Republic of the Philippines
DEPARTMENT OF HEALTH
Office of the Secretary

BAGONG PILIPINAS

ADMINISTRATIVE ORDER
No. 2026- 0010

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SUBJECT: Guidelines on the Prevention, Control, and Management of Potential Rabies Exposures

I. RATIONALE

Rabies is a deadly disease prevalent in developing countries, where animal immunization and dog population control are often inadequate. Given the 100% case fatality rate of human rabies, the disease remains a significant public health concern. Preventing rabies infection after exposure is critical to saving lives, particularly among vulnerable populations.

Republic Act (RA) No. 9482, or the "*Anti-Rabies Act of 2007*", and its implementing rules and regulations (IRR), established the National Rabies Prevention and Control Program (NRPCP) as a multi-agency, multi-sectoral initiative implemented through the National Rabies Prevention and Control Committee (NRPCC), mandating mass dog vaccination, responsible pet ownership, public education, and provision of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). In support of this mandate, the Department of Health (DOH), as a key implementing agency of the NRPCP, issued Administrative Order (AO) No. 2018-0013, *Revised Guidelines on the Management of Rabies Exposures*, to establish standardized guidelines for the management of potential rabies exposures, reaffirming its commitment to rabies elimination with the goal of ending dog-mediated rabies deaths among Filipinos by 2027 and a rabies-free Philippines by 2030.

Despite these efforts, rabies continues to be a pressing public health issue in the Philippines, with over 3 million animal bite cases requiring PEP reported in 2024. The DOH Devolution Transition Plan (DTP) 2022-2024 identified rabies control commodities as fully devolved by 2024. Since then, the responsibility to procure anti-rabies commodities, including human anti-rabies vaccines and rabies immunoglobulin (RIG), has shifted to Local Government Units (LGUs), with some procuring inadequately or inconsistently. While the DOH, through the NRPCP, continues to provide limited augmentation to reduce the disease burden, challenges such as vaccine shortages, limited awareness, and gaps in animal control persist. The release of the Philippine Clinical Practice Guidelines on the Management of Animal Bites in 2025 also provided updated evidence to guide management.

In response to these challenges, the DOH has adopted a "One Health" approach to rabies prevention and control, which emphasizes collaboration across the human, animal, and environmental health sectors to address the interconnected factors driving rabies transmission.

Through the updating of guidelines, the DOH aims to enhance the efficiency, coordination, and effectiveness of rabies prevention and control efforts nationwide.

II. OBJECTIVES

This Order shall update policy guidelines and standardize procedures on the management of potential rabies exposures. Specifically, it shall:

A. Provide guidelines on the prevention and control of rabies in line with the One Health Approach;

B. Update recommendations on the use of anti-rabies vaccines and RIG to ensure standardized and quality-assured management of potential rabies exposures; and

C. Clarify the roles and responsibilities of implementing offices across all levels to strengthen coordination and ensure clear accountability.

III. SCOPE

This Order shall apply to all government and private health workers involved in the management of patients with animal bites in DOH-certified Animal Bite Treatment Centers (ABTCs) and Animal Bite Centers (ABCs).

In the case of the Ministry of Health - Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM), the adoption of this issuance shall be subject to the applicable provisions of Republic Act No. 11054 or the Organic Law for BARMM and subsequent laws and policies to be enacted by the Bangsamoro Government.

IV. DEFINITION OF TERMS

A. **Active immunization** refers to the administration of a vaccine to induce protective immune response.

B. **Animal Bite Treatment Centers (ABTC)** refer to health facilities owned and operated by either the National or LGUs, providing Pre-exposure prophylaxis (PrEP) and PEP in accordance with the DOH recommended management protocol. These facilities are provided by the NRPCP with anti-rabies vaccine and RIG augmentation.

C. **Animal Bite Centers (ABC)** refer to health facilities owned and operated by either a private individual or company/corporation, providing PrEP and PEP in accordance with the DOH recommended management protocol. These facilities are not provided by the NRPCP with anti-rabies vaccine and RIG augmentation.

D. **Booster** refers to the administration of active immunization to eligible previously-immunized individuals.

E. **High-risk individuals** refers to personnel in rabies diagnostic laboratories, veterinarians and veterinary students, animal handlers, health care workers directly involved in care of rabies patients, individuals directly involved in rabies control, field workers, and children aged 2-10 years.

F. **Immunologically-naive individual** refers to a patient who has never received rabies pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP), or who has received PrEP or PEP but did not complete the regimen or lack documented evidence of at least three (3) prior doses of anti-rabies vaccine.

G. **Passive immunization** refers to the administration of pre-formed antibodies (immunoglobulins or passive immunization products) to provide immediate protection. These antibodies come from either human or animal sources.

H. **Post-exposure prophylaxis (PEP)** refers to anti-rabies treatment administered *after* an exposure, which consists of (1) immediate and thorough washing of the wound; (2) a series of anti-rabies vaccine administrations immediately started after exposure; and (3) if indicated, rabies immunoglobulin infiltration into and around the wound immediately after exposure.

I. **Potential rabies exposure** refers to the following:
   a. **Animal bite** - an act by which an animal seizes, cuts, or grips with its teeth, resulting in the skin of a person being wounded, pierced, or scratched.
   b. **Animal scratch** - an act by which an animal seizes, cuts, or grips with its claws/nails/hooves resulting in the skin of a person being wounded, pierced, or scratched.
   c. **High mucosal exposure** - contact of potentially rabies-infected saliva with a person's mucous membranes (eyes, mouth, nose) or with a broken skin.

J. **Pre-exposure prophylaxis (PrEP)** refers to anti-rabies vaccination *before* an exposure to a potentially rabid animal, given to high-risk individuals.

K. **Previously-immunized individual** refers to a patient who has documented evidence of at least three (3) prior doses of anti-rabies vaccine.

L. **Rabid animal** refers to a biting animal confirmed positive for rabies virus antigen using an internationally accepted gold standard laboratory test.

M. **Suspected rabid animal** refers to any animal involved in a potential rabies exposure or one that shows clinical signs of rabies, including sudden behavioral changes (e.g, sudden anorexia, apprehension or nervousness, irritability, hypersensitivity), hydrophobia, muscle paralysis, and other neurologic signs, as reported by the patient or as evaluated by a duly licensed veterinarian.

N. **Rabies immunoglobulin (RIG)** refers to an injectable preparation containing rabies antibodies, administered to immunologically-naive individuals to provide immediate but temporary protection until their immune system can produce its own antibodies in response to the anti-rabies vaccine.

O. **Vaccinated animal** refers to a dog or cat with updated annual anti-rabies vaccination for the past two years, supported by documented evidence (i.e., a vaccination certificate) issued by a duly licensed veterinarian. The immunization status is not considered updated if the animal failed to receive the next scheduled dose by its due date, or if more than twelve (12) months have elapsed since the most recent dose.

P. **Vaccine potency** refers to the amount of acceptable active ingredients in an anti-rabies vaccine which is expected to provide at least minimum protection.

V. GENERAL GUIDELINES

A. The NRPCP shall be responsible for the prevention and control of potential rabies exposures through PrEP, rabies awareness, responsible pet ownership, and dog

population management in accordance with RA No. 9482 and the One Health approach.

B. The DOH NRPCP shall ensure that potential rabies exposures are managed solely in DOH-certified ABTCs or ABCs with the respective physician and nurse trained by a DOH-recognized facility, as enumerated in the Department Circular (DC) No. 2025-0204, *"List of Government Facilities Providing Training Course on Rabies and Animal Bite Management as of May 2025"*.

C. The DOH shall provide annual augmentation of NRPCP commodities to certified ABTCs and encourage PhilHealth accreditation for the ABT Package, while Local Government Units (LGUs) shall cover the remaining costs to ensure uninterrupted PEP provision and minimize out-of-pocket expenses, in accordance with RA Nos. 7160 and 9482, their IRR, and other pertinent laws and issuances.

D. The ABTCs and ABCs shall ensure timely reporting of potential rabies exposures and rabies cases through quarterly reporting to regional rabies program coordinators, and through the Field Health Services Information System (FHSIS) and the Philippine Integrated Disease Surveillance and Response - Information System (PIDSR-IS).

E. The DOH, through the NRPCP, shall conduct regular monitoring and evaluation of the implementation of this Order to ensure compliance with its provisions, track progress toward objectives, and identify areas for improvement.

VI. SPECIFIC GUIDELINES

A. Prevention and Control of Potential Rabies Exposure

1. Human Health

a. Pre-exposure Prophylaxis (PrEP)

i. PrEP eliminates the need for passive immunization (RIG) and allows for a shorter vaccine regimen, thereby reducing overall costs.

ii. PrEP is highly recommended to high-risk individuals who are at risk of occupational exposure. It is also recommended to those living in and traveling to remote and/or highly endemic areas with limited access to proper PEP and rabies biologicals. The following individuals are the target population for PrEP administration:

1. Personnel in rabies diagnostic laboratories;
2. Veterinarians and veterinary students;
3. Animal handlers (dog trainers, workers in pet shops, zoos, etc.);
4. Healthcare workers directly involved in care of rabies patients or at risk of potential rabies exposures;
5. Individuals directly involved in rabies control;
6. Field workers exposed to stray animals;
7. Pet owners; and
8. Children aged 2-10 years (because of the increased risk and severity of animal bites in this age group).

Table 1. Updated Pre-exposure Prophylaxis Schedule

Route	**Day of immunization**	**Dose and Site**
Intradermal (ID)	Days 0, 7, 21/28	0.1 ml each on left and right deltoids or anterolateral thighs (2 sites)
Intramuscular (IM)		1 vial on deltoid or anterolateral thigh (1 site)

iii. The recommended schedule for PrEP for all patients, including immunocompromised individuals, is a three-dose regimen administered either via the ID or IM regimen, both on days 0, 7, 21/28 *(as seen in Table 1)*. Routine booster is not recommended for the general population.

iv. Patients who have previously received two doses of PrEP under earlier vaccination schedules may be managed as follows:

1. If the individual did not experience any potential rabies exposure between receipt of the second dose and the time of assessment, one additional dose of anti-rabies vaccine may be administered to complete the three-dose PrEP series in accordance with the current recommendation. This additional dose shall be considered as the third dose of the primary PrEP series, and the series need not be restarted.
2. If a potential rabies exposure occurred after receipt of two PrEP doses, the patient shall be managed in accordance with existing PEP guidelines. Documentation of prior PrEP vaccination shall be verified prior to administration of the additional dose.

v. **Routine Booster for PrEP**

1. Routine booster for PrEP is only recommended for the following individuals:
   a. Personnel in rabies diagnostic laboratories;
   b. Veterinarians and veterinary students;
   c. Animal handlers (dog trainers, workers in pet shops, zoos, etc.);
   d. Healthcare workers directly involved in care of rabies patients or at risk of potential rabies exposures; and
   e. Immunocompromised individuals.

2. One (1) routine booster dose 1 year after primary immunization shall be administered to the aforementioned individuals:
   a. Individuals who work in laboratories with high concentrations of live rabies virus (RABV) or lyssavirus may be tested for antibodies every 1–2 years to monitor the levels in order to ensure adequate immune response.
   b. Professionals who are not at continual risk of exposure, such as certain veterinarians and animal health officers, may undergo serological monitoring every 2 years.
   c. Booster vaccination is recommended only if RABV neutralizing antibody titres fall to < 0.5 IU/mL.

d. If serological testing is not available, a routine booster vaccination of one (1) booster dose every 5 years is recommended.

b. **Rabies Awareness**

i. The DOH, through the NRPCP and Health Promotion Bureau (HPB), shall ensure conduct of health promotion activities through health education, risk communication, and capacity building of health workers involved in patient education at all levels to increase rabies awareness.

ii. All LGUs, especially the rabies-endemic areas, are highly encouraged to observe the National Rabies Awareness Month for the whole month of March and the World Rabies Day on September 28 annually which serves as a platform to inspire action, celebrate progress, and raise awareness at the community level.

iii. In accordance with the RA No. 9482 and its IRR, the Department of Education shall strengthen the integration of the NRPCP in the curriculum and activities of elementary and secondary schools to educate students, who are also considered as vulnerable population, on rabies prevention and control.

2. **Animal Health**

In accordance with RA No. 9482 and its IRR, the following provisions outline the responsibilities of pet owners, DA, and LGUs regarding animal health, and reinforce the One Health approach to rabies prevention and control.

a. **Responsible Pet Ownership**

i. Dog owners play a critical role in rabies prevention and control by ensuring their pets are:
   1. Vaccinated against rabies annually and maintaining a registration card to document all vaccinations for accurate record-keeping; and,
   2. Leashed in public places and not allowed to roam freely.

ii. Community education shall emphasize the importance of responsible pet ownership, such as avoiding abandonment and ensuring pets are properly housed and cared for.

iii. Sheltering and rehoming stray dogs shall be prioritized. By combining humane population control measures with public health education, LGUs can effectively reduce the prevalence of stray dogs and the associated risks of rabies transmission.

iv. In the event of a dog biting incident, dog owners shall:
   1. Report the incident to the concerned officials (e.g., local veterinary office, agriculture office, or designated office) within 24 hours and place the dog under observation for 14 days.
   2. Assist the animal bite victim promptly and take responsibility for medical and incidental expenses related to the injuries.
   3. Keep their dogs under observation in accordance with RA No. 9482 and its IRR, with penalties to violators provided for by the law.

b. **Dog Population Management**

Effective dog population management is essential to controlling rabies and ensuring community safety. The Local Government Veterinary Services, in collaboration with non-governmental organizations (NGOs) shall conduct ethical dog population control activities to mitigate rabies at its source.

B. **Management of Potential Rabies Exposure** *(as summarized in Annex B)*

1. **Components of Post-exposure prophylaxis**

a. **Local Wound Management**

i. Immediate and thorough washing of the bite wound or exposed area with soap and water for a minimum of 15 minutes should be done (World Health Organization [WHO], 2018). If soap is not available, the wound shall be thoroughly and extensively washed with water for the same amount of time. Antiseptic solution such as povidone iodine or alcohol may be applied.

ii. Unnecessary ointments or creams and tight, occlusive wound dressing shall *not* be applied to the exposure site as this can favor the growth of bacteria and may occlude the drainage of the wound. Procedures that may further contaminate the wounds should not be done (e.g., *tandok*, *bato*, rubbing garlic on the wounds, and other traditional practices).

iii. Suturing of wounds due to animal bite is generally not recommended since it may inoculate virus deeper into the wounds. Alternatively, wounds may be coaptated using sterile adhesive strips.

iv. If there is a severe and extensive wound that needs debridement and intravenous antibiotics is deemed necessary, it is recommended that patients be referred for admission.

b. **Tetanus Prophylaxis**

Animal bites shall be considered tetanus prone wounds. Therefore, anti-tetanus immunization should be given, if indicated. History of tetanus immunization, such as tetanus toxoid (TT), Diphtheria, Pertussis Tetanus (DPT), and Tetanus and Diphtheria (Td) vaccines, should be reviewed, and completion of the primary series of tetanus immunization is recommended.

Table 2. Guide to Tetanus Prophylaxis in Routine Wound Management

Indication for TT Immunization	**Vaccination History**			
	Unknown or <3 Doses		3 or More Doses	
	Td*	TIG/ATS	Td*	TIG/ATS
All Animal Bites	YES	YES	NO**	NO

**Tdap may be substituted for Td if the person has not received Tdap and is 10 years or older; DPT may be given for patients < 7 years old; TT may be given if Td not available*

***Yes, if more than 5 years since last dose*

c. **Antibiotics**

The most common organism isolated from dog and cat bites is *Pasteurella spp*. Other organisms include *S. aureus*, *Bacteroides sp*, *Fusobacterium*, and *Capnocytophaga*. Antimicrobial, with coverage to the aforementioned organisms, shall be recommended for the indications detailed in Annex A.

d. **Active Immunization**

Anti-rabies vaccine shall be administered to induce antibody and T-cell production in order to neutralize the rabies virus in the body. It induces an active immune response in 7-10 days after vaccination, which may persist for years provided that primary immunization is completed.

i. **Types of Anti-Rabies Vaccines and Doses**

The NRPCP shall provide augmentation of the following Cell Culture and Embryonated Egg-based Vaccine (CCEEVs): a) Purified Vero Cell Rabies Vaccine (PVRV) 0.5 mL/vial and b) Purified Chick Embryo Cell Vaccine (PCEC) 1.0 mL/vial (Table 4).

Table 3. List of CCEEV provided by the NRPCP to ABTCs with corresponding preparation and dose

Generic Name	Preparation	Dose
Purified Vero Cell Rabies Vaccine (PVRV)	0.5 mL/vial	Intradermal (ID) - 0.1 mL Intramuscular (IM) - 0.5 mL
Purified Chick Embryo Cell Vaccine (PCEC)	1 mL/vial	Intradermal (ID) - 0.1 mL Intramuscular (IM) - 1.0 mL

ii. **Anti-Rabies Vaccine Criteria**

1. The WHO recommends vaccination through intradermal (ID) administration, as it is more cost-saving and dose-sparing compared to intramuscular (IM) administration. According to the WHO, the ID use of CCEEV can decrease the cost of PEP by as much as 60-80%. As such, patients shall be vaccinated using the ID route for administration.
2. To ensure compliance to these recommendations and guarantee that patients with potential rabies exposure seeking treatment in ABTCs/ABCs receive only CCEEVs that have been proven to be safe and effective, the program shall only utilize for its ID regimen the CCEEVs that satisfy the following criteria:
   a. The vaccine is registered with and approved by the FDA;
   b. The vaccine must have gone through clinical trials on safety, immunogenicity and efficacy in comparison with a vaccine of demonstrated efficacy which are published in peer reviewed journals;
   c. The potency of vaccines for ID use shall be at least 0.5 IU/ID dose as evidenced by their lot release certificate. The potency of the vaccine batch shall be provided by the manufacturer; and

d. The product insert shall contain the vaccine's approved ID dose and consistent with its Certificate of Product Registration (CPR).

3. To safeguard patient safety and ensure that only quality-assured vaccines are administered, ABTCs/ABCs shall implement verification measures to prevent the procurement and use of counterfeit anti-rabies vaccines, in accordance with Department Memorandum (DM) No. 2025-0368, *"Interim Guidelines on Addressing Incidents on Administration of Suspected and Confirmed Counterfeit Anti-Rabies Vaccines."* These measures can include verifying product authenticity against official FDA advisories, confirming that delivered batch and lot numbers correspond to approved and documented supplies, conducting physical inspection upon receipt for signs of tampering or compromise, and promptly isolating and reporting any suspected counterfeit products in accordance with existing FDA reporting mechanisms.

iii. **Administration of Anti-Rabies Vaccines**

1. One dose shall be given on each site on Days 0, 3, 7, and 28 intradermally. The last dose (Day 28) shall be omitted if the biting dog or cat is alive and healthy after 14 days from the date of exposure, except for immunocompromised individuals as detailed in Section VI.B.3.d.
2. Only the ID regimen shall be used in the administration of vaccines in all government facilities except for conditions that require IM administration such as those specified in Section VI.C.3.d. One dose for ID administration is equivalent to 0.1ml for PVRV and PCEC, with one dose having at least 0.5 IU vaccine potency.
3. A one (1) mL syringe with gauge 27-29 needle, preferably auto-disable syringe, shall be used for ID injection.
4. The ID injection shall produce a minimum of 3 mm wheal. In the event that a dose of vaccine is inadvertently given subcutaneously or IM, the dose shall be repeated.
5. Anti-rabies vaccines shall be administered on the deltoid area of each arm in adults or at the anterolateral aspect of the thigh in adults and in infants.
6. Vaccines shall never be injected in the gluteal area as absorption is unpredictable, immunogenicity is decreased, and vaccine stability is reduced.

iv. **Storage of Vaccines**

1. Vaccines shall be stored at +2 to +8 °C in a biomedical refrigerator or a two-door domestic refrigerator, calibrated annually, with a thermometer and monitoring sheet. Vaccines shall not be stored in the freezer.
2. There shall be a contingency plan in case of power interruptions, like use of generators and uninterrupted power supply. In the event of a power interruption, anti-rabies vaccines shall be assessed for temperature excursions in accordance with cold

chain management guidelines. Those exposed to temperatures outside the recommended range are recommended to be used only upon clearance by the appropriate authority (e.g., Supply Chain and Management Services, supply officers, manufacturer).

3. Once reconstituted, vaccines and RIG shall be kept in the refrigerator and strictly used within the time period specified in the product insert.
4. The first expiry-first out principle shall always be observed in the storage and use of vaccines.

e. **Passive Immunization**

Rabies immunoglobulin or RIG, also called passive immunization products, shall be given in combination with anti-rabies vaccine to provide the immediate availability of neutralizing antibodies at the site of the exposure before it is physiologically possible for the patient to begin producing his or her own antibodies after vaccination. This is especially important for patients with Category III exposures. RIGs have a half-life of approximately 21 days.

i. **Types of Rabies RIG**

1. **Human rabies immunoglobulin (HRIG)** is derived from plasma of human donors.
2. **Equine rabies immunoglobulin (ERIG)** is derived from purified horse serum administered. ERIG is clinically equivalent to HRIG and is considered safe and efficacious life- and cost-saving biologics.
3. **Highly purified antibody antigen binding fragments [F(ab')2]** produced from ERIG.

Table 4. List of Rabies Immunoglobulins Available

Generic Name	Preparation	Maximum Dose
Human Rabies Immunoglobulin (HRIG) in a.i	150 IU/mL at 2 mL/vial	20 IU/kg
Equine Rabies Immunoglobulin (ERIG) in a.ii or a.iii	200 IU/mL at 5 mL/vial	40 IU/kg

ii. **Rabies Immunoglobulin Criteria**

To ensure that only safe and efficacious RIG are procured by the NRPCP at all levels, the program shall be guided by the following criteria in procuring the RIG:

1. RIG must be registered and approved by FDA; and
2. RIG must be proven to be safe and effective when used together with human anti-rabies vaccine as evidenced by publication in peer-reviewed journals. These include studies on:
   a. Safety;
   b. Efficacy;
   c. Immunogenicity;

d. Non-interference when used with anti-rabies vaccine;
e. Animal survivorship, if any; and
f. Post-marketing surveillance.

3. Results of Rapid Fluorescent Focus Inhibition Test (RFFIT) showing antibody content as claimed by the manufacturer.

iii. **Administration of Rabies Immunoglobulin**

1. Skin testing is not recommended before administration of RIG.
2. A gauge 23 or 24 needle, 1 inch length shall be used for infiltration.
3. RIG shall not exceed the computed dose as it may reduce the efficacy. If the computed dose is insufficient to infiltrate all sites of exposure, it may be diluted with sterile 0.9% sodium chloride 2 or 3-fold for thorough infiltration of all wounds. It shall never be given intravenously.
4. RIG shall be infiltrated at or below the maximum dose indicated in Table 4. The total computed RIG dose shall be infiltrated around and into the wound as much as anatomically feasible, even if the lesion has healed. In areas where RIG infiltration is difficult, infiltration shall be performed as close to the site of exposure as possible, and IM administration at a distant site is **not** recommended. Multiple needle injections into the same wound shall be avoided.
   a. If a finger or toe needs to be infiltrated, care shall be taken to ensure that blood circulation is not impaired, and only an adequate amount (e.g., 0.5-2 mL) shall be infiltrated.
   b. After the wound has been sufficiently infiltrated, the remainder of the computed dose of RIG does not need to be injected IM at a distance from the site of exposure. Prior to infiltration, the computed RIG volume can be fractionated in smaller, individual syringes and the excess RIG in the other unused syringes can be used for other patients needing RIG.
5. In case of wounds where suturing is indicated upon assessment by a physician (e.g., uncontrolled bleeding, high tension areas such as back or joints, etc.), infiltrate the wound adequately with RIG and wait for 2 hours before suturing to allow diffusion of the RIG through the tissues.
6. For eye exposures with no visible wound is present, adequate flushing of the affected area with diluted RIG may be considered, in addition to local infiltration at the most feasible area closest to the eye (e.g., the lateral canthus of the eye)
7. RIG shall always be given in combination with the anti-rabies vaccine and only once during the same course of PEP.
   a. RIG shall be administered at the same time as the first dose of anti-rabies vaccine (Day 0). If RIG is unavailable on Day 0, it may still be given up to 7 days after the first dose of the vaccine.
   b. Beyond Day 7, regardless of whether Day 3 and Day 7 doses were received, RIG is not indicated because an active antibody response to the anti-rabies vaccine has already

started and interference between active and passive immunization may occur.

c. In the event that RIG and vaccine cannot be given on the same day, the vaccine shall be given before RIG because the latter inhibits the level of neutralizing antibodies induced by immunization.

8. Patients shall be observed for at least one hour after injection of RIG for immediate allergic reactions. All ABTCs and ABCs shall be equipped to handle allergic reactions. Severe adverse events or perceived lower efficacy of RIG (e.g., batches of insufficient potency or lower purification degree) should be monitored, recorded, and reported so that biological producers receive immediate feedback and can respond accordingly.

2. **For the General Population**
   a. Bites by rabies-susceptible mammals such as domestic animals (dog, cat), livestock (cows, pigs, horses, goats, etc), and wild animals (bats, monkeys, etc.) shall require PEP upon assessment. Meanwhile, bites from rodents, guinea pigs, hamsters, rabbits, snakes and other reptiles, birds and other avians, insects, and fish shall not require rabies PEP.
   b. Patients needing PEP shall be referred to the nearest DOH-certified ABTC/ABC where anti-rabies immunizing agents (vaccines and RIG) are administered.
   c. There are no absolute contraindications to rabies PEP. Patients allergic to a specific vaccine/RIG or its components shall be given the alternative vaccine/RIG.
   d. Previously-immunized individuals only require a booster regimen after a category II or III exposure, as the booster results in a rapid recall of the immune response, even in cases where no measurable antibody is present and a lengthy period of time has passed since the previous vaccine dose. For the same reason, RIG is also not indicated.
   e. **Regardless of category, if the biting animal starts to show signs of rabies, immediately give active immunization.**
   f. Categories of exposure to a rabid or suspected rabid animal, with their corresponding management guidelines, are outlined in Table 5 below:

Table 5. Categories of potential rabies exposure with corresponding management for the general population (immunologically-naive and previously-immunized) exposed to a rabid or suspected rabid animal.

CATEGORY OF EXPOSURE	MANAGEMENT	
	Immunologically-naive Individual	**Previously-immunized Individual***
CATEGORY I a) Feeding/ touching an animal b) Licking of intact skin with reliable history and thorough physical examination	1. Wash exposed skin immediately with soap and water	1. Wash exposed skin immediately with soap and water

c) Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensils d) Casual contact such as talking to, visiting, and feeding suspected rabies cases, and routine delivery of health care to patient with signs and symptoms of rabies	2. No vaccine or rabies immunoglobulin (RIG) needed 3. Pre-exposure prophylaxis may be considered for high-risk individuals	2. No vaccine or rabies immunoglobulin (RIG) needed 3. Pre-exposure prophylaxis may be considered for high-risk individuals
CATEGORY II a) Nibbling of uncovered skin with or without bruising/ hematoma b) Minor/ superficial scratches/ abrasions without bleeding, including those induced to bleed	1. Wash wound immediately and thoroughly with soap and running water for a minimum of 15 minutes 2. Antiseptic solution may be applied on the affected area 3. Start and complete vaccination immediately *a. Exception: If exposure is from a vaccinated animal** that is available for observation for 14 days, and no high-risk criteria*** are present, vaccination is not indicated.* 4. RIG is *not* indicated 5. Review tetanus immunization and give if indicated 6. Assess the need for antibiotic prophylaxis	1. Wash wound immediately and thoroughly with soap and running water for a minimum of 15 minutes 2. Antiseptic solution may be applied on the affected area 3. Start booster immediately if any high-risk criteria*** are present 4. RIG is *not* indicated 5. Review tetanus immunization and give if indicated 6. Assess the need for antibiotic prophylaxis
CATEGORY III a) Transdermal bites (puncture wounds, lacerations, avulsions) or scratches/	1. Wash wound immediately and thoroughly with soap and running water for	1. Wash wound immediately and thoroughly with soap and running water for

abrasions with spontaneous bleeding b) Licks on broken skin or mucous membrane c) Exposure to a rabies patient through bites, contamination of mucous membranes such as eyes, oral/ nasal mucosa, genital/ anal mucous membrane, or open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation d) Unprotected handling of infected carcass e) Ingestion of raw infected meat f) Exposures due to direct contact with bats (touching, bite, scratch, or mucous membrane contact) g) Category II exposures on head and neck area	a minimum of 15 minutes 2. Antiseptic solution may be applied on the affected area 3. Start and complete vaccination and RIG immediately. 4. Review tetanus immunization and give if indicated 5. Assess the need for antibiotic prophylaxis	a minimum of 15 minutes 2. Antiseptic solution may be applied on the affected area 3. Start booster immediately if any high-risk criteria*** are present 4. RIG is *not* indicated 5. Review tetanus immunization and give if indicated 6. Assess the need for antibiotic prophylaxis

** Previously-immunized individual, as defined in the Definition of Terms*
***Vaccinated animal, as defined in the Definition of Terms*
****Vaccination for immunologically-naive individuals with Category II exposures, and booster doses (Day 0 and 3 [1 site ID/IM] OR Day 0 [4 sites ID]) for previously-immunized individuals with Category II or III exposures, shall be given if ANY high-risk criteria are present:*

1. *Vaccinated >6 months ago with ≥3 doses*
2. *Biting animal cannot be observed, is sick or rabid, dies, or is a bat*
3. *Wounds in highly innervated areas (neck, head, genital area, hands, toes, or in very close proximity to the CNS)*
4. *Multiple or deep wounds*
5. *Patient has uncontrolled co-morbidities*
6. *Patient is from a hard-to-reach area with infrequent transportation to and from ABTC/ABC*

Table 6. Post-exposure prophylaxis regimens

Route/Regimen	Day 0	Day 3	Day 7	Day 14	Day 21	Day 28
ID	2 sites	2 sites	2 sites	-	-	2 sites*
Shortened IM	1 site	1 site	1 site	1 site	-	-
Zagreb Regimen	2 sites	-	1 site	-	1 site	-

ID dose = 0.1 mL for both PCEC and PVRV
IM dose = full vial = 1.0 mL for PCEC and 0.5 mL for PVRV
**The last dose is omitted if the biting dog or cat is alive and healthy after 14 days from exposure.*

3. **Delays and schedule deviations**
    a. Initiation of PEP shall not be delayed for any reason regardless of interval between exposure and consultation as it increases the risk of rabies and it is associated with treatment failure.
    b. In cases of delayed consultation or when exposed patients present weeks or months after a potential rabies exposure:
        i. If the animal is rabid, dies within 14 days from exposure, stray, or outcome is unknown, treat as if the exposure occurred recently and start PEP as soon as possible.
        ii. If the biting animal has remained healthy and alive with no signs of rabies until 14 days after the bite, no treatment is needed. If the patient is high-risk, pre-exposure prophylaxis may be offered.
        iii. If the patient administered via IM route is unable to return for the Day 14 dose and the biting dog or cat remains alive and healthy beyond the 14-day observation period, the final dose of Day 14 may be omitted.
    c. Should a vaccine dose be delayed for any reason, the PEP regimen should be continued (not restarted) upon thorough assessment.
        i. There is no need to restart regardless of the status of the biting animal, as long as there is NO repeat exposure and previous doses are properly documented.
        ii. If the delay is 1-2 days from the scheduled dose, give the due dose upon visit and follow the original schedule.
        iii. If the delay is $\geq$ 3 days from the scheduled dose, give the due dose and adjust succeeding doses.
    d. In cases of schedule deviation or when exposed patients present 1 or 2 days earlier than the scheduled vaccination date, the dose may be administered rather than deferring and risking non-completion of vaccination.

4. **For special conditions**
    a. Pregnant and lactating women with potential rabies exposure shall be managed accordingly as the general population. There shall be no contraindication for PEP administration.
    b. Babies who are born of rabid mothers shall be given anti-rabies vaccination as well as RIG as early as possible at birth. Those who are born of mothers with recent potential rabies exposure shall not require any PEP.
    c. Patients with hematologic conditions where IM injection is contraindicated shall receive anti-rabies vaccine by ID route.
    d. Immunocompromised individuals (such as symptomatic HIV-infected persons not on antiretroviral therapy or not virally suppressed, cancer or transplant patients, those on chronic steroids or other immunosuppressive therapy, with end-stage renal disease [ESRD], or with chronic liver disease) with Category II and III rabies exposure shall be managed with administration of full course of anti-rabies vaccine using standard IM regimen and RIG in all cases, even if previously immunized against rabies. Vaccination shall not be delayed in these circumstances as it increases the risk of rabies. Consultation with an infectious disease specialist or an immunologist is advised.

e. Changes in the human anti-rabies vaccine product and/or the route during the same PEP course are acceptable, if unavoidable, to ensure PEP course completion. Restarting PEP is not necessary.
   i. When a change in route is necessary (e.g., from ID to IM or vice versa), the remaining doses shall follow the new route's schedule
   ii. When a change in brand or vaccine product is necessary (e.g., from PCEC to PVRV or vice versa), the remaining doses shall follow the schedule of the previous brand already initiated

5. **Prioritization of giving vaccines and RIG**

In cases of shortage or unaffordability, the following groups should be prioritized for vaccine and RIG allocation:

a. **Vaccine**
   i. Patients bitten by animals found to be positive by IFAT or for "Negri bodies" regardless of type of bite exposure;
   ii. Patients with Category III exposure;
   iii. Patients bitten by animals that are not available for observation (stray/slaughtered);
   iv. Individuals exposed to human rabies patients through bite/non-bite exposure;
   v. Patients with Category II exposure; and
   vi. Individuals included in the target population for PrEP.

b. **RIG**
   i. Multiple bites;
   ii. Deep wounds;
   iii. Highly innervated parts of the body;
   iv. Immunocompromised patients;
   v. History of biting animal indicative of confirmed or probable rabies; and
   vi. A bite or scratch or exposure of a mucous membrane by a bat can be ascertained.

6. **Timing and Spacing of Administration of Other Vaccines in Relation to Anti-Rabies Vaccines and Immunoglobulin**
   a. Anti-rabies vaccine and immunoglobulin as part of PEP shall be given regardless of recent receipt of ANY vaccine or immunoglobulin.
   b. Non-live vaccines can be given anytime. In addition, there are no schedule adjustments in non-live vaccines needed in relation to both anti-rabies vaccine and immunoglobulin.
   c. There is no adjustment of schedule needed for live parenteral vaccines (measles, varicella, MMR, MMR-V) in relation to the anti-rabies vaccine (i.e., Category II patients).
   d. However, doses of live vaccine should be adjusted for those who received tetanus immunoglobulin and rabies immunoglobulin.
      i. Live vaccines should be given at least 4 months after receipt of rabies immunoglobulin.
      ii. Live vaccines should be given at least 3 months after receipt of tetanus immunoglobulin.

e. When 2 vaccines are to be administered, it is recommended to give 1 vaccine into each deltoid.
f. If more than 2 vaccines are to be administered, the option will depend on the deltoid mass:
    i. If the deltoid muscle mass is large enough, give up to 2 administrations into each deltoid muscle (separated by 2.5 cm).
    ii. If the deltoid muscle mass is small, give further administration into either anterolateral thigh (2.5 cm apart if 2 vaccines are given in the same thigh).

7. Injection Safety

a. A safe injection is defined by the WHO as an injection that:
    i. Does not harm the recipient;
    ii. Does not expose the health staff to any avoidable risks; and
    iii. Does not result in waste that is dangerous to the community.

b. **Injection Equipment**
    i. Auto-Disable (AD) Syringes - are disposable injection devices that are especially made to prevent re-use and are therefore less likely than standard disposable syringes to cause person-to-person transmission of blood-borne diseases. It is recommended that health workers shall use AD syringe in their respective ABTC.
    ii. Conventional Syringes - are plastic syringes with steel needles that are provided usually by the manufacturer in sterile packages. The needle may either be fixed to the syringe when it is produced or attached by the health staff just before use.

c. **Management of Sharp Wastes**
    i. Used syringes and needles shall never be discarded in open areas where they could be picked up, stepped on, or otherwise come into contact with people.
    ii. Proper management of used or contaminated sharps should be ensured through the use of safety boxes or sharps containers. These puncture-resistant containers allow used syringes and needles to be safely and temporarily stored immediately after use until their final disposal.

d. **Waste Disposal**

Collector boxes filled with used syringes and needles, as well as empty vials, shall be immediately brought to its final disposal. The following methods of disposal are recommended:
    i. Septic vault;
    ii. Pit burial; and
    iii. Waste treatment and final disposal to landfill.

8. Management of Adverse Reactions

Adverse reactions shall be managed as follows:

a. **Anaphylaxis**
    i. Give 0.1% adrenaline or epinephrine (1:1,000 or 1mg/mL) underneath the skin or into the muscle.
        1. Adults: 0.5 mL

2. Children: 0.01mL/kg, maximum of 0.5 mL

ii. Repeat epinephrine dose every 10-20 minutes for 3 doses.

iii. Give steroids after epinephrine.

iv. Bring to the nearest emergency room.

b. **Hypersensitivity reactions**

i. Give antihistamines, either as a single drug or in combination.

ii. If the status quo for 48 hrs despite combination of antihistamines, may give a short course (5-7 days) of combined oral antihistamines plus steroids.

iii. If the patient's condition worsens, necessitating hospitalization or becomes life threatening, IV steroids may be administered in addition to antihistamines.

C. **Financing**

1. The DOH shall provide annual augmentation of NRPCP commodities to its certified ABTCs.
2. To further defray costs, certified facilities are encouraged to apply for accreditation with the Philippine Health Insurance Corporation (PhilHealth) so patients can avail of the Animal Bite Treatment (ABT) Package.
3. Local Government Units (LGUs) shall remain responsible for filling the remaining gap to ensure uninterrupted PEP provision and minimize out-of-pocket expenditure at the local level.

D. **Reporting of potential rabies exposure**

1. Until the National Rabies Information System (NaRIS) and/or an alternative information system is fully operational, reports of potential rabies exposures shall continue to be submitted through quarterly reporting of cases to the respective regional rabies program coordinators (per the NRPCP Manual of Procedures [MOP], 2019) and via the FHSIS, subject to any subsequent policy guidance.
2. Refer cases of rabies and/or signals of health events involving animal bites to their appropriate Epidemiology and Surveillance Units (ESUs) through their PIDSR-IS.

E. **Monitoring and Evaluation**

The DOH, through the NRPCP, shall conduct regular monitoring and evaluation of the implementation of this Order to ensure compliance with its provisions and to identify areas for improvement. All implementing units shall submit the required reports and participate in periodic reviews as may be initiated by the DOH-NRPCP, in accordance with the NRPCP Manual of Procedures 2019 and the NRPCP Strategic Plan 2020–2025, and any amendments thereto. Findings from monitoring and evaluation activities shall serve as the basis for policy refinement, capacity building, and the continuous improvement of the implementation of this Order.

VII. ROLES AND RESPONSIBILITIES

A. The **Disease Prevention and Control Bureau - National Prevention and Control Program** shall:

1. Procure anti-rabies vaccines and RIG to provide augmentation to all DOH-certified ABTCs through the Centers for Health Development (CHD); and
2. Conduct regular monitoring and evaluation of the implementation of this Order.

B. The **Centers for Health Development** shall:
1. Ensure that all DOH-certified ABTCs within their respective regions maintain an adequate and uninterrupted supply of anti-rabies vaccines and RIG;
2. Oversee the proper storage, handling, and cold chain management of rabies biologicals to maintain vaccine potency and safety; and
3. Provide technical assistance and supportive supervision to ABTCs, including guidance on clinical management of potential rabies exposures and adherence to national protocols.

C. The **Local Government Units** shall, in accordance to RA No. 9482 and its IRR:
1. Implement the NRPCP and ensure compliance with their mandated responsibilities;
2. Appropriate funds from Internal Revenue Allotment or other local sources for procurement of rabies biologicals;
3. Enact and enforce local ordinances to support the NRPCP, including but not limited to dog population control, human and animal anti-rabies vaccination, and responsible pet ownership; and
4. Coordinate with the DOH, Department of Agriculture - Bureau of Animal Industry, and other concerned agencies to ensure the implementation of the NRPCP through an integrated One Health approach to rabies prevention and control.

VIII. REPEALING CLAUSE

Administrative Order No. 2018-0013 entitled "Revised Guidelines on the Management of Rabies Exposures" and all other issuances inconsistent or contrary to the provisions of this Order are hereby repealed or modified.

IX. EFFECTIVITY

This Order shall take effect fifteen (15) days from the date of its publication in the Official Gazette or in any national newspaper of general circulation, with three (3) certified copies to be filed with the Office of the National Administrative Register (ONAR) of the UP Law Center.

TEODORO J. HERBOSA, MD
Secretary of Health

Annex A. Recommendations for Antibiotic Treatment for Animal Bites

Indications	Recommended	Alternative
I. Treatment For frankly infected wounds *Duration of therapy: 5-7 days*	**Adults**	
	Oral Amoxicillin/clavulanic 500/125mg tab PO TID or 875/125mg tab PO BID Intravenous Ampicillin-sulbactam 1.5-3.0g IV q6-q8h	Oral Doxycycline 100mg cap PO BID Intravenous Cefuroxime 750 mg IV q8h **PLUS** • Clindamycin 300 mg IV q6h **OR** • Metronidazole 500 mg IV q6-q8h
	Children	
	Oral Amoxicillin/clavulanic 30-50mg/kg/day • If using 457 mg/5 mL formulation (400mg amoxicillin), give BID • If using 312.5 mg/5 mL (250mg amoxicillin), give TID Intravenous Ampicillin-sulbactam • Mild to moderate infections: 100-200 mg/kg/day in 4 doses (max: 4g/day) • Severe infections: 200 mg/kg/day in 4 doses (ampicillin component) (max: 8 g/day)	Oral Cefuroxime 20-30 mg/kg/day divided into 2 doses OR TMP-SMX **PLUS** • Clindamycin 10-30 mg/kg/day divided into 3-4 doses **OR** • Metronidazole 30 mg/kg/day in 3-4 doses (max:4g/day) Intravenous Cefuroxime 75-150 mg/kg/day divided q8h **PLUS** • Clindamycin 25-40 mg IV q6-q8h **OR** • Metronidazole 30 mg/kg/day in 3-4 doses (max: 4 g/day)
II. Prophylaxis No obvious signs of infection but high-risk for subsequent infection	**Adults**	
	Oral Amoxicillin/clavulanic 500/125 mg tab PO TID or	Oral Doxycycline 100 mg cap PO BID

<table>
<tr><td rowspan="4">Indications:
• All category III cat bites
• Immunocompromised patients (such as asplenia, advanced liver and kidney disease, uncontrolled DM)
• All category III bites that are either deep, penetrating, multiple or extensive
• Bites/injuries involving the face, hand or genital area
• Bites in extremities with underlying venous or lymphatic compromise
• Injuries where bone or joint penetration is possible or where the bite wound is adjacent to a prosthetic joint
• Moderate to severe injury <8hours old, especially if edema or crush injury is present

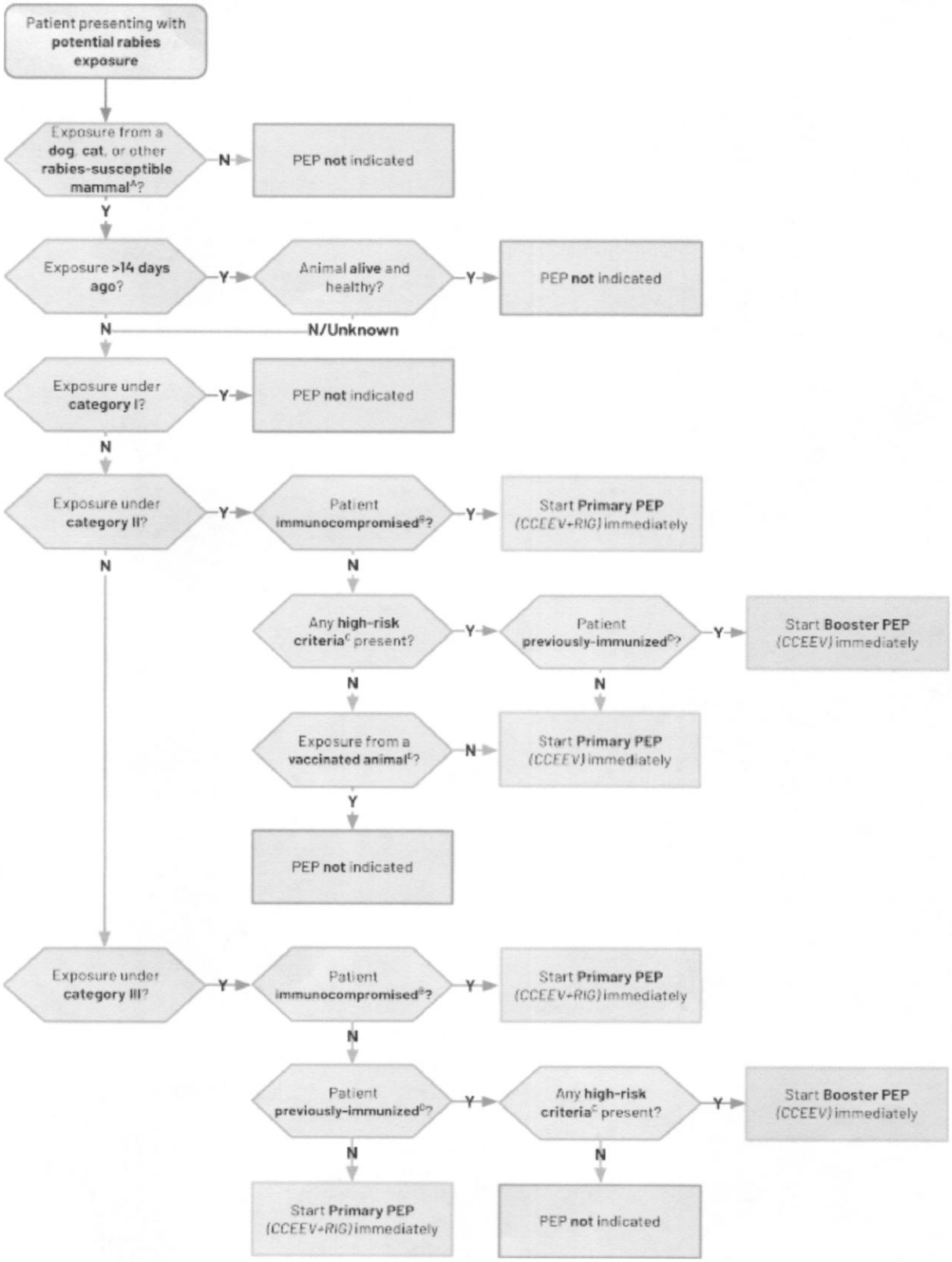
Duration of therapy: 3 days
*should be initiated within 12-24hrs from exposure
*if exposure is beyond 72hrs and there is no sign of infection, no prophylaxis is needed</td><td colspan="2">875/125mg tab PO BID</td></tr>
<tr><td colspan="2">Children</td></tr>
<tr><td><u>Oral</u>
Amoxicillin/clavulanic 30-50 mg/kg/day
• If using 457 mg/5mL formulation (400mg amoxicillin), give BID
• If using 312.5mg/5mL (250mg amoxicillin), give TID</td><td><u>Oral</u>
Cefuroxime 20-30 mg/kg/day divided into 2 doses OR TMP-SMX <u>PLUS</u>
• Clindamycin 10-30 mg/kg/day divided into 3-4 doses
<u>OR</u>
• Metronidazole 30 mg/kg/day in 3-4 doses (max:4 g/day)</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="4">III. Allergy to penicillin or to the other alternative regimens provided above

Duration of therapy: 3 days of prophylaxis and 5-7 days for treatment as above</td><td colspan="2">Adults</td></tr>
<tr><td colspan="2">Doxycycline as above

Levofloxacin 750 mg tab 1tab OD <u>OR</u>
Ciprofloxacin 500 mg tab 1tab BID <u>OR</u>
Cotrimoxazole 800/160 mg tab 1tab BID
<u>PLUS</u>
Clindamycin 300 mg cap 1cap QID</td></tr>
<tr><td colspan="2">Children</td></tr>
<tr><td colspan="2">TMP-SMX (Cotrimoxazole)
Weight ≤ 40kg: 8-12 mg/kg of TMP divided into 2 doses</td></tr>
</table>

	Weight > 40kg: 800/160 mg tab 1tab BID **PLUS** Clindamycin 10-30 mg/kg/day divided into 3-4 doses

Annex B. Rabies Post-exposure Prophylaxis (PEP) Decision Tree



Annex C. References

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