PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)

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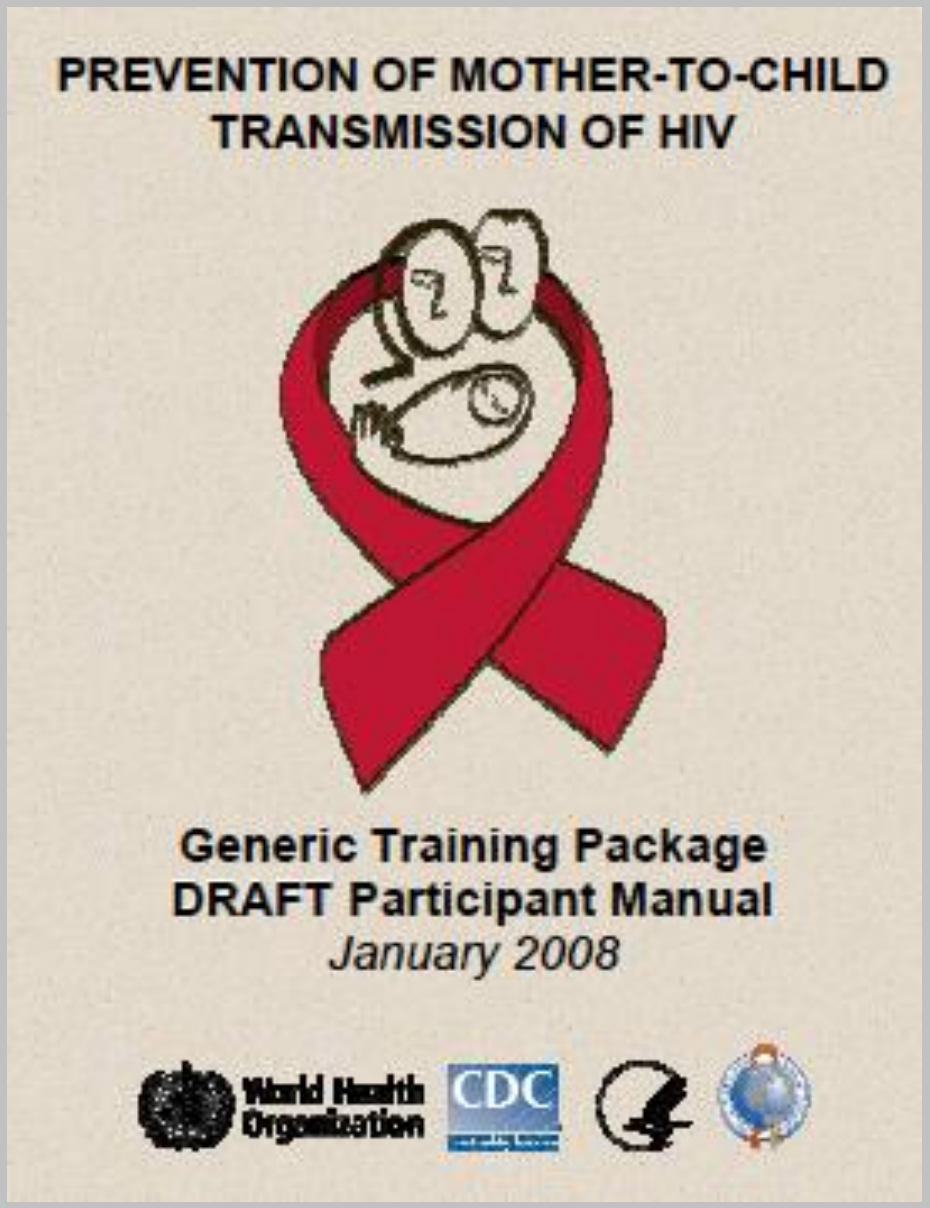
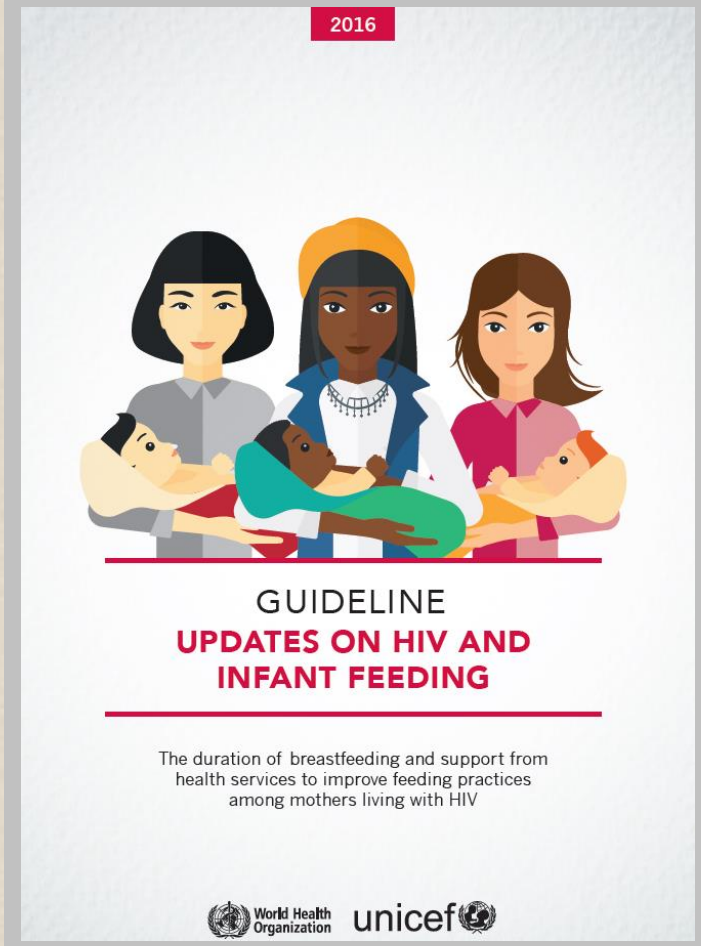

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV
Generic Training Package
DRAFT Participant Manual
January 2008
World Health Organization
CDC


2016
GUIDELINE
UPDATES ON HIV AND INFANT FEEDING
The duration of breastfeeding and support from health services to improve feeding practices among mothers living with HIV
World Health Organization
unicef

PMTCT

- Mother-to-child transmission of HIV (MTCT) is the transmission of HIV from an infected mother to her baby during pregnancy, labour and delivery and breastfeeding.
- MTCT is also referred to as **“vertical transmission” or “perinatal transmission”.**
- Most of the children infected with HIV acquired the virus through MTCT.
- Prevention of mother-to-child transmission of HIV (PMTCT) is a common term for programmes, services and interventions designed to reduce the risk of MTCT.

Rates and Timing of MTCT

- Risk of transmission without intervention
  - Without intervention, the overall MTCT rate is approximately 20–45%. The risk of transmission during breastfeeding depends on whether the mother uses safer breastfeeding practices (e.g., avoiding mixed feeding) and duration of breastfeeding:

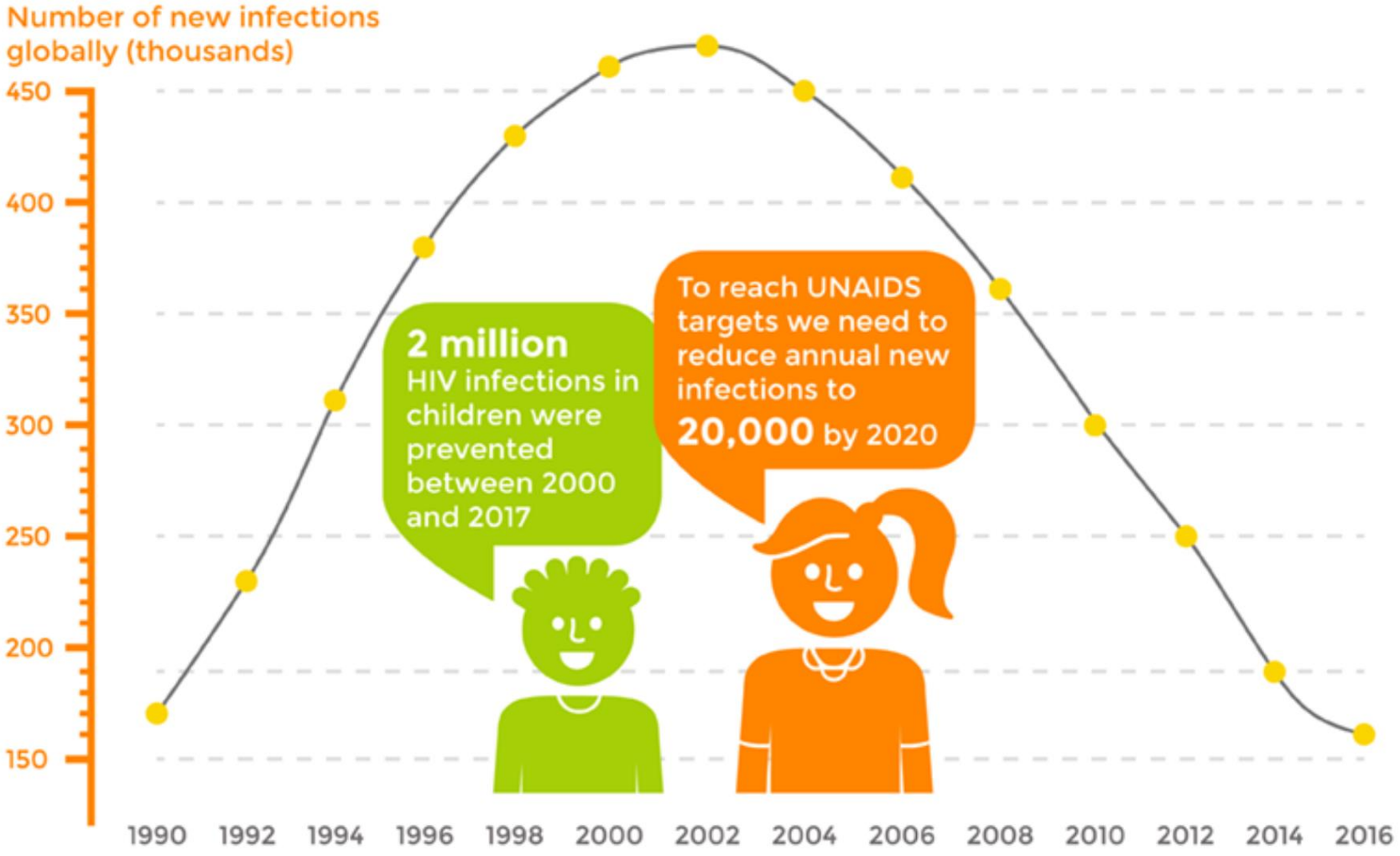
    - With breastfeeding to six months: overall transmission rate is 20-35%
    - With breastfeeding to 18-24 months: overall transmission rate is 30-45%

Reducing MTCT through core interventions

- MTCT can be reduced by 40-70% through core PMTCT interventions, including ARV therapy or prophylaxis, particularly if provided in combination with other interventions such as safer obstetric practices, infant feeding information, counselling and support.

- In industrialized countries where women infected with HIV receive long-term combinationARV therapy and do not breastfeed—and where elective caesarean sections are safe,feasible and commonly performed—the rate of MTCT has been reduced to about 2%.

New HIV infections in children aged 0-14 years old.



Source: World Bank – accessed 5th December 2017 and UNICEF analysis of UNAIDS 2017 data

Avert www.avert.org

Global MTCT

- The Middle East and North Africa is the region that has shown the least amount of progress, as nearly one third of women living with HIV passed the virus on to their children in 2015.

- The MTCT rates in Asia and the Pacific and western and central Africa were also well above the global average of 10%.

- As of June 2016, *Armenia*, *Belarus*, *Cuba and Thailand* had been certified by the WHO to have eliminated MTCT.

- By 2015, seven countries in East and Southern Africa had greater than 90% coverage of PMTCT services. This includes South Africa, which is home to 25% of the region's pregnant women living with HIV.

- East and Southern Africa has achieved the largest decline in MTCT anywhere in the world, falling from 18% of infants born to mothers living with HIV in 2010 to 6% in 2015—a threefold decrease.

Table 1. Quick Facts

Demographic Data	November 2017	Jan-Nov 2017	Jan 2012 - Nov 2017	Cumulative Jan1984 - Nov 2017
Total Reported Cases	894	10,111	41,369	49,733
Asymptomatic Cases	767	8,834	37,409	44,791
AIDS Cases	127	1,277	3,960	4,942
Male	859	9,625	39,536	46,426[a]
Female	35	486	1,833	3,296[a]
Age Range (Median)	2-70 (27)	1-79 (27)	1-82 (28)	1-82 (28)
Less than 15 y/o	5	36	89	147[b]
15-24 y/o	288	3,119	11,922	13,839[b]
25-34 y/o	436	5,089	21,667	25,475[b]
35-49 y/o	144	1,635	6,755	8,875[b]
50 y/o & above	21	232	936	1,323[b]
Pregnant Living with HIV	2	67		216
Newly Started on ART	658			
Total PLHIV on ART				24,311
Reported Deaths	13	428		2,397

[a] 11 cases did not report sex
[b] 74 cases did not report age

MTCT in the Philippines
HIV/AIDS registry, as of Nov 2017

From January 1984-November 2017, 1,965 (4%) of the reported cases were 19 years old and below.

135 out of 1,965 (7%) were children and among them 132 were infected through mother -to -child transmission

1,830 out of 1,965 (93%) were adolescents and among them 8 (<1%) were infected through mother-to- child transmission

Comprehensive Approach to Reducing HIV Infection in Mothers, Infants and Young Children

- Element 1 Primary prevention of HIV infection
- Element 2 Prevention of unintended pregnancies among women infected with HIV
- Element 3 Prevention of HIV transmission from women infected with HIV to their infants
- Element 4 Provision of treatment, care and support to women infected with HIV, their children and their families

Element 1: Prevention of Primary HIV Infection

- ABCs of primary HIV prevention for parents-to-be:

A = Abstain

B = Be faithful to one HIV-uninfected partner

C = Condom use – use condoms consistently and correctly

Element 2: Prevention of Unintended Pregnancies Among Women Infected with HIV

- Access to counselling and referral for family planning
- Safe, consistent, effective contraception

Element 3: Prevention of HIV Transmission from Women Infected with HIV to their Infants

Core Interventions

- HIV testing and counselling
- Antiretrovirals
- Safer delivery practices
- Safer infant-feeding practices

Element 4: Provision of treatment, Care and Support to women infected with HIV and their Families

- Prevention and treatment of opportunistic infections
- ARV treatment
- Palliative and non-ARV care
- Nutritional support
- Reproductive healthcare
- Psychosocial and community support

Antiretroviral Treatment and Prophylaxis

- **ARV Treatment**

- Long-term use of antiretroviral drugs to treat maternal
- HIV/AIDS and prevent MTCT

  - Reduces viral replication and viral load.
  - Treats maternal infection
  - Protects the HIV-exposed infant
  - Improves overall health of mother
  - Requires ongoing care and monitoring

Antiretroviral Treatment and Prophylaxis

ARV Prophylaxis

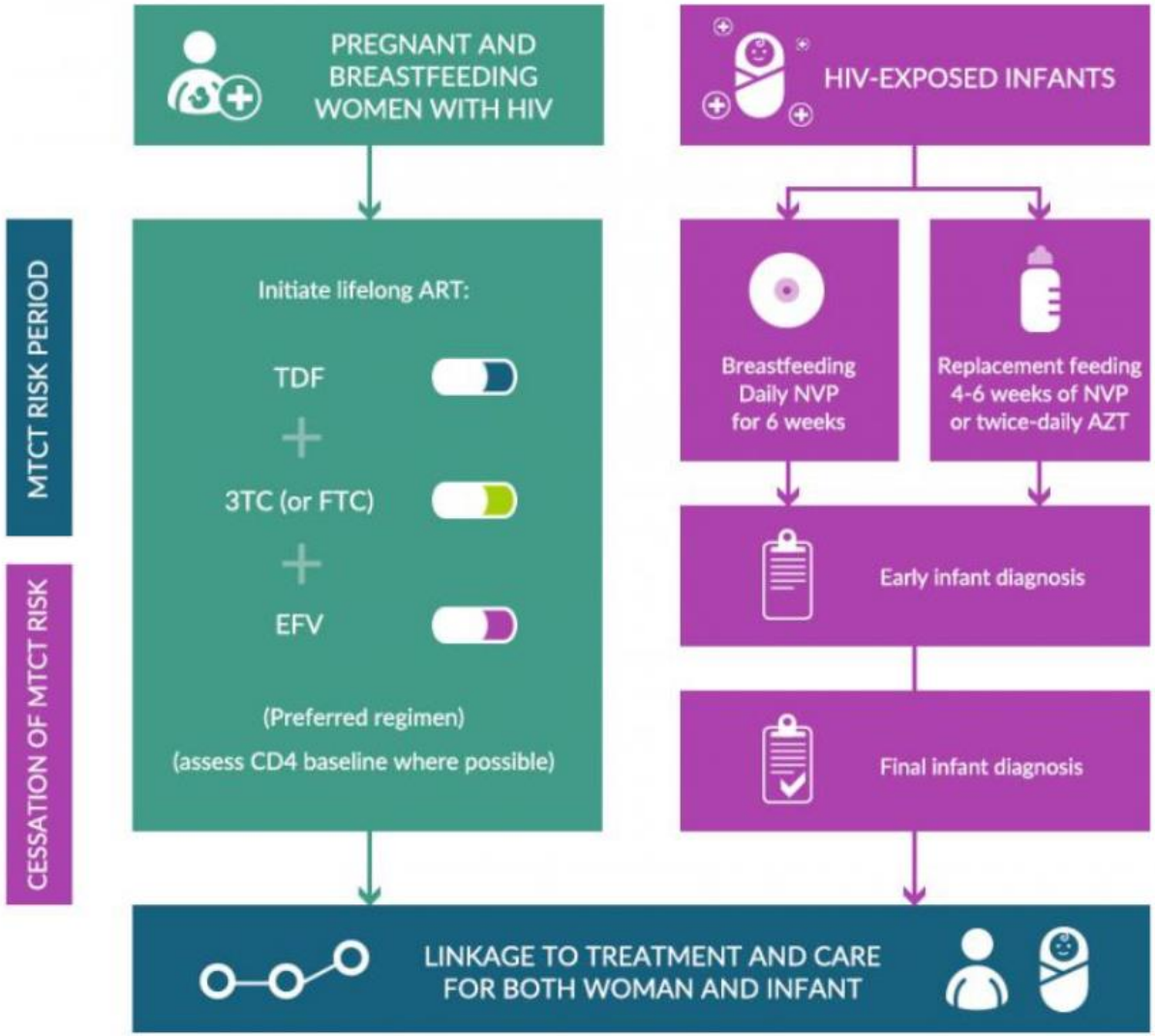
Short-term use of antiretroviral drugs to reduce HIV transmission from mother to infant

Table 2.1 Maternal and neonatal factors that may increase the risk of HIV transmission

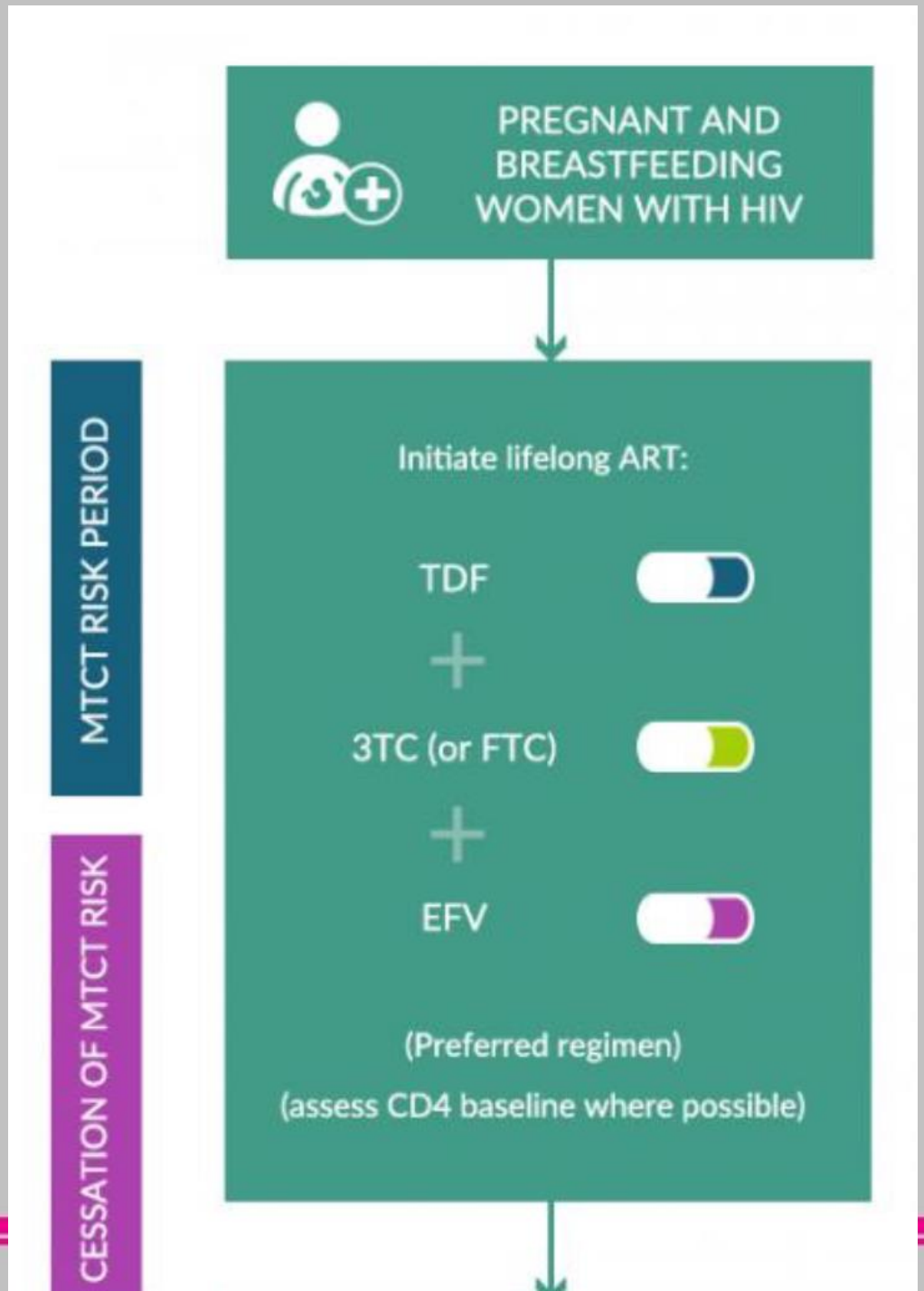
Pregnancy	Labour and Delivery	Breastfeeding
▪ High maternal viral load (new infection or advanced AIDS) ▪ Viral, bacterial, or parasitic placental infections, such as malaria ▪ Sexually transmitted infections (STIs)	▪ High maternal viral load (new infection or advanced AIDS) ▪ Rupture of membranes for more than 4 hours[1] ▪ Invasive delivery procedures that increase contact with mother's infected blood or body fluids (e.g. episiotomy, artificial rupture of membranes) ▪ Chorioamnionitis (from untreated STI or other infection) ▪ Preterm delivery ▪ Low birthweight	▪ High maternal viral load (new infection or advanced AIDS) ▪ Duration of breastfeeding ▪ Mixed feeding (giving water, other liquids, or solid foods in addition to breastfeeding) ▪ Breast abscesses, nipple fissures, mastitis ▪ Oral disease in the baby (e.g. thrush or sores)

[1] Studies have found there is an increased rate of HIV transmission after a mother's membranes have been ruptured for more than 4 hours. The longer the membranes are ruptured, the higher the risk of HIV transmission.

OPTION B+: LIFELONG ART FOR ALL PREGNANT AND BREASTFEEDING WOMEN WITH HIV



Source: WHO (2013) 'Consolidated


PREGNANT AND BREASTFEEDING WOMEN WITH HIV
MTCT RISK PERIOD
Initiate lifelong ART:
TDF
+
3TC (or FTC)
+
EFV
(Preferred regimen)
(assess CD4 baseline where possible)
CESSATION OF MTCT RISK

C. HIV Test Services

1. All pregnant women and male partners, and women (pregnant or not) belonging to a key population at high risk shall be offered HIV counselling and testing at the birthing centers and primary HIV services clinics
2. For pregnant women who refused to undergo HIV testing, health care providers shall offer HIV screening test on her subsequent ante-natal care visits.
3. Women who tested HIV—non-reactive shall be given counselling on risk reduction interventions focusing mainly on how to maintain their HIV Negative status including the use of condoms in all sex acts especially during the entire course of pregnancy.

C. HIV Test Services

4. For all women who tested positive shall receive, in addition to the standard messages for all people diagnosed with HIV infection, PMTCT services including, but not limited to the following:

a. **Childbirth plans**: providers should encourage HIV-positive pregnant women to deliver in a health facility for their own well-being as well as to ensure access to PMTCT services;

b. **Anti-retroviral Treatment**: use of ARVs for the mother's health, as well as to prevent transmission of HIV to the infant;

c. **Maternal nutrition:** counselling on adequate maternal nutrition, including iron and folic acid;

d. **Infant feeding:** Opening of infant feeding options and support to carry out the mother's infant feeding choice. This will include exclusive breastfeeding counseling and post partum support to the mothers.

- **HIV status of partner:** Importance of partner testing, and disclosure
- **Other Screening:** Ensuring screening for TB and testing for other infections such as syphilis and Hepatitis B;

a. **HIV Exposed Infant health care:** HIV-exposed infants should be given ARV for prophylaxis, HIV test or early infant diagnosis, congenital STD evaluation and treatment, follow up and **appropriate schedule and form** of vaccinations

F. Antiretroviral Treatment (ART) for Pregnant Women Living with HIV

1. ART shall be initiated on ALL pregnant WLHIV, regardless of CD4 count or of clinical status

2. ART shall be continued even after delivery and breastfeeding of the infant.

G. Management of Labour and Delivery

- HIV infected women who are about to deliver should be referred and admitted to the nearest birthing facility. The birthing facility shall facilitate for the access of ARV for the woman and newborn infant.

- Pregnant WLHIV need not be isolated during labor and delivery because of their HIV status. Health facility staff must use *standard precautions* in all patients regardless of their patients' HIV status.

- The attending physician should consider vaginal delivery unless one the following conditions are present:
  - Scarred uterus (previous caesarean delivery: classical, low transverse)
  - Signs and symptoms of prolonged labor
  - Malpresentation
  - Fetal Distress

G. Management of Labour and Delivery

- The physician should discuss caesarean section delivery with the WLHIV if any following conditions are found

  - Signs and symptoms of STI
  - ARV medications have not been taken or was on ART in less than 3 weeks
  - Viral load of >1,000 copies/mL

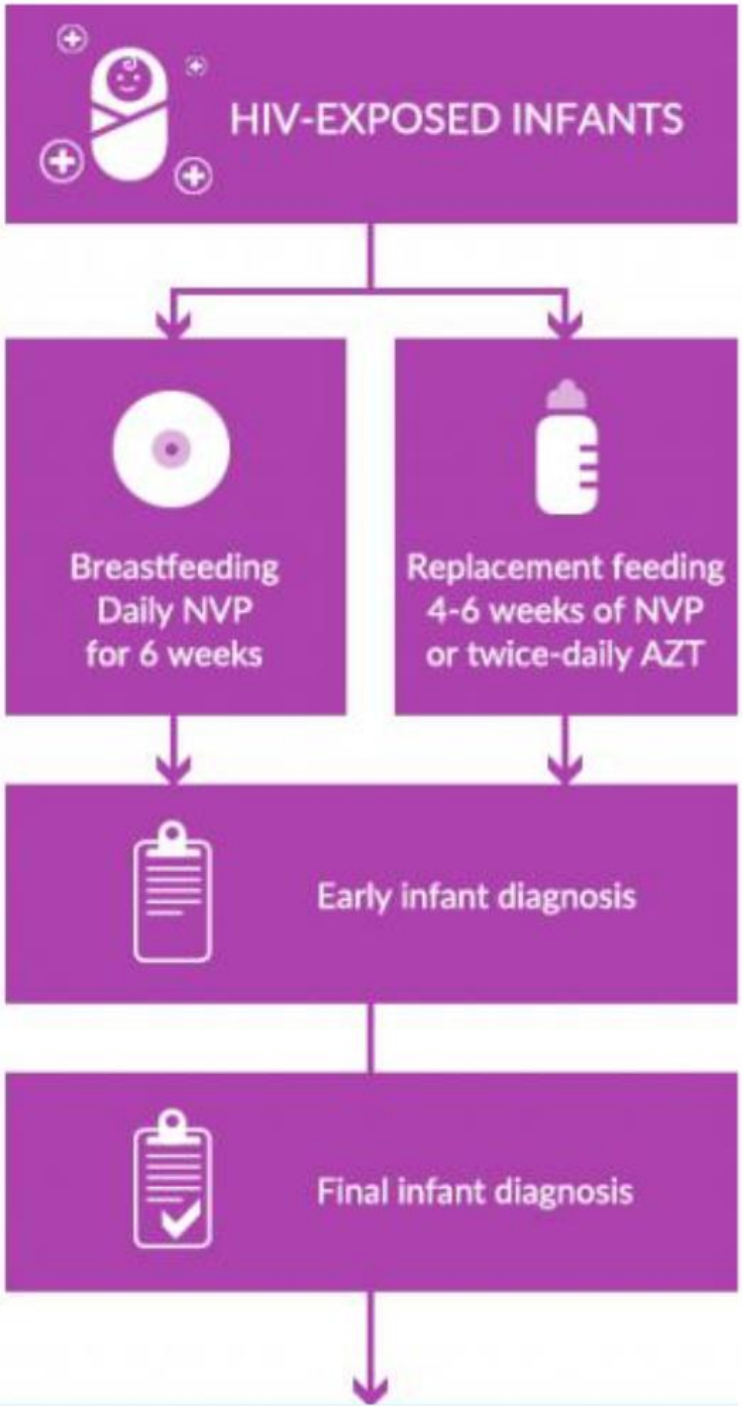
Elective Caesarean Section VS Vaginal Delivery

Elective cesarean section

- Consider elective cesarean delivery when safe and feasible
- Done at the onset of labour or membrane rupture

Vaginal delivery

- When ARV prophylaxis or treatment has effectively reduced the viral load


HIV-EXPOSED INFANTS
Breastfeeding
Daily NVP
for 6 weeks
Replacement feeding
4-6 weeks of NVP
or twice-daily AZT
Early infant diagnosis
Final infant diagnosis

H. Management of HIV Exposed Infant

1. All newborn of WLHIV shall be given the following services:
   a. **ARV prophylactic regimen**
   b. Early infant diagnosis should be ensured at **4-6 weeks** and **as breastfeeding ceased.**
   c. **For confirmed HIV infected infants, ART is initiated**
   d. If the other STI infection status of the mother is unknown, the infant should also be evaluated for congenital syphilis and other forms of STDs that can affect the newborn.

HIV Treatment Failure and Acquired Drug Resistance after One Year on Antiretrovirals in the Philippines

Edsel Maurice Salvana, MD, FIDSA[1,2], Brian Schwem, PhD[2], Genesis Samonte, MD[3], Rosario Tactacan-Abrenica, MD[4], Elizabeth Telan, MD[5], Kevin Mendoza, RN3, Geraldine Arevalo, BS[2], Marissa Alejandria, MD[1], Katerina Leyritana, MD[1,6], Lyka Trinidad, RN[3] and Jodor Lim, MD[1], (1)Department of Medicine, Section of Infectious Diseases, University of the Philippines - Philippine General Hospital (2)Institute of Molecular Biology and Biotechnology, National Institutes of Health, University of the Philippines (UP-NIH) (3)Epidemiology Bureau, Department of Health, Republic of the Philippines, (4)San Lazaro Hospital, Department of Health, Manila, Philippines, (5)STD and AIDS Cooperative Center Laboratory (SACCL), San Lazaro Hospital, Department of Health, Manila, Philippines, (6)Sustained Health Initiatives of the Philippines, Mandaluyong, Philippines

Background

The Philippines has one of the fastest growing HIV epidemics globally. As antiretroviral (ARV) use increases, the risk of acquired drug resistance (ADR) grows. Only 7 ARV agents are widely available locally (Table 1). The objectives of this study are to look at the rate of viral suppression after one year on ARVs, and to determine rates of resistance to specific ARVs.

Table 1. Locally available ARVs and resistance rates after one year of treatment.

Locally available ARVs	Resistance in Unsuppressed (%) N=45	Overall % Resistance N=458
AZT	10 (22)	2.2
3TC	34 (76)	7.4
TDF	23 (51)	5.0
D4T	27 (60)	5.9
NVP	39 (87)	8.5
EFV	39 (87)	8.5
LPV/r	0 (0)	0

Methods

Following institutional board review, patients on ARVs for one year from 3 of the largest HIV treatment hubs (San Lazaro Hospital, the Philippine General Hospital and Vicente Sotto Hospital) were recruited. Blood samples underwent HIV viral load testing at a national reference laboratory (SACCL-NRL). Samples with >1000 copies/mL were sent to UP-NIH for genotyping and drug resistance testing.

Results

458 patients (13 female, 445 male) with a median age of 30 years (range 1-72) were recruited. Median CD4 count was 298 cells/μL (range 3-1608). The most common regimens were TDF+3TC+EFV (236), AZT+3TC+EFV (135), and AZT+3TC+NVP (52). 45 (9.8%) patients were not virally suppressed [median viral load 130,000 copies/mL (range 1,150 to 3,410,000)]. 14 of the 45 unsuppressed subjects admitted missing pills in the past year. Failure rates for NVP-based regimens (15.9%) were significantly higher than for EFV-based regimens (8.6%)(p= 0.048).

Genotypes in unsuppressed subjects were CRF01_AE (84%), B (13%) and G (2%). No baseline genotype was available. 39 patients had clinically significant resistance mutations. The most common resistance mutations were M184V (22), K65R (18), Y181C (13), K101E (10), and K103N (9). 3 patients had a single PI mutation each (G48R, L33F, M46I). Resistance rates are shown on Table 1. 26/45 (58%) patients did not have an appropriate local second line regimen of three active drugs.

Conclusion

Conclusion: HIV viral suppression on ARVs is 90.2% at 1 year in the Philippines. NNRTIs are the least durable, and more agents are needed for second-line treatment. Treatment failure cannot be explained by compliance alone, and may be from transmitted drug resistance, which needs investigation.

Acknowledgments: Supported with funding from the Department of Health and the Department of Science and Technology – Philippine Council for Health Research and Development

Contact Information: Dr. Edsel Salvana edsel.salvana@gmail.com

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Infant ARV Prophylaxis for Different Clinical Scenarios

Scenario	Infant ARV prophylaxis	Duration
Infants of mothers who are receiving ART for at least 4 weeks and are breastfeeding	daily NVP	12 weeks
Infants of mothers who are receiving ART for at least 4 weeks and are on replacement feeding	daily NVP	6 weeks
Infants born to mothers with HIV who are at HIGH RISK* of acquiring HIV and is breastfeeding	AZT (twice daily) + NVP (once daily) + 3TC	12 weeks
Infants who are at HIGH RISK* of acquiring HIV including those first identified as exposed to HIV during the postpartum period (breastfeeding/replacement feeding)	ABC+ 3TC+ LPV/r	12 weeks

*High Risk Infants are defined as those:

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

Diagnosing HIV in Infants exposed to HIV

Antibody Tests

- **Rapid Tests**
  - Sample: blood from finger prick, saliva swabs
  - Lab: no special equipment
  - Ease: minimal training
  - Result time: less than 30minutes

- **ELISA**
  - Sample: blood from arm
  - Lab: special equipment
  - Ease: trained lab technician
  - Result time: up to 2 weeks

HIV Viral Antigen Tests

- **HIV viral antigen tests** (or assays) detect the presence of HIV in blood and must be done by laboratory personnel.

  - **PCR** (polymerase chain reaction) tests detect DNAor measure RNA (viral load) in the blood.
  - **p24 antigen tests** measure one of the proteins found in HIV

Diagnosing HIV in Infants Exposed to HIV

- Antiretroviral treatment and prophylaxis reduces but does not eliminate MTCT transmission of HIV infection.
- Since maternal antibodies cross the placenta, antibody testing is not recommended prior to 18 months of age.
- Infants who are breastfeeding require additional testing once breastfeeding has completely discontinued.

Non Breastfeeding Infants Who are exposed to HIV

HIV DNA PCR after 6 weeks of age

- **Positive, infant is HIV-infected**
- **Negative, infant is NOT HIV- infected**

Breastfeeding Infants Who are Exposed to HIV

HIV DNA PCR after 6 weeks of age

- Positive, infant is HIV-infected
- Negative, repeat the test 6 weeks after cessation of breastfeeding
  - **Negative, infant is not infected**
  - **Positive, infant is HIV-infected**

Antibody Test infants

Non-breastfeeding

- At or after 18 months of age:
  - Negative HIV antibody test indicates that the child is not infected.
  - Positive HIV antibody test indicates that the child is infected.

Breastfeeding

- At or after 18 months of age:
  - Negative HIV antibody test should be *repeated 6 weeks after complete cessation of breastfeeding.*
  - Positive HIV antibody test indicates that the child is infected.

I. Counselling of WLHIV regarding feeding options for their infants

1. Counselling of WLHIV for infant feeding should include and emphasize on the **role and the effectiveness of ARV in preventing post-natal transmission of HIV**.
2. The mothers should be guided to make their choice in feeding their child and the following messages shall be given:
   a. HIV-positive mothers (and whose infants are HIV uninfected or of unknown HIV status) are strongly encouraged to **exclusively breastfeed** their children for the first six (6) months of life, introducing appropriate complementary foods thereafter and continue breastfeeding.
   b. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided
   c. Mixed feeding must be avoided at all times.

I. Counselling of WLHIV regarding feeding options for their infants

1. If the **mother opted not to breastfeed** her child; the following should be communicated during counselling:

a. The concern of transmission of HIV transmission through breastfeeding should be balanced with the increased risk of morbidity and mortality when infants are not breastfed.

b. The importance of adhering to ARV and its role in preventing post-natal transmission of HIV should be reiterated

c. Options to access from milk banks

J. Follow-up Care, Treatment and Support for Mothers infected with HIV together with their children and families

1. Follow-up care including HIV-related care, ART adherence support, co-trimoxazole prophylaxis, IPT, sexual and reproductive health services, and early diagnosis of HIV infection in infants shall be provided.
2. Early diagnosis and initiation of treatment for all exposed infants shall be done utilizing the guidelines on the Integrated Management of Pediatric HIV and AIDS

KEY POINTS

- Risk of MTCT without intervention is 20–45%.
- Effective PMTCT programmes provide access to interventions that can significantly reduce the rate of MTCT.
- Risk of transmission to the infant is highest when the mother's viral load is high. Two of the main reasons that a mother may have a high viral load are: recent HIV infection and advanced AIDS.
- A comprehensive approach is needed to prevent HIV infection in infants and young children. The four elements of the comprehensive approach to PMTCT are:
  - Primary prevention of HIV infection
  - Prevention of unintended pregnancies among women infected with HIV
  - Prevention of HIV transmission from women infected with HIV to their infants
  - Provision of treatment, care and support to women infected with HIV, their infants and their families
- MCH services, especially ANC care, are an entry point into the range of services required to meet the needs of HIV-infected women and their families.

PREVENTION OF HIV:
IT BEGINS WITH ME

LIST OF TREATMENT HUBS AND SATELLITES*

Regions	Treatment Hub/Satellite Treatment Hub	Address
1	Ilocos Training and Regional Medical Center	Parian, San Fernando City, La Union
	Mariano Marcos Memorial Hospital and Medical Center	Barangay 6 San Julian, Batac, Ilocos Norte
	Region 1 Medical Center	Dagupan City Hall, AB Fernandez E Ave, Downtown District, Dagupan
2	Cagayan Valley Medical Center	Dalan na Pagayaya, Carig Sur, Tuguegarao, Cagayan
	Veterans Regional Hospital	Magsaysay, Bayombong, Nueva Vizcaya
3	Angeles City HIV Satellite Treatment Hub (Bale Angeleño)	C. Surla St., Balibago, Angeles City
	Bataan General Hospital (Bataan HAVEN)	Manahan St., Tenejero, Balanga City, Bataan
	Dr. Paulino J. Garcia Memorial Research and Medical Center (Sanctuario De Paulino)	Mabini St., Cabanatuan City, Nueva Ecija
	Dr. Paulino J. Garcia Memorial Research and Medical Center - Talavera Extension Hospital (Talevera's Hope)	Maestrang Kikay District, Talavera, Nueva Ecija
	Jose B. Lingad Memorial Regional Hospital (Bahay LInGAD)	Brgy. San Dolores, San Fernando, Pampanga
	James L. Gordon Memorial Hospital (L.E.A.D. Shelter)	#1 Perimeter Rd., New Asinan, Olongapo City
	Maria Aurora Community Hospital	Saturno St. Bargy. 01, Maria Aurora, Aurora
	Premiere Medical Center (TAHANAN sa Premiere)	Maharlika Highway, Daan Sarile, Cabanatuan City, Nueva Ecija
	Tarlac Provincial Hospital (TPH Cares)	Tarlac Provincial Hospital Compound, San Vicente, Tarlac City
	Ospital ng Lungsod ng San Jose del Monte	Sapang Palay, San Jose Del Monte, Bulacan
	Guiguinto RHU II Reproductive Health and Wellness Center (Gintong Kanlungan)	2nd flr, RHU II, Green Estate Subd., Guiguinto, Bulacan
4A	Batangas Medical Center	Kumintang Ibaba, Batangas City
	Laguna Medical Center	J. De Leon St, Santa Cruz, Laguna
	Dasmariñas City Health Office I (SHC)	Zone 2, Manggubat St., City Health Office I, Dasmariñas, Cavite
	Antipolo Social Hygiene Clinic	M. Santos St., Brgy. San Roque, Antipolo City
4B	Ospital ng Palawan	220 Malvas St. Puerto Princesa City
5	Bicol Regional Training and Teaching Hospital	Rizal St., Legazpi City
6	Western Visayas Medical Center	Q. Abeto St., Mandurriao, Iloilo City
	Corazon Locsin Montelibano Memorial Regional Hospital	2nd flr. OPD bldg. CLMMRH, Cor. Burgos, Lacson St. Bacolod City
	Dr. Rafael Tumbokon Memorial Hospital—Kalibo, Aklan	Mabini St, Kalibo, Aklan
7	Vicente Sotto Memorial Medical Center	B. Rodriguez St., Cebu City
	Cebu Social Hygiene Clinic	General Maxilom Ave., Ext., Carreta, Cebu City
	Negros Oriental Provincial Hospital	Real St., Dumaguete City, Negros Oriental
	Gov. Celestino Gallares Memorial Hospital	M. Parras St., Tagbilaran City

8	Eastern Visayas Regional Medical Center	Magsaysay Boulevard, Tacloban City
9	Zamboanga City Medical Center	Dr. Evangelista St., Sta. Catalina, Zamboanga City
10	Northern Mindanao Medical Center	Provincial Capitol Compound Cagayan de Oro City
11	Southern Philippines Medical Center	J. P. Laurel St., Bajada, Davao City
	Davao Regional Medical Center	Apokon, Tagum City, Davao del Norte
	Davao Reproductive Health and Wellness Center	Emilio Jacinto St, Poblacion District, Davao City, Davao del Sur
12	South Cotabato Provincial Hospital	Aguinaldo St., Koronadal City, South Cotabato
	General Santos City Social Hygiene Clinic	City Health Office, Fernandez St., Lagao, General Santos City
CAR	Baguio General Hospital and Medical Center	Gov. Pack Rd., Baguio City
CARAGA	CARAGA Regional Hospital	Rizal St. National Road, Surigao City
	Butuan Medical Center	Km 5 Baan, Butuan City
NCR	San Lazaro Hospital	Quiricada St., Sta. Cruz, Manila
	Philippine General Hospital	Taft Ave., Manila
	Sta. Ana Hospital	New Panaderos Street, Sta. Ana, Manila
	Manila Social Hygiene Clinic	208 Quiricada St., Sta. Cruz, Manila
	Research Institute for Tropical Medicine	Filinvest Corporate City, Alabang, Muntinlupa City
	The Medical City / I-REACT Clinic	Ortigas Ave., Pasig City
	Pasig City Treatment Hub (PATH)	CHAMP Bldg, Caruncho Ave, Pasig City
	Makati Medical Center	#2 Amorsolo St., Legaspi Village, Makati City
	St. Luke's Medical Center—Global City	Rizal Drive cor. 32nd & 5th Ave.,Taguig City
	Klinika Bernardo	Ermin Garcia St., Brgy. Pinagkaisahan, Quezon City
	Marikina City Satellite Treatment Hub	Shoe Ave., Sto. Niño, Marikina City

OTHER FACILITIES PROVIDING HIV TREATMENT

Regions	Facility	Address
3	President Ramon Magsaysay Memorial Hospital (Balin Kalinga)	Zambales Medical Society Building (beside Eye Center Clinic) Palanginan, Iba Zambales
	Bulacan Medical Center (Luntiang Silong)	Bulacan Medical Center 3rd Floor Pay 3 - Room 301 Mojon, City of Malolos Bulacan
4A	Bacoor Social Hygiene Clinic	Floraville Subdivision, Panapaan 1, Bacoor City
	Quezon Medical Center	Bgy XI, Quezon Avenue, Lucena, 4301 Quezon Province
	Ospital ng Biñan	Canlalay Bridge, Biñan, Laguna
4B	Occidental Mindoro Provincial Hospital	Paluan Road, Maburao, Occidental Mindoro
NCR	Bernardo Social Hygiene Clinic	Ermin Garcia St., Brgy. Pinagkaisahan, Quezon City
	Project 7 Social Hygiene Clinic / Klinika Project 7	39 Bansalangin St., Veterans Village, Project 7, Quezon City
	Batasan Hills Super Health Center (Social Hygiene Clinic)	#1 IBP Road, Batasan Hills, Quezon City
	Klinika Novaliches	Annex Bldg. flr., A.J. Maximo Health Center Compound, Quirino Highway, Novaliches, Quezon City
	Las Piñas Social Hygiene Clinic	Barrio Hall, Alabang-Zapote Road, Almansa, Las Piñas City
	Mandaluyong Social Hygiene Clinic	20 M. Lerma St. cor. Vicencio St, Mandaluyong City
	Muntinlupa Reproductive Health and Wellness Center	2nd Floor, Putatan Health Center, National Rd, Putatan, Muntinlupa City
	Pasay Social Hygiene Clinic	2nd Floor, Lagrosa Health Center, F.B. Harrrison St. Pasay City
	RITM Satellite Clinic - Mandaluyong (Love Yourself Anglo)	Room 5, 3/F, 715-A Anglo Bldg., Shaw Blvd., Mandaluyong City
	Taguig Social Hygiene Clinic	3/F Goldilocks Bldg., Gen. Luna St., Taguig City
	Valenzuela Social Hygiene Clinic	Valenzuela City Hall, Poblacion II, Malinta, Valenzuela City

**as per Department Memorandum No. 2016-0188: Updated List of DOH-Designated Treatment Hubs and Satellite Treatment Hubs*