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Administrative Order
No 2009- 0016

SUBJECT: Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)

I. RATIONALE

AIDS has become a leading cause of illness and death among women of reproductive age notably, in countries with a high burden of HIV infection. At the end of December 2007, about 33.2 million people were living with HIV worldwide. About half of these populations are women and at least two million are children younger than 15 years of age. About half a million babies become infected with HIV before birth, during delivery or through breastfeeding.[1]

Global coverage of PMTCT services is still low. By end of 2004, more than 100 countries already established PMTCT programs but only 16 of which were able to achieve national coverage. In 2006, at least eight countries have exceeded the 40% antiretroviral (ARV) prophylaxis uptake mark required to achieve the 2005 PMTCT target of the United Nations General Assembly Special Sessions (UNGASS).[2]

The Philippines HIV and AIDS Registry, as of February 2009 reported a cumulative total of 3,701 HIV cases. As of February 2009, there is a cumulative total of 52 HIV cases that are passed on through mother to child transmission (MTCT). There were two (2) MTCT cases reported for the 1st quarter of 2009.

Although Philippines is classified as a low prevalence country, HIV program response is currently focused and scaled up among the most at risk and vulnerable populations and communities. The country needs to mount HIV prevention of mother to child transmission (PMTCT) program appropriate to the country's needs. In line with this direction, there is a

[1] UNAIDS/WHO AIDS epidemic update: December 2006. Geneva, UNAIDS, 2006 (http://www.unaids.org/en/HIV_data/epi2006/default.asp, accessed 13 June 2007).

[2] WHO Guidance on global scale-up of the prevention of mother-to-child transmission of HIV (Towards universal access for women, infants and young Children and eliminating HIV and AIDS among children) 2007

need to come up with policies and guidelines on PMTCT that shall serve as a guide for health care providers all over the country.

II. OBJECTIVES

General Objective:

To provide policies and guidelines on the prevention of mother to child transmission of HIV that shall be used by health care providers nationwide.

Specific Objectives:

1. To describe the different components of PMTCT at all levels of health care.
2. To define the roles and responsibilities of the different DOH Offices and other agencies in the implementation of the PMTCT guidelines.

III. SCOPE AND COVERAGE

These guidelines are intended to provide guidance on PMTCT of HIV among Sexually Transmitted Infection (STI), Maternal and Child Health (MCH), Family Planning (FP), sexual and reproductive health (SRH) service providers covering public and private, community-based health facilities and the civil society.

IV. DEFINITION OF TERMS

1. **Antiretroviral (ARV) –** drugs that are given to people living with HIV infection in order to improve or maintain their immune function.

2. **Guideline on the Integrated Management of Pediatric HIV and AIDS-** ready reference adapted by the Department which is intended to serve as a guide for health service providers in the management of children with HIV/AIDS.

3. **HIV Counseling and Testing –** a confidential process that enables individuals to examine their knowledge and behavior in relation to their personal risks of acquiring or transmitting HIV. Counseling helps an individual decide on whether or not to undergo HIV testing and provides support to an individual receiving his or her test result.

4. **Prevention of Mother to Child Transmission (PMTCT)** - set of interventions with an aim of preventing the spread of HIV among infants and children.

5. **Replacement feeding** - giving an infant who is not receiving any breast milk a nutritionally adequate diet until the age at which the child can be fully fed on family foods.

6. **Social Hygiene Clinics-** these are clinics at the local government unit that is usually part of the municipal health office or city health office that provides STI services.

7. **Treatment hubs** – a hospital facility with an established HIV/AIDS Core Team (HACT) providing prevention, treatment care and support services to People Living with HIV (PLHIV) including but not limited to HIV counseling and testing, clinical management, patient monitoring and other care and support services. ARV treatment can only be accessed through these facilities. Refer to Annex I for the list of treatment hubs.

V. PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) FRAMEWORK

The PMTCT framework adopts the United Nations' comprehensive four-element strategy to prevent HIV among infants and young children. It has four (4) prongs which are described below:

Prong 1. Primary prevention of HIV among women of childbearing age

This approach is focused on women of child bearing age with an aim of maintaining their HIV negative status by involving their partners in the STI/HIV prevention.

Prong 2. Preventing unintended pregnancies among women living with HIV

This approach emphasizes the importance of providing appropriate counselling and support to women living with HIV to make informed decision about their future reproductive life, with special emphasis on preventing unintended pregnancies.

Prong 3. Preventing HIV transmission from a women living with HIV to her infant

This intervention involves providing women living with HIV with proper treatment, care and support through strengthening of reproductive health services in order to prevent transmission of HIV to their infants.

Prong 4. Providing appropriate treatment, care and support to women living with HIV, their children and their families

This component is focused on providing women and children an integrated care and support services including prevention and treatment of sexually transmitted infections, tuberculosis, family planning, nutritional support and other services that are essential for improving health outcomes of both mother and child.

VI. COMPONENTS OF PMTCT

Based on the above framework, the following are the different components of PMTCT that must be incorporated to the existing SRH and Maternal Newborn and Child Health and Nutrition (MNCHN) services:

1. Information and Education

All women and their partners shall be given basic and essential information on STI, HIV and AIDS including PMTCT through either individual or group education. They shall also be given information on the availability and accessibility of HIV counseling and testing services.

2. Risk Assessment

All pregnant women and those with complaints pertaining to the reproductive tract shall undergo risk assessment. The heath service provider shall interview the client and ask the following questions:

a. Does client or partner have history of multiple sex partners?
b. Does client or partner have or in the past suffered from symptoms of STI (genital tract symptoms such as dysuria, discharge or sores)?
c. Does client or partner have history of injecting drugs?
d. Does client or partner have history of undergoing voluntary HIV counseling and testing?

3. STI Case Management

All women and partners diagnosed to have STI either by syndromic or etiologic approach should receive proper management based on Administrative Order No. 5-A s. 2003, "Revised National Sexually Transmitted Infectious Case Management Guidelines".

4. HIV Counseling and Testing

All women and partners identified with having one or more risk factors shall be offered HIV counseling and testing. For women who refused to undergo HIV testing, health care providers shall offer HIV test on her subsequent visits. Once the client has agreed to undergo the test, the principles of counselling and testing such as informed consent and confidentiality shall be observed at all times.

Women who tested HIV-negative shall be given counselling on risk reduction interventions, focusing mainly on how to maintain their HIV-negative status. All women who tested positive shall receive counseling on available PMTCT services, including family planning options. Likewise, all partners of women infected with HIV shall be offered HIV counseling and testing.

5. Counseling on the Prevention of Unintended Pregnancies

All women living with HIV and their partners shall receive counseling on family planning including information and access to safe and effective contraception methods to contribute on informed decision-making about pregnancy choices. They shall also be given proper and complete information on the PMTCT program and availability of essential care and support services

6. Referral to Treatment Hubs

All women and partners who tested positive for HIV shall be referred to the nearest treatment hub in order to access proper treatment and care such as antiretroviral (ARV) prophylaxis and treatment.

7. ARV Treatment and Prophylaxis for HIV-Infected Pregnant Women and Their Newborn

Antiretroviral Therapy (ART) is initiated among treatment eligible HIV infected pregnant women. ARV prophylactic regimen is provided to HIV infected pregnant women with no indication for ART (see Annex II).

All newborns of HIV infected pregnant women shall be given ARV prophylactic regimen (see Annex II). For confirmed HIV infected infants, ART is initiated based on the Guideline on the Integrated Management of Pediatric HIV and AIDS.

8. Management of Labor and Delivery of HIV Positive Pregnant Women

HIV infected pregnant women who are about to deliver should be referred and admitted to the nearest treatment hub. The attending physician should consider vaginal delivery if the following criteria are satisfied:

- HIV medications have been taken during pregnancy
- no previous uterine surgery or elective cesarean section
- no signs and symptoms of STI
- no indications of prolonged labor.

Cesarean section is recommended if vaginal delivery cannot be performed due to presence of contraindications. Cesarean section should be scheduled prior to the rupture of the membrane.

HIV infected pregnant women need not be isolated during labor and delivery because of their HIV status. Hospital staff must use standard precautions in all patients regardless of their status.

9. Counseling of HIV Infected Mothers Regarding Feeding Options for Their Infants

Counseling of HIV infected mothers should include information about the risk and benefits of exclusive breastfeeding and exclusive replacement feeding and guidance in selecting the most suitable option in their circumstances.

Exclusive breastfeeding is recommended for HIV infected for the first six (6) months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time. Mixed feeding must be avoided.

Breastfeeding mothers of infants and young children who are known to be HIV infected should be strongly encouraged to continue breastfeeding.

10. Follow up, Care, Treatment & Support for mothers infected with HIV, their children and families

Follow-up care including HIV-related care and ART when indicated, adherence support, cotrimoxazole prophylaxis, sexual and reproductive health services, and diagnosis of HIV infection in infants shall be provided.

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. Cotrimoxazole prophylaxis for infants (daily 2.5 ml suspension for < 6 months, 5.0 ml for > 6 months to 5 years old of 200 mg sulfamethoxazole/40 mg trimethoprim) shall be started at 6 weeks of age until cessation of risk of HIV transmission and exclusion of HIV infection.

VII. RECOMMENDED PMTCT SERVICES AT DIFFERENT LEVELS OF HEALTH CARE

1. Rural Health Units (RHU)/ City Health Offices (CHO)
   - Information and Education
   - Risk Assessment
   - STI Case Management
   - Referral to treatment hubs
   - Counseling on the prevention of unintended pregnancies
   - Counseling of HIV positive mothers regarding feeding options for their infants

2. Social Hygiene Clinics
   - ALL of the above services provided in the RHU/CHO
   - HIV Counseling and Testing
   - Referral to testing center if HIV testing is not available

3. Treatment Hubs
   - ALL of the above services provided in the Social Hygiene Clinics
   - ARV treatment and prophylaxis
   - Management of labor and delivery of HIV positive pregnant women
   - Follow up, Care, Treatment & Support for mothers infected with HIV, their children and families.

VIII. ROLES AND RESPONSIBILITIES

A. National Center for Disease Prevention and Control (NCDPC)

- ❖ Develop evidence-based policies, standards and programs to support country-level PMTCT implementation;
- ❖ Mobilize national, local and international community support for PMTCT program;

- ❖ Foster partnerships among and between LGUs, civil society, private sector;
- ❖ Organize and convene the PMTCT Committee;
- ❖ Monitor and evaluate the implementation of PMTCT guidelines in coordination with the PMTCT Committee; and
- ❖ Provide support through health systems strengthening for delivering an integrated package of services for women, their children and families.

B. National Epidemiology Center (NEC)

- ❖ Provide evidence-based information through various surveillances and researches to help improve PMTCT program implementation.

C. Philippine National AIDS Council (PNAC)

- ❖ Advocate the adoption of PMTCT guidelines to both government and private health care sector, and
- ❖ Work in coordination with NCDPC and PMTCT Committee in reviewing and updating PMTCT guidelines. .

D. Center for Health Development (CHD)

- ❖ Provide technical assistance and support for PMTCT program implementation;
- ❖ Disseminate PMTCT policies and guidelines to DOH-retained hospitals and other health care providers within the region; and
- ❖ Monitor the implementation of this guideline.

E. PMTCT Committee

- ❖ Shall be established upon the signing of this Administrative Order with a subsequent issuance of a Department Personnel Order;
- ❖ Provide technical assistance to the NCDPC in the implementation of PMTCT national program guidelines;
- ❖ Identify issues and challenges in the implementation PMTCT guidelines and/ or protocols; and
- ❖ Review and update PMTCT guidelines and programs customized to the current needs of the country as initiated by NCDPC.

F. Treatment Hubs

- ❖ Ensure that PMTCT program is in place through provision of basic PMTCT services;
- ❖ Act as a referral center for PMTCT program, through HIV and AIDS Core team (HACT) and/or Infectious committee of different hospitals;
- ❖ Ensure provision of optimum obstetrical and delivery care for HIV positive pregnant women; and
- ❖ Submits regular PMTCT program-related reports to DOH NEC.

G. Social Hygiene Clinics

- ❖ Ensure referral services are available for the provision of PMTCT services.

H. Non-government organizations (NGOs) providing Reproductive Health (RH)/Family Planning Services and or HIV Voluntary Counseling and Testing

- ❖ Adopts PMTCT guidelines and protocols with its current HIV and AIDS service operations; and
- ❖ Shall work in coordination with Local Health Departments, HACT and treatment hubs in the provision of treatment care and support for people living with HIV/AIDS (PLHIV) and their families.

IX. FUNDING

The Infectious Disease Office of the NCDPC shall allocate funds for the operationalization of the PMTCT guidelines at the different levels of health care. Likewise other DOH Offices and other organizations are encouraged to contribute a part of their budget in order to facilitate the implementation of the PMTCT guidelines.

X. REPEALING CLAUSE

Provisions in previous issuances that are inconsistent and contrary to the provisions of this Administrative Order are hereby rescinded and repealed.

XI. EFFECTIVITY

This Administrative Order shall take effect immediately.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

Annex I. List of Treatment Hubs in the Philippines

Treatment Hub	Address	Contact Details	Point Person
LUZON			
San Lazaro Hospital (SLH)	Quiricada St., Sta. Cruz, Manila	(02) 7438301 local 6000	HACT Leader
Research Institute for Tropical Medicine (RITM)	Department of Health Compound, FILINVEST Corporate City, Alabang, Muntinlupa City	(02) 8072628 local 208; 5668807	HACT Leader
Philippine General Hospital (PGH)	Taft Ave., Manila	(02) 5673394	HACT Leader
			HACT Leader
Ilocos Training and Regional Medical Center (ITRMC)	San Fernando City, La Union	(072) 2421143 local 122	HACT Leader
Baguio General Hospital and Medical Center (BGHMC)	BGHMC Compound, Baguio City	(074) 442-2012; 4423165	HACT Leader
Bicol Regional Training and Teaching Hospital (BRTTH)	Legaspi City, Bicol	(052) 4830015	HACT Leader
Cagayan Valley Medical Center	Tuguegarao City, Cagayan Valley	(078) 846-7240 844-3789	HACT Leader
Jose B. Lingad Memorial Medical Center	San Fernando City, Pampanga	(045) 961-3921 961-3380	HACT Leader
VISAYAS			
Vicente Sotto Sr. Memorial Medical Center (VSSMMC)	B. Rodriguez St., Cebu City	(032) 2537564	HACT Leader
Western Visayas Medical Center (WVMC)	Mandurriao, Iloilo City	(033) 3212841 to 50	HACT Leader
Corazon Locsin Montelibano Memorial Regional Hospital (CLMMRH)	Lacson St., Bacolod City	(034) 4351591 local 226; 4332697	HACT Leader
MINDANAO			
Davao Medical Center	J.P. Laurel Ave., Davao City	(082) 2244915 / 2221347	HACT Leader
Zamboanga City Medical Center	Dr. Evangelista St., Sta. Catalina, Zamboanga City	(062) 9910573	HACT Leader

Annex II. Recomended ARV Treatment and Prophylaxis for HIV Infected Pregnant Women and Their Newborn

Scenario	Recommendations/ Options
Scenario #1: HIV-infected woman of childbearing potential but not pregnant, and who has indications for initiating antiretroviral therapy	• Initiate ART as per adult treatment guidelines (AO 2009-0006).
Scenario #2: HIV-infected woman who is receiving ART and becomes pregnant	**For the Woman:** • Continue current ART • For women on EFV and pregnancy is recognized during the first trimester – substitute NVP for EFV **For the Newborn:** Give AZT for seven days
Scenario #3: HIV – infected pregnant woman with indications for ART	**For the Woman:** • Start ART once indicated per adult treatment guidelines **Recommended ARV Regimen** ***First line regimen:*** NNRTI-based (2 NRTI + 1 NNRTI) i. First line NRTIs : Zidovudine (AZT) + Lamivudine (3TC) *Alternative first line NRTI* : Stavudine (d4T) + Lamivudine (3TC) ii. First line NNRTI: Nevirapine (NVP) *Alternative first line NNRTI*: Efavirenz (EFV) – use only for pregnant patients with severe hypersensitivity to nevirapine and/or taking rifampicin and on their 2nd to 3rd trimester of pregnancy with assurance of effective contraception post-partum. ***Second line regimen***: 2 NRTIs + Lopinavir/ritonavir (LPV/r) - AZT + 3TC + LPV/r - d4T + 3TC + LPV/r • Women with indications for ART who present very late in pregnancy should be started on ART,

	irrespective of the gestational age of the pregnancy • **Monitor toxicity and response to ART per adult treatment guidelines** o For NVP-containing ART in a pregnant woman with a CD4 cell count above 250 cells/mm^3, close monitoring of clinical symptoms and hepatic transaminases is recommended during the first 12 weeks of therapy. (e.g. 2, 4, 8 and 12 weeks) • **Follow adult treatment guidelines in changing treatment regimen** **For the Newborn** • Give AZT for seven days. • Give AZT for four weeks if woman receive less than four weeks of ART before delivery
Scenario #4: HIV-infected pregnant woman who is not eligible for ART	**For the Woman:** • Start ARV Prophylaxis Antepartum - AZT starting at 28 weeks of pregnancy or as soon as feasible thereafter Intrapartum- Sd-NVP + AZT and 3TC Postpartum – AZT and 3TC × 7 days • For pregnant women with severe anemia (hgb<7g/dl), the priority is to treat severe anemia first. **For the Newborn:** • Start Sd-NVP and one week of AZT. • Give AZT for four weeks if woman receive less than four weeks of AZT before delivery
Scenario #5: HIV – infected pregnant woman who are in labor and have not received ARV prophylaxis	**For the woman:** • Do clinical and immunological assessments to determine eligibility for ART as part of postpartum follow-up services • Start ARV Prophylaxis Intrapartum – Sd-NVP + AZT and 3TC; Postpartum – AZT and 3TC x 7 days **For the Newborn:** • Sd-NVP immediately after delivery and AZT for four weeks

Scenario #6: Infants born to HIV – infected pregnant woman who have not received ARV drugs during pregnancy or labor	Infants should receive Sd-NVP plus four weeks of AZT immediately after delivery or within 12 hours after delivery if possible

> All regimens are administered by mouth.
> **ARV Prophylactic dosages:**
Antenatal: AZT at 300 mg twice a day
Intrapartum: AZT 600 mg at onset of labour or AZT 300 mg at onset of labour and every 3 hours until
delivery, Sd-NVP 200 mg at onset of labour, 3TC 150 mg at onset of labour and every 12 hours until
delivery
Post-partum ARV Prophylactic Regimen: AZT 300 mg twice a day for 7 days **PLUS** 3TC 150 mg
twice a day for 7 days
Post natal ARV Prophylaxis for the Newborn: NVP 2 mg/kg oral suspension or 6 mg at once immediately after birth **PLUS** AZT 4 mg/kg twice a day for 7 days or 4 weeks depending on the
scenario

Acronyms: ***ARV*** *– Antiretroviral ,* ***ART*** *- Antiretroviral therapy,* ***AZT*** *– Azidothymidine,* ***d4T*** *– Stavudine,* ***EFV*** *–Efavirenz,* ***LPV/r-*** *Lopinavir/ritonavir,* ***NNRTI-*** *Non-nucleoside reverse transcriptase inhibitor,* ***NRTI*** *- Nucleoside reverse transcriptase inhibitor,* ***NVP-*** *Nevirapine,* ***Sd-NVP-*** *Single-dose nevirapine, .****3TC*** *Lamivudine*

Source: ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV INFECTION IN INFANTS IN RESOURCE-LIMITED SETTINGS
TOWARDS UNIVERSAL ACCESS (WHO 2006)