended to start daily oral tenofovir plus emtricitabine beginning 1 month before conception is attempted and continued for 1 month after conception is attempted. Recommended laboratory testing should include HIV diagnostic testing at baseline then every 3 months, renal function testing at baseline and then every 6 months, and pregnancy testing at baseline and when necessary. Testing for hepatitis B virus (HBV) infection should be performed when initiating PrEP. HBV -uninfected individuals should be vaccinated if they

have not received HBV vaccination or they lack immunity to HBV. Individuals receiving PrEP should be educated about symptoms associated with acute HIV infection and advised to contact their providers immediately for further evaluation, should symptoms occur. HIV-uninfected partners should undergo frequent HIV testing to detect HIV infection quickly. If HIV infection is documented, the PrEP ARV agents should be discontinued to minimize selection of drug-resistant virus, measures should be instituted to prevent perinatal transmission if pregnancy has occurred and attempts at conception stopped if pregnancy has not occurred, and the patient should be referred to an HIV specialist immediately. Individuals with chronic HBV should be monitored for possible hepatitis flares when PrEP is stopped.

Couples should be advised to use condoms at all times except during peri ovulatory intercourse.

11.2 Sero-Concordant Couples

Both partners should be on ART with maximum viral suppression before attempting conception. Periovulatory unprotected intercourse (with use of condoms at all other times) is a reasonable option. The risk of HIV superinfection or infection with a resistant virus is negligible when both partners are on ART and have fully suppressed plasma viral loads.

The only scenario where concordant couples should be discouraged from attempting to conceive naturally is when drug resistance has been identified in one or other partner.

12 Immunization

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

Table2. Immunization Schedule

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

Age	Standard schedule	Infant with HIV	Remarks
3rd year	MMR 2nd dose	MMR 2nd dose	
5 years	OPV+DT	Inactivated polio+DT	
12 years	aTd	aTd	
12-13 years (females ,males)		HPV (Gardasil) 3 doses (0,1, 6 months	

Annexures:

Annexure1.1 General circular letter No. 01-51/2016

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சுவசிரிபாய
SUWASIRIPAYA

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

ඔබේඅංකය)
உமது இல)
Your No. :)

දිනය)
திகதி)
Date) 2016.09. 30

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

General Circular No : 01 - 51 /2016

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

Programme for Ending AIDS by 2025 in Sri Lanka

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Ministry of Health, Nutrition& Indigenous Medicine

පොදු වක්‍රලේඛ අංක: 01 - 51 /2016

සියලුම පළාත්/ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂකවරුන්,
සියලුම ශික්ෂණ රෝහල් අධ්‍යක්ෂකවරුන්,
සියලුම විශේෂිත ව්‍යාපාර ප්‍රධානීන්,
සියලුම සෞඛ්‍ය ආයතන ප්‍රධානීන්,

වසර 2025 වන විට ශ්‍රී ලංකාවෙන් ඒඩිස් තුරන් කිරීමේ වැඩසටහන.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

පිටපත්:-

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

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සුවසිරිපාය
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මගේ අංකය)
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දිනය)
திகதி)2016.09. 30
Date)

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

பொது சுற்றறிக்கை இல:- 01 -51 /2016

அனைத்து மாகாண/பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்களுக்கும்,
அனைத்து போதனா வைத்தியசாலைகள் பணிப்பாளர்களுக்கும்,
அனைத்து விசேட செயற் திட்டங்களின் தலைவர்களுக்கும்,
அனைத்து நிறுவனங்களின் தலைவர்களுக்கும்.

2025 ஆம் ஆண்டளவில் இலங்கையில் எய்ட்ஸ் நோயை முற்றுமுழுதாக ஒழிப்பதற்கான செயற்திட்டம்

இலங்கை இப்போது 2025 ஆம் ஆண்டளவில் எய்ட்ஸ் நோயை முற்றுமுழுதாக இல்லாதொழிப்பதற்கான செயற்திட்டத்தை நடைமுறைப்படுத்தத் திட்டமிட்டுள்ளது. எச்.ஐ.வி தொற்றுடன் வாழும் எல்லா மக்களுக்கும், மனித நிர்ப்பீடன எதிர்ப்பு வைரசுக்கான மருந்து வகைகளைக் கொண்டு சிகிச்சை வழங்குவதற்கான சுகாதார அமைச்சின் தீர்மானம், உலக சுகாதார தாபனத்தின் பரிந்துரைப்பிற்க்கு அமைய மேற்கொள்ளப்பட்ட தொடர்ச்சியான கலந்துரையாடுதலின் பின்னர் எடுக்கப்பட்டது. இந்தச் செயன்முறையை எளிதாக்குவதற்கு, சுகாதார அமைச்சு எ.ஆர்.ரி. (ART) மருந்துவகைகளை 2016 ஆம் ஆண்டிலிருந்து அரச செலவில் கொள்முதல் செய்வதற்கான முடிவுகளை எடுத்துள்ளது. எச்.ஐ.வி தொற்றுடன் வாழும் மக்களுக்கான தகுந்த சிகிச்சை மூலம், அநேகமானவர்களின் குருதியிலுள்ள வைரசின் எண்ணிக்கை, சில மாதங்களுக்குள் நன்றாகக் குறைவடைவதனால், இன்னொருவருக்கு தொற்று ஏற்படுவதற்கான அபாயம் குறைகின்றது. எ.ஆர்.ரி (ART) மருந்துவகைகளைப் பாவிப்பதனால் எச்.ஐ.வி தொற்றுடன் வாழும் மக்களின் வாழ்க்கைத் தரமும், எதிர்பார்க்கும் ஆயுட்காலமும் அதிகரிக்கின்றது. சிகிச்சையை ஒழுங்காகப் பின்பற்றும் எச்.ஐ.வி தொற்றுடன் வாழும் மக்களில் அநேகமானவர்கள் எந்தவித நோய் அறிகுறியுமின்றி பல ஆண்டுகளுக்கு வாழ முடிவதுடன், எய்ட்ஸ் நிலைக்கு ஆளாவதற்கான அபாயத்தைத் தவிர்த்துக்கொள்ளவும் முடியும். அத்துடன் அவர்களால் தங்களுடைய நாட்டினது, சமுதாயத்தினது, மற்றும் குடும்பத்தினது நன்மைக்காக உதவவும் முடியும்.

02. ஒருவரின் எச்.ஐ.வி தொற்று கண்டறியப்படுதலானது, அவரை உடலளவிலான, உளவியல் மற்றும் சமூகரீதியான தாக்கங்களுக்கு உட்படுத்தும். சுகாதாரப் பராமரிப்பு பணியாளர்களினால் வழங்கப்படும், பாகுபாடு மற்றும் களங்கமின்றிய போதிய கவனிப்பு மற்றும் ஆதரவு, அவர்கள் எச்.ஐ.வி தொற்றுடன் வாழ்வதற்கு தங்களை பழக்கிக்கொள்வதற்கு மிகவும் உதவும். குருதிப்பரிசோதனை மூலம் ஆரம்பத்திலேயே கண்டறிதலானது, எச்.ஐ.வி தொற்றுடன் வாழ்பவர்களுக்கு தகுந்த விரிவான சேவையை வழங்குவதற்கு மிகவும் அவசியமாகும். அவர்களுக்கான எ.ஆர்.ரி (ART) மருந்துவகைகள் உட்பட அனைத்து சேவைகளும் பாலியல் நோய் சிகிச்சை (STD Clinics) நிலையங்களிலும், தேசிய தொற்றுநோய் கட்டுப்பாட்டு மருத்துவமனையிலும் (IDH) கிடைக்கப்பெறும்.

03. எச்.ஐ.வி தொற்றுடன் வாழ்பவர்களுக்கு, தகுந்த விரிவான பராமரிப்பு சேவையை வழங்குவதனை எளிதாக்குவதற்கு கீழே கொடுக்கப்பட்டுள்ள வழிகாட்டுகைகளுக்கு (guideline) அமைய, நடவடிக்கைகளை எடுத்தல் அவசியம்.

i. நோயாளி ஒருவருக்கு நோய் அறிகுறிகள் மற்றும் ஆபத்தான நடத்தை (risk behaviour) இருக்குமிடத்து, சேவை வழங்குனரால் முன்வைக்கப்பட்ட எச்.ஐ.வி பரிசோதனை வழங்கப்படுதல் மிகவும் அவசியம். எச்.ஐ.வி பரிசோதனைக்காக, மருத்துவமனை கிளினிக் அல்லது வாட்டில் இருந்து 3 மி.லீ. (3 CC) குருதியை ஒரு வெற்றிடமாக்கப்பட்ட குழாயினுள் (vacutainer tube) சேகரித்து, பாலியல் நோய் (STD Clinics) சிகிச்சை நிலையத்திற்கு அனுப்புதல் வேண்டும்.

ii. பாலியல் நோய் (STD Clinics) சிகிச்சை நிலையங்களினால், வாட்டுகளில் இருந்து பெறப்பட்ட இரத்த மாதிரிகளின் எச்.ஐ.விக்கான (HIV screening test) பரிசோதனை மேற்கொள்ளப்பட்டு அறிக்கைகள் வழங்கப்படுதல் வேண்டும். எச்.ஐ.வி தொற்று கண்டறியப்படுமிடத்து, அந்தப் பரிசோதனை அறிக்கை உடனடியாக தொடர்பான வைத்தியருக்கு அல்லது விசேட வைத்திய நிபுணருக்கு இரகசியமான முறையில் தெரியப்படுத்தப்படல் வேண்டும்.

iii. ஆரம்ப பரிசோதனையிலிருந்து எச்.ஐ.வி தொற்றுள்ளவர் (Positive HIV screening test) எனக் கண்டறியப்படுமிடத்து, அவரை எச்.ஐ.வி தொற்று உறுதிப்படுத்தல் (confirmatory test) பரிசோதனைக்காக பாலியல் நோய் (STD Clinic) சிகிச்சை நிலையத்திற்கு அனுப்புதல் வேண்டும். உறுதிப்படுத்தல் பரிசோதனை எச்.ஐ.வி தொற்றினை உறுதிப்படுத்துமாயின், அவர்கள் மேலதிக சிகிச்சைக்காகப் பாலியல் நோய் சேவைநிலையத்தில் எச்.ஐ.வி தொற்றுடன் வாழ்பவர்களாகப் பதிவுசெய்யப்படுவர்.

iv. உள்ளக மருத்துவ சிகிச்சை தேவைப்படும் பட்சத்தில், எச்.ஐ.வி தொற்றுடன் வாழ்வோருக்கான நிறுவன ரீதியான மருத்துவ கவனிப்பு, பொது வாட்டுக்களில் (general wards) வழங்கப்படும் என்பது சுகாதார அமைச்சின் கொள்கையாகும். இந்தக் கொள்கை முடிவின் பிரகாரம், பின்வரும் நடைமுறைகள் ஏற்றுக்கொள்ளப்படல் வேண்டும். உள்ளக மருத்துவ சிகிச்சை தேவைப்படும் பட்சத்தில், எச்.ஐ.வி தொற்றுடன் வாழ்வோருக்கான மருத்துவ சேவை தகுந்த முறையில், கொழும்பிலோ அல்லது வெளி மாவட்டங்களிலோ, எந்தவித வேறுபாடுகள் அல்லது தனிப்படுத்தலோ இன்றி, பொது வாட்டுக்களில் (general wards- மருத்துவ சிகிச்சைப்பிரிவு, சத்திரசிகிச்சைப் பிரிவு அல்லது வேறு விசேட பிரிவுகளில்) உள்வாங்கப்பட்டு வழங்கப்படும். இந்தத் திட்டத்தை அடிப்படையாகக் கொண்டு பின்வரும் நடைமுறைகள் பின்பற்றப்படல் வேண்டும்.(பொதுச் சுற்றறிக்கை இல:02/125/98)

v. இரகசியத்தன்மை பேணப்படுவதற்கான எல்லா நடவடிக்கைகளும் எடுக்கப்படல் வேண்டும்.

vi. வேறு கிருமித் தொற்றுக்கு ஆட்பட்டு, சிக்கலான நிலையிலுள்ளவர்களுக்கு (infectious complications) தடுப்பு கவனிப்பு (barrier nursing) தேவைப்படுமிடத்து, அவருக்கு சிகிச்சை வழங்குவதற்கு குறிப்பிட்ட மருத்துவ நிலையத்தில் போதுமான வசதிகள் இல்லாதவிடத்து மட்டுமே அவரை தேசிய தொற்று நோய் கட்டுப்பாட்டு மருத்துவ மனைக்கு (IDH) மாற்ற முடியும்.

04. இலங்கையின் தேசிய எச்.ஐ.வி. கொள்கைக்கமைய, "எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்கள், களங்கம் மற்றும் பாகுபாடு இன்றிய நிறுவன சேவைகளை நாடுவதற்கான உரிமையை இலங்கை அரசாங்கம் ஏற்றுக்கொள்கின்றது. எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்களுக்குத் தேவையான மனித நிர்ப்பீடன எதிர்ப்பு வைரசுக்கான மருந்துவகைகளும், சந்தர்ப்பவாதத் தொற்று நோய்களுக்கான சிகிச்சையும் தேசிய வழிகாட்டுகைகளுக்கு அமையவும், நடைமுறையிலுள்ள தேசிய சுகாதார கொள்கையின்படியும், அரசினால் வழங்கப்படும்." (3.8 பக்கம் 22)

05. மேலும், 14.03.2016 அன்று SC.FR.No.77/2016 க்கு அமைய வழங்கப்பட்ட தீர்ப்பின் பிரகாரம் "எச்.ஐ.வி/எய்ட்ஸ் உடன் வாழும் மக்களின் மனித உரிமைகளை மேம்படுத்தி, அவற்றைப் பாதுகாப்பதுடன் அவற்றை மதிக்கத்தகுந்த நடைமுறைகளை செயற்படுத்துவதன் மூலம் அவர்களை வேறுபடுத்துதலை ஒழிப்பதற்கான நடவடிக்கைகளை மேற்கொள்ளும் என்பதனை இலங்கை அரசாங்கம் உறுதிப்படுத்த வேண்டும் என்பதை நீதிமன்றம் பதிவேட்டில் பதிவு செய்யவிரும்புகின்றது." (பக்கம் 4)

06. 2025 ஆம் ஆண்டளவில், இலங்கையில் எய்ட்ஸ் நோயை இல்லாதொழிப்பதற்கான செயற்திட்டத்தினை வெற்றிகரமாகச் செயற்படுத்த, சுகாதார அமைச்சு சகல மருத்துவ மனைகளின் அதிகாரிகளினதும் பூரண அர்ப்பணிப்பையும் ஒத்துழைப்பையும் எதிர்பார்க்கின்றது.

07. எச்.ஐ.வி/எய்ட்ஸ் உடன்வாழும் மக்களுக்கான, எந்தவித வேறுபாடுகள் அல்லது தனிப்படுத்தலோ இன்றிய தகுந்த விரிவான பராமரிப்பு சேவையை வழங்குவதற்கான நடவடிக்கைகளை மேற்கொள்ள வேண்டும் எனும் இலங்கை அரசாங்கத்தின் கொள்கையை மீண்டும் வலியுறுத்துகின்றேன். உங்களது ஒத்துழைப்பு மிகவும் வேண்டப்படுகிறது.

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வைத்தியர்.பி.ஜி.மஹிபால
சுகாதார சேவைகள் பணிப்பாளர் நாயகம்

பிரதிகள்

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

Annexure 1.2 General circular letter No. 01-59/2016

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දිනය)
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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.

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Director General of Health Services

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

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

පොදු චක්‍රලේඛ අංක: 01 - 59/2016

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

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

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

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

03. සෞඛ්‍ය අමාත්‍යාංශය විසින් සාකච්ඡා වට කිහිපයකින් පසුව සියලුම ගර්භනී මව්වරුන්ගේ HIV සඳහා වන මූලික පරීක්ෂණය කිරීමට ප්‍රතිපත්තිමය තීරණයක් ගත් අතර එය දැනට පවතින උපදංශය සඳහා වන රුධිර පරීක්ෂණය සිදුකරන අවස්ථාවේම කිරීමට තීරණය විය. ගර්භනී මව්වරුන් HIV සඳහා පරීක්ෂා කිරීම 2013 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 වැකුයුටෙනර් 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 තිබේදැයි 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 ආසාදිත ලෙස තහවුරුවන රුධිර සාම්පල පිළිබඳ තොරතුරු අදාළ වෛද්‍ය නිලධාරීන් (MO), සෞඛ්‍ය වෛද්‍ය නිලධාරීන් (MOH) හෝ විශේෂඥ ප්‍රසව හා නාරීවේද වෛද්‍යවරුන් (VOG) වෙත රහස්‍යභාවය රැකෙන පරිදි දැන්විය යුතුය.

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

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

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

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

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

(ආ) පුද්ගලික අංශය

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

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

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

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

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

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

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

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

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

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

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

පිටපත්:-

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

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சுவசிரிபாய
SUWASIRIPAYA

මගේ අංකය)
எனது இல)DDG/(PHS-I)/NSACP/2011
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.

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.

x. 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 வேன்டும்.

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.

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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

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

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

Standard

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

Aim

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

Requirements

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

Applying the standard

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

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

- Manage all women who are sero reactive 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
- Still birth rate.

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

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

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

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

Annexure 4: Laboratory Form

NATIONAL STD/AIDS CONTROL PROGRAMME, MINISTRY OF HEALTH.

REQUEST FORM FOR SYPHILIS/HIV TESTING IN ANTENATAL MOTHERS.

Institution/clinic ……..

MOH area ……..

Date of sample collection ……..

PatientNo (ANC)	Age	Parity.	POA	HIV Results	VDRL Results

…… ……. ……..

Name of collecting officer Designation Signature.

……. …… ……..

Name of Medical officer Designation Signature

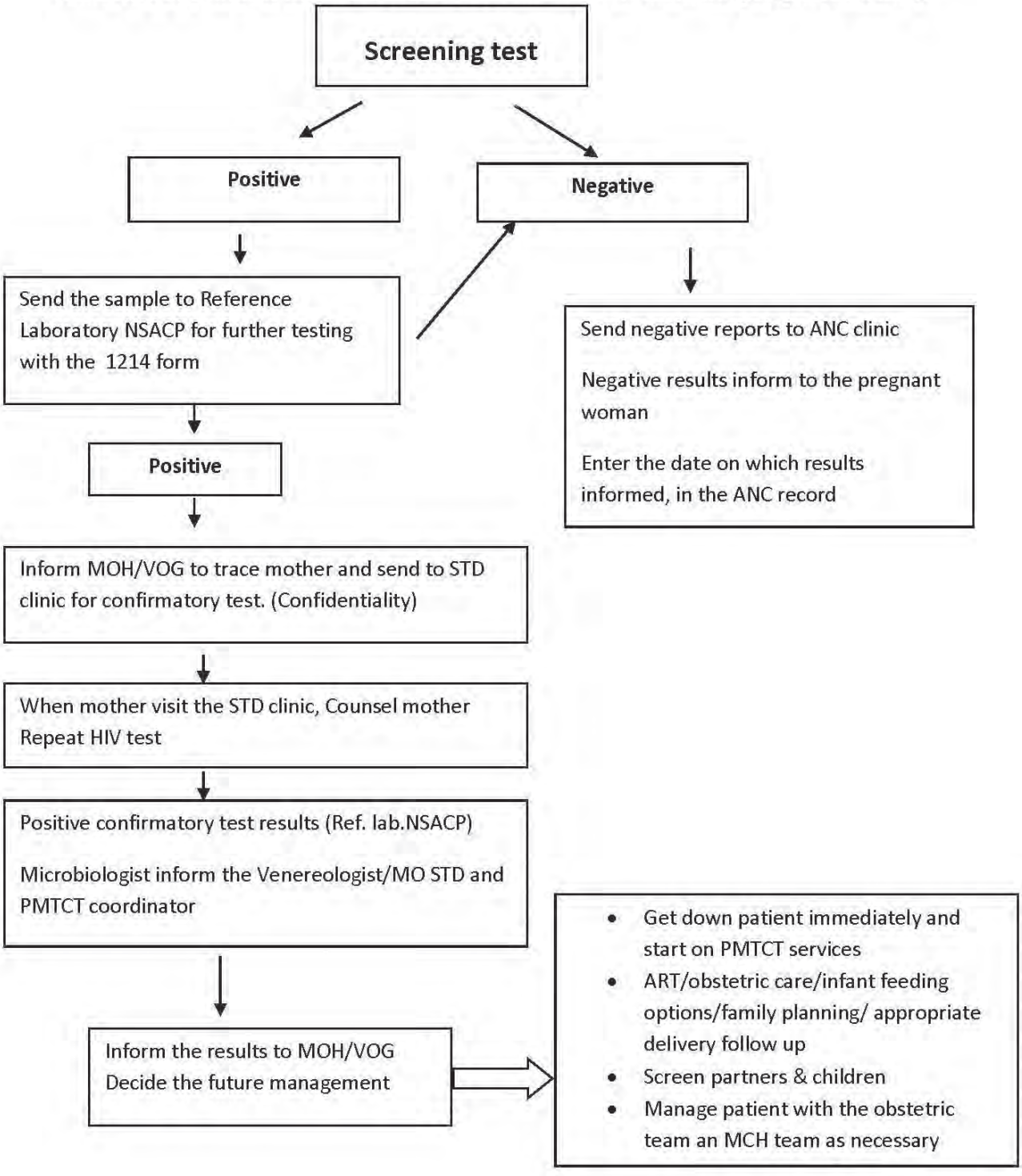
Lab use only.

Date/Time of receipt of samples:…… ……..am/pm

MLT:……. Medical officer STD/Lab:……..

Date…… Date: ……..

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



Annexure 6 Letter 1- Informing positive HIV screening test to MCH services

Telephone
Director
Office
Fax
Email: ilo@sltnet.lk
Web: www.sltnet.lk

தேசிய பாலியல் நோய்/எயிட்ஸ் தடுப்பு கொணைத்திட்டம்
National STD/AIDS Control Programme

29 ද සරම් පෙදෙස කොළඹ 10 ශ්‍රී ලංකාව
29 ஆ சரம் இடம், கொழும்பு 10, இலங்கை
29 De Saram Place, Colombo 10, Sri Lanka

My No:
Your No:
Date:

Urgent & Confidential

Director/CSHW/DMH/MOH/VOG

.....

Dear Sir/ Madam,

Screening of antenatal blood samples

ANC Clinic area/PHM area:

ANC clinic NO:.....

Date of specimen collection:

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

Thank you

.....

Director NSACP/ Venereologist/ MO STD

Annexure 7: Letter 2- To mother, requesting early visit to clinic

නම:.....

වයස: .....

පූර්ව ප්‍රසව සායනය :.....

පූර්ව ප්‍රසව අංකය : .....

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

නිරෝගී දරු උපතක් සඳහා මෙය ඉතා වැදගත් බව සලකන්න.

මේට

.....

Annexure 8 : Letter 3 – Referral letter to STD clinic

Confidential.

.....

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

.....

Referral of antenatal mother with positive screening test

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

Thank you

.....

.....

Annexure 9 : Letter 4 – Letter informing confirmed positive status

Telephone

Director

Office

Fax

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

தேசிய பாலியல் நோய்/எயிட்ஸ் தடுப்பு கொத்தணித் திட்டம்
National STD/AIDS Control Programme

29 ද සෙනරත් පෙදෙස කොළඹ 10 ශ්‍රී ලංකාව
29 டி சேரம் இடம், கொழும்பு 10, இலங்கை.
29 De Saram Place, Colombo 10, Sri Lanka

My No

Your No

Date:

Urgent & Confidential

MOH/VOG

Dear Sir/Madam,

<u>Confirmatory test results of ANC blood samples</u>

ANC Clinic area/PHM area:

ANC clinic NO:.....

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

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

The copy of the report is attached here with.

Thank you.

.....

Director NSACP/Venereologist/ MO STD

Annexure 10.1

Details of pregnant mother with confirmed HIV infection

STD Clinic:

Date of registered: Master No:

Age : : LMP EDD:

CD 4 count in early pregnancy (Date):

Diagnosed: During pregnancy / Already diagnosed

If already diagnosed: on ART / not on ART

If already diagnosed POA at the time informed pregnancy:

Pregnancy: Planned / Unplanned

If diagnosed in Pregnancy

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

ART regimen:

ART started at POA: **Date:**

Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory

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

Delivery Date:

Elective LSCS/Emergency LSCS/ NVD

Any Invasive procedure during delivery: None/Forceps/ Vacuum

Family planning method after delivery:

Baby

Feeding method: Formula feeding/Breast feeding under ART covers

ART syrup for 6 weeks: Completed / Defaulted

Age of First DNA PCR: Positive/Negative

Age of second DNA PC Positive/Negative

HIV antibody test at 18 months: Positive/Negative

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

.....

Consultant Venereologist/MO STD

Annexure 10.2

Details of Paediatric patients with HIV infection

STD Clinic: ☐

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

Age at the time of diagnosis ☐

Sex: Male / Female

Baby confirmed diagnosis on (Date): ☐☐☐

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

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

WHO clinical stage at the diagnosis: ☐

Is child on ART: Yes/No

Date ART started: ☐☐☐

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

Adherence: Unsatisfactory /Satisfactory / >95% Satisfactory

Current WHO clinical Stage now: ☐

Remarks:

.....

.....**Consultant Venereologist/MO STD**

Annexure 12: Pregnancy Record (H 512)

සායනික සංරක්ෂණය/பிணியாய்வு நிலைய பராமரிப்பு / Clinic care

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

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

ශ්වසන පද්ධතිය சுவாசத்தொகுதி Respiratory System	
පියයුරු පරීක්ෂාව மார்பகப் பரிசோதனை Breast Examination	

පරීක්ෂණ/ பரிசோதனைகள்
Investigations

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

වෙනත් පරීක්ෂණ ஏனைய பரிசோதனைகள் Other Investigations

පණු ප්‍රතිකාර பூச்சித் தடுப்பு மருந்துகள் Antihelminthic Drugs	
භ්‍රෑණ චලන සටහන්පත ලබා දුන් දිනය Date of issuing kick count chart	

උපදංශය සඳහා පූර්ව පරීක්ෂාව/ சிபிலிசுக்கான முற்பரிசோதனை / Syphilis Screening

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

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

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

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

3

Annexure 13: Poster EMTCT of HIV

Annexure 14.1: Leaflet for pregnant women on service package (Page 1)

- අදාල පරීක්ෂණයන් කර ගැනීමෙන්
- අවශ්‍ය උපදෙස් පිළිපැදීමෙන්

නීරෝගී බිළිඳකු වෙනුවෙන් ඔබේ පැතුම ඉටු වේ.

ඔබේ වගකීම වනුයේ

ගැබ්ගත් බව දැනගත් වහාම

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

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

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

ඔබේ පැතුම සැබෑ වීමට නම්

සෑම කාන්තාවකගේම පැතුම නිරෝගී දරු සම්පතකි.

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

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

සායනයේදී මුත්‍රා හා රුධිරය පරීක්ෂා කල යුත්තේ ඇයි ?

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

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

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

රුධිර වර්ගය හා ආර් එච් ෂනය(Grouping & Rh)

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

හිමොග්ලොබින්(Hb)

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

රුධිරයේ සීනි පරීක්ෂණය (Blood Sugar)

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

වී.ඩී.ආර්.එල් (VDRL)පරීක්ෂණය

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

එච්.අයි.වී (HIV) පරීක්ෂණය

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

Annexure 15: Request for HIV antibody test (H 1214)

CONFIDENTIAL Health 1214

REQUEST FOR HIV ANTIBODY TEST / NOTIFICATION

(To be retained by the Physician Requesting Test)

PATIENT No : ☐☐☐☐☐☐

NAME OF PATIENT : .....

ADDRESS : ..... DATE OF REQUEST ☐☐☐☐☐☐
..... D M Yr

ETHNICITY : .....

Tear off : ———————————————————————

DATE OF REQUEST ☐☐☐☐☐☐ PATIENT No : ☐☐☐☐☐☐
D M Yr

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

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

DISTRICT OF RESIDENCE : ..... ☐

DATE OF BIRTH : ☐☐☐☐☐☐ AGE ☐☐
D M Yr

SEX : 1. MALE 2. FEMALE ☐

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

OCCUPATION : ..... ☐☐
(Please Specify)

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

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

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

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

DESIGNATION : .....

SIGNATURE : .....

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

TO BE COMPLETED WHEN REQUESTING FOR CONFIRMATORY TESTING FOR HIV ANTIBODY IN A PATIENT WITH SYMPTOMS AND SIGNS INDICATIVE OF ADVANCED HIV DISEASE/AIDS.

CLINICAL CRITERIA

Group A

1. > 10% of the body weight loss or cachaxia, with diarrhoea or fever, or both, intermittant or constant, for at least 1 month, not known to be due to a condition unrelated to HIV infection ☐
2. Tuberculosis. disseminated (2≥ organs) or miliary or extra pulmonary or noncavitatory pulmonary ☐
3. Kaposi's Sarcoma ☐
4. Unexplained, objective neurological impairment interfering with normal daily activities ☐
5. Toxoplasmosis of the brain ☐
6. Candidiasis of the Oesophagus ☐
7. Pneumocystis carinii pneumonia ☐
8. Clinically diagnosed, life threatening or recurrent episodes of pneumonia, with or without aetiological confirmation ☐
9. Extra-pulmonary crytococosis ☐

Group B

1. Multidermatomal or recurrent herpes zoster ☐
2. Generalised or persistent pruritic papular dermatitis not responding to treatment ☐
3. Chronic persistent and disseminated herpes simplex virus infection ☐
4. Oral hairy leukoplakia ☐
5. Cytomegalo virus retinitis ☐
6. Recurrent salmonella septicaemia ☐
7. Recurrent vulvo-vaginal candidiasis ☐
8. Invasive carcinoma of the cervix, in a female < 40 yrs of age ☐
9. Recurrent, resistent pelvic inflammatory disease ☐
10. Recurrent fistulae-in-ano or recurrent perianal abscesses ☐
11. Anaemia (Hb<11 gr in a male and < 10G in a female and lymphopenia (<1000/mm^3) or thrombocytopenia (<100,000/mm^{3}of blood) ☐

Please place a ☑ in the appropriate cage