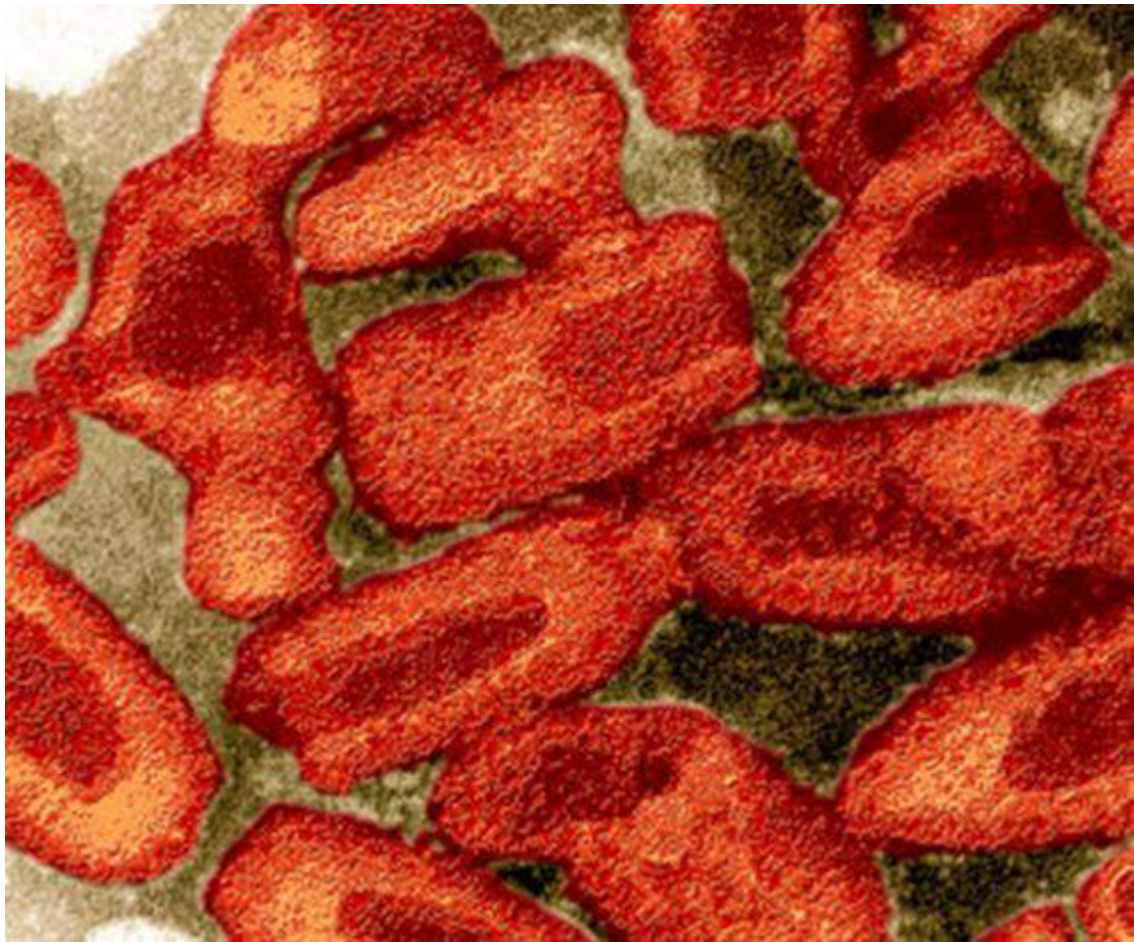


National Rabies Prevention and Control Program Manual of Operations (2012)



Department of Health, Philippines

In collaboration with



DepED
DEPARTMENT OF EDUCATION

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ACRONYMS

ACRONYMS

BAI	Bureau of Animal Industry
DA	Department of Agriculture
DENR	Department of Environment and Natural Resources
DepED	Department of Education
DILG	Department of Interior and Local Government
DME	Direct Microscopic Examination
DOH	Department of Health
ERIG	Equine Rabies Immunoglobulin
FAT	Fluorescent Antibody Test
HRIG	Human Rabies Immunoglobulin
MIT	Mouse Inoculation Test
NGOs	Non-government Organizations
PAHC	Philippine Animal Health Center
POs	People's Organizations
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
RFFIT	Serum Rapid Fluorescent Focus Inhibition Test
WHO	World Health Organization

GLOSSARY OF TERMS

GLOSSARY OF TERMS

Active Immunization - Administration of a vaccine to induce protective immune response

Animal Bite Center - A privately owned/operated bite center where individuals with potential rabies exposures are evaluated and managed with Post-Exposure Prophylaxis. This includes bite centers located in government health facilities.

Animal Bite Treatment Center - A government-operated health facility where individuals with potential rabies exposure are evaluated and managed with Post-exposure Prophylaxis. It is also a facility for administration of rabies exposure prophylaxis to individuals at risk of being infected of rabies.

Impounding - Seizing and holding something or anything under the custody of the law

Incubation Period - The period from the time of exposure up to the appearance of first clinical signs and symptoms of rabies

Observation Period - Observation of biting animal for 14 days from the time of bite for the appearance of expected/presumptive signs of rabies

Passive Immunization - Administration of immune globulins which are pre-formed antibodies of human or animal source to provide immediate protection

Post-exposure Prophylaxis - Formerly called Post Exposure Treatment (PET); refers to anti-rabies prophylaxis administered after an exposure (such as bite, scratch, lick, etc.) to potentially rabid animals. It includes local wound care, administration of rabies vaccine with or without Rabies Immune Globulin (RIG) depending on category of exposure

Pound - Public enclosure for stray animals

Pre-Exposure Prophylaxis - Rabies vaccination administered before an exposure to potentially rabid animals. This is usually given to those who are at high risk of getting rabies such as veterinarians, animal handlers, staff in the rabies laboratory and hospitals handling rabies patients and school children from high risk areas.

Rabid Animal - An animal with clinical manifestations of rabies and/or confirmed laboratory findings

Suspected Rabid Animal - Any animal involved in a biting incident with a potential to have rabies infection.

MESSAGE

MESSAGE

Combating rabies may be a difficult task but certainly not an impossible one. The fight to save human and animal lives and health can be done, especially with a strong commitment to cooperate among public and private partners and the communities at all levels.

This dreadful viral infection is responsible for the deaths of 200 to 300 Filipinos every year. And while this figure may be comparatively lower than other developing countries, the Department of Health, together with its partners and allies are determined, more than ever to eradicate the disease and avert mortality among those who have been infected.

To ensure that the Philippines continue its battle against rabies, various measures have been undertaken. From enacting policies (Republic Act 9482, known as The Anti-Rabies Act of 2007) to implementing different collaborative activities by public and private sector partners; to involving the communities – all these aimed at reducing the public's risk and deaths resulting to rabies.

The Manual of Operations presents appropriate and practical guidelines for the prevention and control of rabies that were designed to be easy to understand and more importantly, administer. While the manual offers clinical guidelines, information and suggested strategies within reach, the bigger challenge is to ensure that service providers, program managers and all concerned partners sustain and adhere to the recommended steps.



ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health



ACKNOWLEDGEMENT

ACKNOWLEDGEMENT

This manual of operations is a product of cooperation among partners and colleagues who share the vision of having a Rabies-free Philippines in 2020. The agencies and their individual representatives not only contributed their time, talent and technical expertise, but further enriched the manual by sharing their personal insights and experiences to make rabies better understood thereby enabling service providers and allied partners better equipped to prevent and manage this dreadful disease.

The National Rabies Prevention and Control Program is grateful to the following who responded generously to our call for assistance in bringing this manual to completion:

- Infectious Disease Office of the National Center for Disease Prevention and Control of the Department of Health
- National Epidemiology Center of the Department of Health
- National Center for Health Promotions of the Department of Health
- Center for Health and Development
- Research Institute for Tropical Medicine
- San Lazaro Hospital
- Department of Agriculture-Bureau of Animal Industry
- Department of Agriculture Regional Field Units
- Department of Education
- Local Government Units
- World Health Organization
- and all other partners - individuals or organizations

The guidelines in the manual present the collaborative efforts of both the medical and veterinary communities in safeguarding health of humans and animals. It is our hope that this Manual of Operations, will enable all agencies to be more involved in preventing the disease, through various cooperation and collaborative efforts from clinical management, information dissemination and advocacy at all levels.

CHAPTER 1: INTRODUCTION

1. INTRODUCTION

Rabies is a zoonotic disease and human infection caused by Lyssavirus, usually occurring after a transdermal bite or scratch by an infected animal. Transmission may also occur when infectious material, usually the saliva, comes into direct contact with the victim's mucosa or fresh skin lesions. Very rarely, rabies may occur through inhalation of virus-containing aerosol or via infected organ transplants. It is a highly fatal disease characterized by fluctuations in consciousness, phobic or inspiratory spasms and autonomic instability.

Rabies is estimated to cause 55,000 deaths every year worldwide, with about 56% of the cases occurring in Asia and 43.6% in Africa, mostly in rural areas. Rabies is present on all continents with the exception of Antarctica. Once symptoms of the disease develop, rabies is nearly always fatal.

Rabies is a neglected disease of poor and vulnerable populations whose deaths are rarely reported. It occurs mainly in remote rural communities where measures to prevent dog to human transmission have not been implemented. Under-reporting of rabies also prevents mobilization of resources from the international community for the elimination of human dog-mediated rabies.

Rabies remains to be a public health problem in the Philippines. It is the most acutely fatal infectious disease responsible for the death of 200-250 Filipinos every year. At least one-third of human rabies deaths are among children less than 15 years of age. Two thirds of human rabies cases are males. Dogs are the source of the vast majority of human rabies deaths. The high cost of anti-rabies vaccine and immunoglobulins, expenditure for medical consultations and the loss of income are an additional burden to a regular Filipino family confronted with a potential rabies exposure.

Several initiatives at the local level were undertaken to minimize death due to rabies, such as the following: the provision of pre-exposure treatment to high risk personnel and post exposure prophylaxis to animal bite victims; provision of free routine immunization or pre-exposure prophylaxis; mass vaccination of dogs, establishment of a central base system for registered and vaccinated dogs; impounding, field control and disposition of unregistered, stray and unvaccinated dogs; and conduct of information and education campaign on the prevention and control of Rabies.

INTRODUCTION

Statistics showed that for the past five years (2007-2011), there has been a decline in the number of Human Rabies cases from 285 (2007) to 219 (2011) a 23% decrease. The same holds true for the canine rabies cases wherein there were 1,122 cases in 2007 and it lowered to 451, a decline of 59%.

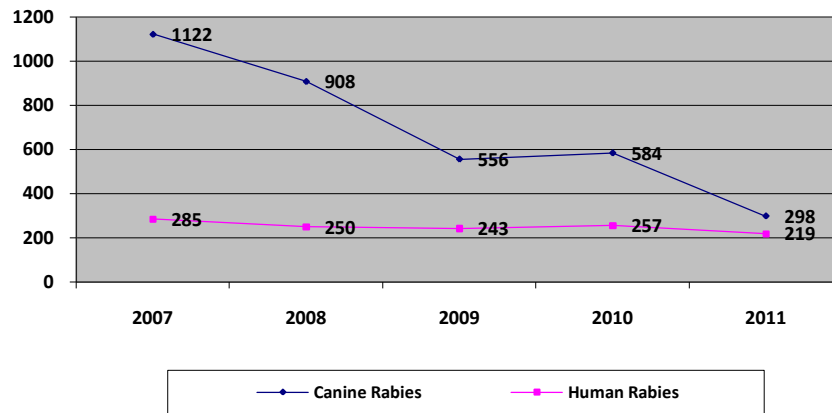
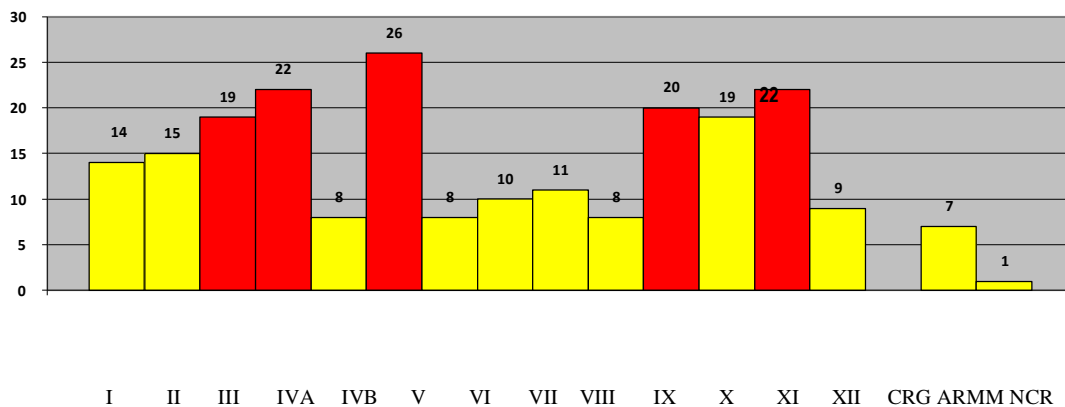


Figure 1: Human and Canine Rabies Cases 2007 to 2011

Source: Infectious Diseases Office, National Center for Disease Prevention and Control, Department of Health and Bureau of Animal Industry, Department of Agriculture, Philippines

In 2011, the top 5 Regions with the highest number of human rabies cases were: Region 5 (26 or 12%); Region VIA and Region 12 both with 22 cases followed by Region X (20); XI (19) and Region II (15 cases).

Figure 2: Human Rabies Distribution per Region 2011



Source: Infectious Diseases Office, National Center for Disease Prevention and Control, Department of Health

INTRODUCTION

TABLE 1: CY 2011 Annual Rabies Exposures According to Sex and Biting Animals

Rabies Exposure							Biting Animals			
Sex*			Age*			Human Rabies	Dog	Cat	Others	Total
Male	Female	Total	<15	>15	Total	No.				
175,754	154,323	330,077	155,862	173,221	329,083	219	281,898	40,963	5,963	328,824

(*Discrepancy in the total is due to incomplete entries in the Rabies Exposure Registry)

Source: Infectious Diseases Office, National Center for Disease Prevention and Control, Department of Health

TABLE 2: CY 2011 Bite Cases per Category of Exposure per Region

Region	Category Of Exposure				
	Cat I	Cat II	Cat III	Total	%Contribution to Total
1	1116	8916	4321	14353	4%
2	1,129	12,410	3,281	16,820	5%
3	1,232	28,733	10,978	40,943	12%
4A	1,181	23,040	13,579	37,800	11%
4B	333	7,089	2,764	10,186	3%
5	58	11,856	5,779	17,693	5%
6	1,522	13,702	19,339	34,563	11%
7	175	21,256	7,633	29,064	9%
8	1,177	4,483	1,803	7,463	2%
9	45	6,200	3,658	9,903	3%
10	498	8,438	11,732	20,713	6%
11	210	3,848	9,034	13,092	4%
12 (375	6,112	3,366	9,853	3%
CARAGA	91	4,387	3,039	7,517	2%
ARMM	No data				
NCR	1,437	33,955	14,801	50,193	15%
CAR	996	4,668	2,973	8,637	3%
TOTAL	11,575	199,138	118,793	328,733	100%

Source: Infectious Diseases Office, National Center for Disease Prevention and Control, Department of Health

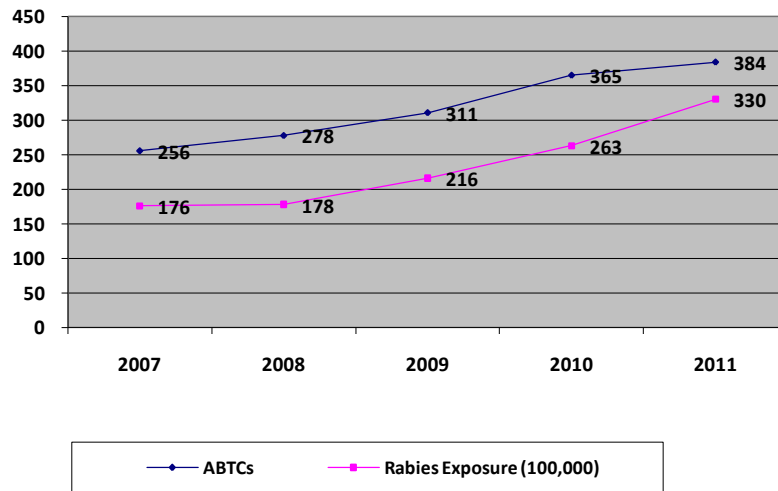
The total animal bite cases reported for the year 2011 totalled to 330,077 where in 47.4% or a total of 155,862 cases were below 15 years old while 52.6% or 173,221 are ages 15 years old and above. Fifty three percent (53.1%) or 174,754 of the animal bite patients were male while 46.9 % or 154,323 were female.

INTRODUCTION

Based on the 2011 Rabies and Bite Victim Annual Report, 85.7% of rabies exposures were mostly through dog bites, 12.5% from cats and 1.8% from other animals. The remaining 3.5% were of Category 1 exposure which did not require Post Exposure Prophylaxis (PEP), while 60.6% belong to Category II and 35.9% belong to Category III, which necessitated the administration of anti-rabies vaccine, with or without rabies immunoglobulin.

Another milestone of the DOH in the control and elimination of human rabies is the establishment of Animal Bite Treatment Centers (ABTCs) and Animal Bite Centers (ABCs) which provide adequate, appropriate, timely, safe, affordable, and quality post exposure prophylaxis services to animal bite patients. The number of ABTCs, where cases of rabies exposures are able to access human anti-rabies vaccine and immunoglobulins for post-exposure prophylaxis, increased from 227 in 2005 to 384 in 2011.

Figure 3: Reported Rabies Exposures and Number of ABTCs, 2011, DOH



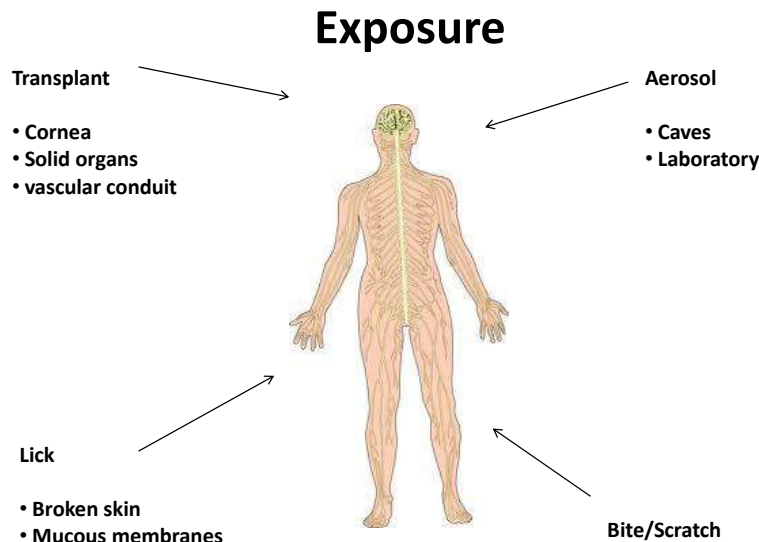
2. RABIES IN HUMANS

Bite and non-bite exposures inflicted by infected humans could theoretically transmit rabies, but no such case has been documented in the country. The only documented human-to-human cases were through corneal as well as through liver, kidney and other organ transplants.

INTRODUCTION

The rabies virus is not found in human or animal blood and feces thus, these body fluids do not pose a risk for rabies transmission.

Casual contact, such as touching/talking to a person with rabies or contact with non-infectious fluid (blood, feces), does not constitute an exposure and does not require post-exposure prophylaxis (PEP).



2.1. Modes Of Transmission

Bites from infected animals are the most common mode of transmission of rabies to humans. Exposure to rabies may come from bites of infected dogs, cats, other domestic and wild animals including bats. However, bites from rats, rabbits, other rodents, reptiles and birds do not pose a risk for rabies infection.

Non-bite exposures are less important and are infrequent modes of transmission. However, scratches, open wounds or mucous membranes that are licked by an infected animal, can be points of entry of the rabies virus and these may be in the form of the following:

- Contamination of intact mucosa (eyes, nose, mouth, genitalia) with saliva of infected animal;
- Licks on broken skin; and
- Inhalation of aerosolized virus in closed areas (e.g. caves with rabid bats, laboratories for rabies diagnosis).

2.2. Incubation period

Incubation period is the period from the time of exposure up to the appearance of first clinical signs and symptoms of rabies.

The average incubation period of human rabies is between one to three (1-3) months. In 90-95 % of cases, incubation period is less than one year but may be longer in 5-10 % cases. The duration of the incubation period depends on certain factors:

- The amount of the virus inoculated into the wound or mucosa.
- Severity of exposure - Patients with multiple and/or deep penetrating bite wounds may have shorter incubation period.
- Location of exposure - Patients with bite wounds in highly innervated areas and/or close to the central nervous system may have shorter incubation period.

2.3. Pathogenesis

After inoculation, the rabies virus multiplies in the muscle cells (myocytes or may invade the nerve directly without prior multiplication in the myocytes. It is possible that the rabies virus may persist locally at the site of inoculation for an unspecified period of time. This could explain the long incubation period for some rabies infections.

The virus then penetrates the peripheral nerve cells via viral uptake at neuronal endings. The virus is transported through both the sensory and motor nerve fibers to the central nervous system (CNS). In vitro studies show that velocity of axonal transport of the virus ranges from 25 to 50 mm per day. The spread of the rabies virus in the oculomotor and optic nerves could be as fast as 12 mm/day.

Once the virus reaches the CNS, rabies replication occurs primarily in the neurons or brain cells through viral budding and the virus spreads and infects the nearby brain cells. Dissemination through the cerebrospinal fluid (CSF) occurs in the late stages of infection.

While viral dissemination occurs in the central nervous system, the rabies virus spreads into the peripheral tissues such as muscle fibers, salivary glands, corneas, adrenal medullae, lacrimal glands, myocardium, kidneys, lungs, pancreas and epidermis. Infection of salivary glands allows further transmission of the disease to other mammals.

2.4. Clinical Stages

2.4.1. Prodromal

The prodromal stage occurs when there is initial viral replication at the striated muscle cells at the site of inoculation *just before it enters the brain*. The virus then spreads centripetally up the nerve to the central nervous system through the peripheral nerve axoplasm.

This stage lasts for 0-10 days with non-specific manifestations, which include fever, sore throat, anorexia, nausea, vomiting, generalized body malaise, headache and abdominal pain. Paresthesia or pain at the site of bite is due to viral multiplication at the spinal ganglion just before it enters the brain.



2.4.2. Acute Neurologic

The acute neurologic stage is the stage when the virus reaches the CNS and replicates most exclusively within the gray matter. This stage has two types of presentation: encephalitic or furious type, which is present in 80% of rabies cases, and paralytic or dumb type, which is seen in 20 %.

Autonomic manifestations such as hypersalivation appear during this stage. The virus passes centrifugally among autonomic nerves to reach other tissues- the salivary gland, adrenal medulla, kidney, lung, liver, skeletal muscle, skin and heart. Passage into the salivary gland facilitates further

INTRODUCTION

transmission of the disease through infected saliva. This stage lasts for 2-7 days, characterized by hyperactivity, hypersalivation, disorientation, hallucination, bizarre behavior interspersed with lucid intervals, seizures, nuchal rigidity or paralysis.

Table 3: Two Types of Presentation of the Acute Neurologic Stage of Rabies In Humans

Neurologic or Furious type	Paralytic or dumb type
Hyperactivity (anxiety, agitation, running, biting, bizarre behavior alternating with periods of calm) which may occur spontaneously or may be precipitated by tactile or auditory, visual or other stimuli. The most characteristic symptom is spasm of the pharyngeal muscles often triggered by an attempt to drink water (hydrophobia) or by blowing air on patient's face (aerophobia). Spasmodic contractions of the muscles may spread to the respiratory and other muscles leading to attacks of apnea.	Acute progressive ascending myelitis, symmetrical or asymmetrical with flaccid paralysis, pain and fasciculation in the affected muscles with mild sensory disturbance. A complete paraplegia develops eventually with fatal paralysis of the respiratory and pharyngeal muscles.

2.4.3. **Coma** - begins within 10 days of onset, and the duration varies.

2.4.4. **Death** - without intensive supportive care, respiratory depression, cardio respiratory arrest, and death occur in almost 100% of cases.

2.5. Differential Diagnosis

Guillain-Barré Syndrome (GBS) is an autoimmune inflammatory disease of the peripheral nervous system, affecting one or more nerves outside the brain and spinal cord. This syndrome is characterized by the rapid onset of weakness, sensory loss, and impairment of reflexes; often paralysis of the legs, arms, breathing muscles, and face develops in ascending order.

Encephalitis (due to other viruses) is an acute inflammatory disease of the brain. Patient experiences fever, a stiff neck and/or back pain, tremors, seizures, paralysis of extremities, abnormal walk (gait), and abnormal reflex reactions. Deep loss of consciousness (coma) may occur and last for days or weeks.

2.6. Laboratory Diagnosis

Often the diagnosis of rabies is based on the clinical manifestations and a history of exposure to a rabid animal. In cases where the pathognomonic hydrophobia and/or aerophobia are present, the diagnosis is straight forward. However, clinical diagnosis may be difficult in cases of paralytic rabies and atypical presentations. Thus, rabies laboratory confirmation is necessary. Rabies diagnosis can be performed on fresh tissue specimens stored at appropriate temperatures, preferably refrigerated. The specimens to be collected depend on the test to be performed.

In transporting specimen glycerine preservative (temperature: +4°C or -20°C) or dried smears of brain tissue on filter paper (temperature: +30°C) enables safe transport.

2.6.1. Ante-Mortem

Samples for Laboratory diagnosis of rabies during life secretions and biological fluids (saliva, spinal fluid, tears, etc.) can be used to diagnose rabies during life (intra vitam). They should be stored at -20°C or below. Serum should be collected from blood samples prior to freezing and stored at -20°C.

Timing of the collection and interpretation of the sample is very crucial.

Recommendation of the WHO-CC Reference and Research on Rabies, France Intra-Vitam Diagnosis of Human Rabies, (Dacheux et al., Plos NTD, 2010)					
Intra-Vitam Diagnosis of Human Rabies					
SAMPLES	Sensitivity Considering the Clinical Evolution of the Patient (in days following the Onset of Symptoms)		Comments	Storage	Technique (Reference)
	0-8 days	>8 days			
Saliva (1ml or saliva swabs)	High	High	At least three saliva samples collected at intervals of 3-6 hours, liquid saliva is preferred to saliva swabs	-20°C/-80°C	RT-hnPCR (3)
Urine (at least 1ml)	Low	Low	At least three urine samples collected in an interval of 3-6	-20°C/-80°C	RT-hnPCR (3)

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			hours		
Skin biopsy (diameter of 4mm, total volume of 20 mm ³)	High	High	Skin biopsy collected at the nape of the neck, with hair follicles, using biopsy punch (Stiefel).	-20°C/-80°C	RT-hnPCR (3)
Serum (500µL)	Low	Average	Sample collection can be repeated, depending on the length of survival period (1-2 samples per week)	+4°C/-20°C	RFFIT (31) and/or ELISA (3,6,33)
CFS (>300µL)	Low	Average	Sample collection can be repeated, depending on the length of survival period (1-2 samples per week)	-20°C/-80°C	RT-hnPCR (3); RFFIT (3) and/or ELISA (3,6,33)

The following laboratory tests can be done to confirm rabies in humans:

- **Fluorescent Antibody Testing (FA)**

The Fluorescent Antibody (FA) technique is the gold standard for rabies diagnosis. It is a rapid and sensitive test based on microscopic examination under ultraviolet light. Tissue samples from brainstem, thalamus, cerebellum and the hippocampus (Ammon's horn) are recommended for increased sensitivity of the test. Viral antigen may be detected by using the FA test on skin biopsies taken from the nuchal area of the neck, with hair follicles containing nerve endings.

- **Polymerase Chain Reaction (PCR)**

The Polymerase Chain Reaction (PCR) is a laboratory technique for "amplifying" a specific DNA sequence. PCR is extremely efficient and sensitive; it can make millions or billions of copies of any specific sequence of DNA, even when the sequence is in a complex mixture

- **Serology**

Serum Rapid Fluorescent Focus Inhibition Test (RFFIT). Serum neutralization assays are used to determine the potency of rabies serum and immunoglobulins used for PEP, and to evaluate the immunogenicity of human and, to a lesser degree, animal rabies vaccines.

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The standard procedures recommended at the seventh meeting of the WHO Expert Committee on Rabies were the mouse neutralization test (MNT) and the plaque reduction assay. Since then, plaque reduction methods have been superseded by fluorescent focus inhibition tests, which are more convenient. Although the MNT is still widely used as a reference test, the RFFIT has become the test of choice in most modern laboratories.

The RFFIT has been shown to be at least as sensitive as the MNT in measuring virus-neutralizing antibodies. Only 50% of which will give positive results among rabies cases. Serologic testing is more useful to ascertain the immune status of immunized animals and humans.

- **Histologic Findings**

Negri bodies or Cerebral inclusion bodies are round cytoplasmic inclusions of assembling nucleocapsid are pathognomonic of rabies infection, but are found in only about 80% of cases. The biting animal should be examined for rabies

2.6.2. Post Mortem

Samples for post-mortem diagnosis includes brain tissue that can be collected through transorbital or transforamen magnum route if autopsy cannot be performed.

Recommendation of the WHO-CC Reference and Research on Rabies, France Intra-Vitam Diagnosis of Human Rabies, (Dacheux et al., Plos NTD, 2010)				
Post- Mortem Diagnosis of Human Rabies				
Samples	Sensitivity	Comments	Storage	Technique (Reference)
Brain Biopsy	High	Brain biopsy collected via the orbital route with Tru-Cut biopsy needles for soft tissues with manual clip (allegiance) or via the occipital route using lumbar puncture needles.	+4°C/-20°C	FAT (28); RTCIT (29); WESLYSSA (26,270;RT-hnPCR (3)
Skin biopsy (diameter of 4mm, total volume of 20mm ³)	High	Skin biopsy collected at the nape of the neck, with hair follicles, using biopsy punch (Stiefel).	-20°C/-80°C	RT-hnPCR (3)

3. RABIES INFECTION IN DOGS

3.1. Animal Reservoirs of Rabies

Dogs are the principal reservoir of rabies in the country. Rabies in domestic animals like cattle, carabao, pigs goats and horses has been reported since the 1930's but were all traced to bite of rabid dogs.

3.2. Incubation Period of Rabies in Dogs

Incubation period of rabies in dogs vary from 10-80 days after exposure. The incubation period varies from a few days to several months, and the virus can be shed in the saliva a few days prior to the appearance of any clinical neurological manifestations. In majority of dogs, virus excretion begins at the earliest 2-7 days shortly before or after the appearance of the clinical signs and symptoms of rabies.

3.3. Mode of Transmission

Rabies is transmitted among animals and from animals to man through excretion of rabies virus via saliva and is transmitted to a new victim through a bite or through penetration of infected saliva into broken skin or mucosa.

3.4. Clinical Stages of Rabies in Dogs

Table 4: Clinical Stages and Signs of Rabies

1. Prodromal Stage (usually lasts 2-3 days: sometimes, only a few hours)	
2. Clinical Rabies	
Furious Stage (usually lasts 1-7 days)	Paralytic(dumb) stage (develops 2-10 days after clinical signs; usually last 2-4 days)
1. Increased response to auditory and visual stimulation such as <ul style="list-style-type: none"> • Restlessness • Photophobia • Hyperesthesia • Eating unusual objects • Aggression • Attacking any live or inanimate objects 2. Erratic behavior <ul style="list-style-type: none"> • Biting or snapping • Licking or chewing of wound/bite 	1. Paralysis <ul style="list-style-type: none"> • Paralysis may begin at the bite area and progress until entire CNS involvement • Following paralysis of the head and neck the entire body becomes paralyzed • Laryngeal/pharyngeal paralysis) • Change in tone of vocalization/ barking (indicative of laryngeal/pharyngeal paralysis) • Hypersalivation or frothing;

<ul style="list-style-type: none"> • site • If caged, biting of their cage • Wandering and roaming • Excitability: • Irritability; • Viciousness 	<ul style="list-style-type: none"> • drooling/slobbering of saliva (indicative of laryngeal/pharyngeal paralysis) • Dysphagia/ difficulty/inability to swallow • "Jaw drop"/Dropped jaw due to masseter muscle paralysis (suspects foreign body in mouth or esophagus) • Pupillary dilation or constriction • Protrusion of third eyelid • Ataxia, progressive paralysis and cannibalism (terminal stage)
<ul style="list-style-type: none"> 3. Self-mutilation 4. Muscular in-coordination and seizures 5. Disorientation <ul style="list-style-type: none"> • Roams and bites inanimate object and also other animals including man 	
3. Coma	
4. Respiratory paralysis resulting in death within 2-4 days	

3.5. Clinical Signs Of Rabies In Other Domestic Animals

In cats, the incubation periods ranged from 2-12 weeks with a median of 4-6 weeks. Major signs of rabies in cats include behaviour change, gait abnormality, strange or unusual look in the eyes, increased frequency of vocalization and a reported wound within the preceding 6 months.

In horses the incubation period averages 2-4 weeks (range of 2 weeks to 3 months). Clinical signs of disease at the time of initial examination usually include weakness of the hind quarter (ataxia and paresis) lameness and colic. After excitation period, paralytic signs occur that cause the difficulty in swallowing, followed by the in coordination of the extremities.

Rabies in cattle and small ruminants is characterized by long incubation period of 14-26 days. Clinical signs include behavioural change, anorexia, hypersalivation, aggressiveness, hyperexcitability and hyperesthesia. The animal dies within one week.

3.6. Laboratory Diagnosis

The diagnosis of animal rabies is based on laboratory confirmation. The gold standard for laboratory diagnosis for animal rabies is **Fluorescent Antibody Test (FAT)**. In the absence of FAT, other examinations are **Direct Microscopic Examination (DME) and Mouse Inoculation Test (MIT)**.

- **Fluorescent Antibody Test (FAT)**

The gold standard for laboratory diagnosis for animal rabies is **Fluorescent Antibody Test (FAT)**. An immunoassay using monoclonal antibodies specific for rabies in an impression smear of the hippocampus (Ammon's horns) and brain stem treated with fluorescent in isothiocyanate-labeled anti-rabies globulin. It needs a fluorescent microscope to determine the staining reaction and the result may be obtained within 24 hours.

- **Reverse Transcriptase-Polymerase Chain Reaction (RT-PCR)**

PCR is molecular detection of rabies nucleoprotein in a sample using rabies-specific primers. Results should correlate clinically with other diagnostic tools.

- **Rabies Fluorescent Focus Inhibition Test (RFFIT)**

A serologic assay uses a cell culture technology to determine the rabies **virus neutralizing antibody (VNA)** in an immunized or sick individual.

- **Seller's Test or Negri Body Detection in Direct Microscopic Examination (DME)**

Technique using impression smear for the detection of rabies inclusion bodies known as Negri bodies, through direct microscopic examination. Demonstration of typical Negri bodies with Direct Microscopic Examination (DME) is considered diagnostic; however, the brains of as many as 15% of the infected animals may not contain demonstrable Negri bodies. In cases in which Negri bodies cannot be demonstrated, Mouse Inoculation Test (MIT) should be done.

- **Mouse Inoculation Test (MIT)**

The MIT is an in vivo test to confirm the infectivity of the rabies virus through virus isolation. It is also conducted on specimens that are unsuitable for histopathologic or Fluorescent Antibody Test (FAT) of cases where additional verification is desired. Suckling mice (less than 3 days old) are more susceptible to rabies than weaning and adult mice and should be used whenever possible. The long post-inoculation observation period of 21 days limits its clinical usefulness in the management of animal bite cases.

CHAPTER II:
THE NATIONAL RABIES PREVENTION AND
CONTROL PROGRAM

1. INTRODUCTION

In the late 1980s, the Department of Agriculture through the Bureau of Animal Industry and the Department of Health through the then Communicable Disease Control Service initiated efforts to prevent and control rabies in the country.

In May 1991, a Memorandum of Agreement was signed among the Secretaries of Health (DOH), Agriculture (DA), Local Government (DILG) and Education, Culture and Sports (DECS) now Department of Education (DepEd) with representatives from the LGUs committing their agencies to launch concerted efforts in eliminating rabies in the country. This also led to the creation of the Rabies Control Consultative Committee (RCCC) composed of top level officials from these four Departments and representatives from NGOs. The function of the RCCC was to provide guidance in the implementation of the program. At the same time a National Rabies Committee (NRC) composed of the technical experts from DA and DOH served as the implementing body.

A program to control and eliminate rabies in the country by year 2020 was drafted by the NRC. Activities were laid down which emphasized the creation of multi-sectoral rabies committees at the regional, provincial, city and municipal levels on dog immunization, anti-rabies human immunization and rabies awareness.

In 1992, the WHO Expert Committee on Rabies recommended to replace the Nerve Tissue Vaccine (NTV) with the modern tissue culture vaccine since NTV are less immunogenic and caused more severe adverse reactions. They also recommended the use of the intradermal (ID) regimen of anti-rabies vaccination especially for developing countries where vaccines are costly and the supply is usually inadequate. The ID regimen had significantly reduced cost but its efficacy was not compromised.

In 1997, the Philippines stopped using the old nerve-tissue vaccine and was replaced with tissue culture vaccines. Purified Verocell Rabies Vaccine (PVRV), Purified Duck Embryo Vaccine (PDEV) and Purified Chick Embryo Vaccine (PCVEC) were introduced in the Philippine market. In order to mitigate the cost of shifting from NTV to TCV, the DOH adopted the intradermal regimen of anti-rabies vaccination.

On March 13, 1999, President Joseph E. Estrada signed Executive Order No. 84 declaring March as Rabies Awareness Month creating the National Rabies Prevention Committee composed of representatives from the DOH, DA-BAI, DILG, DECS (DEPED) and NGOs to formulate policies and coordination implementation

THE NATIONAL RABIES PREVENTION AND CONTROL PROGRAM

of the National Rabies prevention control program and to conduct massive information drive on rabies prevention complemented by mass dog vaccination.

In 2006, Rabies Prevention Program through curriculum integration and instruction was developed by CHD and DepEd in Region 5 (Bicol) and pilot tested in Cabusao, Camarines Sur.

In 2007, Republic Act 9482 also known as Anti-Rabies Act of 2007 was signed into law by President Gloria Macapagal Arroyo, mandating that there shall be a National Rabies Prevention and Control Program to be implemented by a multi-agency/multi-sectoral committee chaired by the Bureau of Animal Industry of the Department of agriculture. The Program shall be a multi-agency effort in controlling and eliminating Rabies in the country. Among the component activities include: (1) mass vaccination of Dogs; (2) establishment of a central database system for registered and vaccinated Dogs; (3) impounding field control and disposition of unregistered, stray and unvaccinated dogs; (4) information and education campaign on the prevention and control of Rabies; (5) provision of pre-exposure treatment to high risk personnel and Post Exposure Treatment to animal bite victims; (6) provision of free routine immunization or Pre-Exposure Prophylaxis (PrEP) of schoolchildren aged five to fourteen in areas where there is high incidence of rabies as well as the (7) encouragement of the practice of responsible pet ownership. The program shall be implemented by the Department of Health (DOH), Department of Agriculture (DA), Department of Interior and Local Government (DILG) and the Department of Education (DepEd), as well as Local Government Units (LGUs) with the assistance of the Department of Environment and Natural Resources (DENR), Non-Government Organizations (NGOs) and People's Organization (POs).

In 2009, the Philippines, through the DOH was selected as one of the three demonstration sites of the World Health Organization (WHO) – Bill and Melinda Gates (BMG) Foundation project to eliminate human rabies through mass dog vaccination entitled “Philippine Road Map for National Rabies Elimination Demonstration Project – The Rabies-Free Visayas Project.” The project is in collaboration with DA, LGUs from Regions 6, 7 and 8 and partner NGOs. The project started in 2009 and will end in 2013. The Rabies Free Visayas Project is by far, the largest rabies elimination project implemented in the country covering the entire Visayas Region. Likewise, the DA was able to secure support from the Japan International Cooperation Agency (JICA) to eliminate rabies in the priority island provinces of Catanduanes, Camiguin, Cebu City and Marinduque.

2. VISION AND GOAL

Vision: *Rabies Free Philippines by 2020*

Goal: *To eliminate rabies and declare the Philippines Rabies Free by the year 2020*

3. COMPONENTS

NRPCP is a multi-agency effort to control and eliminate rabies in the country by the Department of Agriculture (DA) and Department of Health (DOH), Department of Interior and Local Government (DILG), Department of Education (DepEd) in coordination with other Government Organizations (GOs), Non-Governmental Organizations (NGOs) and People's Organizations (POs).

The following components of the program as mandated by RA 9482 (Anti-Rabies Act of 2007) should be implemented at all levels.

3.1. Post-Exposure Prophylaxis (PEP) and Pre-Exposure (PrEP)

- Post Exposure Prophylaxis (PEP) -anti-rabies prophylaxis should be administered after an exposure (such as bite, scratch, lick, etc.) from potentially rabied animals.
- Pre-Exposure Prophylaxis (PrEP) –vaccination should be given to individuals who are at high risk of getting rabies.

3.2. Health Promotion

The following are the significant activities in the conducting the nformation and education campaign on the prevention and control of rabies:

- **Celebration of Rabies Awareness Month** under Executive Order No. 84, March is Rabies Awareness Month
- **Celebration of World Rabies Day** - September 28 has been declared as World Rabies Day.
- **Development of IEC Materials** -All agencies involved in the implementation of the program are encouraged to conceptualize, produce/reproduce and distribute IEC materials and collaterals.
- **Massive Health Information Campaign using Tri-Media**
- **Integration of Rabies Program into the School Curriculum** - The integration of the program into the curriculum is a collaborative effort

of DOH and DepEd to educate school children who are the most vulnerable to animal bites.

3.3. Dog Vaccination

This is the most effective measure to control canine rabies. The Department of Agriculture takes the lead in mass dog vaccination campaigns and provision of animal rabies vaccine.

3.4. Dog Population Management

This include stray dog management through impounding, field control and disposal, surgical and non-surgical sterilization and habitat control.

3.5. Central Database System

The Philippine Animal Health Information System (PhilAHIS) was established to provide data on dog registration, vaccination and reports of canine rabies maintained by the Department of Agriculture .

3.6. Responsible Pet Ownership

The program adopts the strategy of promoting Responsible Pet Ownership to prevent spread of rabies. The public is advised to bring their pet dogs for anti-rabies vaccination when they reach three months of age and yearly thereafter, provide proper nutrition, exercise and shelter to their pet dogs and not to allow their pet dogs to loiter to prevent contact with infected animals.

4. SUPPORT SERVICES

4.1. Capability -Building

The Department of Health provides the following Training to health personnel involved in the implementation of the program :

- Management of Rabies Exposure
- Management of Human Rabies
- Training of Traditional Healers on Animal Bite Management

The Department of Agriculture provides training to Veterinarians and laboratory technicians on diagnosis and surveillance of animal rabies.

5. MANAGEMENT AND IMPLEMENTATION STRUCTURE OF THE NATIONAL RABIES PREVENTION AND CONTROL PROGRAM

R.A. 9482 (The Anti-Rabies Act of 2007) mandates the establishment of a National Rabies Prevention and Control Program chaired by the Bureau of Animal Industry of the Department of Agriculture to be implemented by a multi-agency /multi sectoral- committee at all levels .

The suggested composition of the Rabies Committee in each level is as follows:

National

Chairman	-	Department of Agriculture
Vice Chairman		DOH
Members		Dep Ed, DILG, Non-Government
Organizations		

Regional

Chairman	-	Regional Director, DA
Vice Chairman	-	Regional Director, DOH
Members	-	DedEd, DILG,PNP, NGO, PIA

Provincial

Chairman	-	Governor/Provincial Veterinarian
Vice Chairman	-	Provincial Health officer
Member	-	DedEd, DILG, NGO, PNP, PHTL, Sanitary
Inspector(SI)		

City

Chairman	-	Mayor/City Veterinarian
Vice Chairman	-	City Health Officer
Members	-	DepEd, DOH Rep, PNP, DILG,NGO, SI

Municipal

Chairman	-	Mayor/Municipal Agriculturist
Vice Chairman	-	MHO
Members	-	DedEd, DILG, NGO, PNP, DOH Rep., RSI

Barangay

Chairman	-	Barangay Captain
Vice Chairman	-	Physician/PHN/RHM
Member		Councilor for Health, Lupon Tagapamayapa, Barangay Health Worker (BHW), Brgy. Tanod, NGO, Key Purok Leaders

6. RESPONSIBILITIES OF GOVERNMENT AND NON-GOVERNMENT UNITS

6.1. Department of Health

- Ensure the availability and adequate supply of DOH pre-qualified human Anti-Rabies vaccine in animal bite treatment centers at all times and coordinate with other implementing agencies and concerned NGOs;
- Provide Post-Exposure Prophylaxis at the minimum expense to individuals bitten by animals suspected of being rabid which will consist of the initial vaccine and immunoglobulin dose;
- Provide Pre-Exposure Prophylaxis to high-risk personnel, such as, but not limited to laboratory staff, veterinarians, animal handlers, vaccinators and other persons working with rabies virus for free;
- Coordinate with the DA in the development of appropriate health education strategies to inform the public on rabies prevention and control and responsible pet ownership;
- Develop and maintain a human rabies surveillance system;
- Encourage collaborative activities with the DA, DepEd, DILG, DENR, NGOs, POs and other concerned sectors; and
- Immediately approve the registration of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs in coordination with the Philippine Drug Enforcement Agency (PDEA).

6.2. Department of Agriculture

- Improve and upgrade existing animal rabies laboratory diagnostic capabilities to ensure better services to the people;
- Ensure the availability and adequate supply of animal Anti-Rabies vaccine at all times;
- Undertake free anti-rabies vaccination of dogs giving priority to high risk and depressed areas;
- Maintain and improve animal Rabies surveillance system;
- Establish and maintain Rabies free zone in coordination with the LGUs;
- Immediately facilitate for the approval of the sale and use of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs by the DOH and the PDEA;
- Strengthen the training of field personnel and the Information Education and Communication (IEC) activities on Rabies prevention and control and responsible pet ownership;
- Conduct research on Rabies and its control in coordination with other agencies;

- Formulate minimum standards and monitor the effective implementation of this Act; and
- Encourage collaborative activities with the DOH, DepEd, DILG, DENR, NGOs, POs and other concerned sectors.

6.3. Department of Interior and Local Government (DILG)

- Ensure compliance of the roles and responsibilities of the different LGU's.

6.4. Department of Education (DepEd)

- Strengthen rabies education program through school health teaching/curriculum;
- Assist in the dog mass immunization campaigns in the community;
- Encourage collaborative activities with the DA, DOH, DILG, DENR, NGOs, POs and other concerned sectors; and
- Integrate proper information and education on responsible pet ownership in the relevant subjects in the Elementary and High School levels.

6.5. Local Government Units

- Ensure that all dogs: are properly immunized, registered and issued a corresponding dog tag upon registration and immunization
- Strictly enforce dog Impounding activities and field control to eliminate stray dogs;
- Ensure that dogs are leashed or confined within the premises of the owner's house or owner's fenced surroundings;
- Allocate funds to augment the implementation of the National Rabies Prevention and Control Program, particularly on the financing of supplies and human and dog vaccines needed for immunization;
- Ensure the enforcement of Section 6 of Republic Act No. 8485 or "The Animal Welfare Act of 1998";
- Enact additional local ordinances that will support the National Rabies Prevention and Control Program that should include the regulation of the traditional treatment locally known as "tandok";
- Prohibit the trade of dogs for meat;
- With respect to cities and first class municipalities, establish and maintain a dog pound where impounded dogs shall be kept, and other municipalities, shall, on their own, establish a dog pound or opt to share the expense of establishing and maintaining a dog pound with other

adjoining municipalities and/or with private animal shelters and control facilities;

- Prohibit the use of electrocution as a euthanasia procedure;
- Appoint a veterinarian and establish a veterinary office in every province, city and first-class municipality, provided, that the other municipalities shall, on their own, opt to share the expense of having a veterinary office;
- Require pet shops to post information regarding rabies and responsible pet ownership; and
- Shall collect the fines imposed by R.A. 9482 for the violation any of its provision.

6.6. Non-Government Organizations (NGOs) and the Academe

- NGOs and academe can or may participate in the following activities of the program:
 1. Community mobilization;
 2. Health education/information dissemination on Rabies and responsible pet ownership; and
 3. Mass anti-rabies campaign
- Promotion of the anti-rabies campaign during pet or any animal shows.
- Surveillance/reporting of Rabies cases in animals and humans.
- Any other activities geared towards the prevention and complete eradication of Rabies.

7. ROLES AND FUNCTIONS OF HEALTH PERSONNEL

7.1. Center for Health (CHD) Regional Coordinators

- Oversee the implementation of the program at the regional level
- Prepare WFP in coordination with the different partners;
- Act as resource person/facilitator during the training/orientations/workshops;
- Compute vaccine requirement and make the necessary requisition to the national program;
- Allocate and distribute vaccines and other logistics needed for the program implementation;
- Ensure proper cold chain management;
- Ensure efficient accurate and timely submission of report;
- Conduct monitoring and evaluation;
- Conduct assessment and certification of ABTC/ABC; and
- Conduct health promotion activities.

7.2. Provincial Coordinators

- Prepare WFP in coordination with the different partners;
- Compute vaccine requirement and make the necessary requisition to the regional program;
- Allocate and distribute vaccines and other logistics needed for program implementation;
- Oversee the implementation of the program at the provincial level.
- Act as resource person/facilitator during the conduct of trainings/orientations/workshops;
- Ensure proper cold chain management;
- Ensure efficient accurate and timely submission of report to the CHDI office;
- Conduct monitoring and evaluation; and
- Conduct health promotion activities.

7.3. Animal Bite Treatment Center Personnels

- Receive allocated immunizing agents from the CHD/ Provincial Rabies Coordinator;
- Ensure proper cold chain management;
- Screen all animal bite cases and manage accordingly;
- Maintain animal bite registry;

- Submit accurate report to the CHD on a quarterly basis;
- Advocate to the LCE additional funds for the program;
- Conduct investigation of reported human rabies cases; and
- Conduct health promotion activities.

7.4. Municipal Health Office Staff

- Screen, initiate wound care and refer animal bite cases to Animal Bite Treatment Center; and
- Conduct health promotion activities in collaboration with MAO and other partners.

7.5. Hospital Staff Admitting Rabies Cases

- Screen all animal bite cases and initiate wound care;
- Maintain animal bite registry;
- Submit accurate report to the regional office on a quarterly basis;
- Conduct investigation of reported human rabies cases; and
- Conduct health promotion activities in collaboration with and other Partners.

8. ROLES AND FUNCTIONS OF DA AND LGU VETERINARY PERSONNEL

8.1. DA-RFU Regional Coordinators

- Initiate and coordinate all rabies control activities in the provinces/cities/municipalities;
- Prepare the yearly regional action plan;
- Disseminate program information, guidelines, E.O. to all provincial/city/municipal coordinators;
- Allocate/distribute vaccines from central office (BAI) to the different provinces/cities/municipalities;
- Ensure proper cold storage of vaccines;
- Ensure availability of vaccines for the campaign;
- Monitor vaccine utilization;
- Consolidate reports from the different provincial coordinator and submit to the central office;
- Monitor the implementation of dog ordinance and dog pound in the Provinces;
- Assist the province in overseeing the implementation; and
- Collect empty/used vaccine vials from the provinces and ensure proper disposal (burning/burying) at the Regional Office or at the Bureau of Animal Industry.

8.2. Provincial Coordinator (Provincial Veterinarian)

- Prepare yearly provincial action plans and submit to the regional level for consolidation;
- Provide actual dog survey and other monitoring data to the regional coordinator;
- Allocate and distribute vaccine to the different municipalities; Provide and ensure cold storage for vaccines;
- Monitor proper vaccine utilization during vaccination campaign;
- Assist in training vaccinators during mass immunization;
- Monitor proper implementation of rabies ordinance and dog control measures in all municipalities;
- Organize rabies control committees in all cities/municipalities;
- Initiate and coordinate all rabies control activities in the cities/municipalities
- Consolidate reports of vaccination to be submitted to the regional coordinator; and
- Collect used vaccine vials and return it to the regional coordinator for proper disposal.

8.3. Municipal/City Coordinator (City/Municipal Veterinarian/Agriculturist)

- Coordinate all rabies control activities to other agencies in the local government unit;
- Provide dog population survey to update provincial data;
- Receive vaccine allocation from the provincial coordinator for dog vaccination at the barangay level;
- Ensure proper implementation of the rabies ordinance, dog pound and stray dog control;
- Consolidate report of vaccination for submission to the provincial coordinator;
- Ensure cold storage of dog vaccine and provide vaccine container (styrofoam) to maintain and ensure temperature requirement while vaccinating in the area;
- Provide mobility for vaccinators during campaign; and
- Collect used vaccine vials and return it to the regional coordinator through the provincial coordinator for proper disposal.

CHAPTER III: GUIDELINES IN THE PREVENTION AND CONTROL OF RABIES

PART A: GUIDELINES IN THE PREVENTION AND CONTROL OF HUMAN RABIES

1. INTRODUCTION

In the Philippines, rabies is responsible for 200- 250 deaths every year. Bite exposures, through inoculation of saliva of an infected animal directly through the bite wound, are the most common mode of transmission of the rabies virus to humans. The most common reservoir of the rabies virus is the domestic dog.

People most at risk live in rural areas where human rabies vaccines and immunoglobulins are not readily available or accessible. Poor people are at a higher risk, as the cost of rabies post-exposure prophylaxis (PEP) after contact with a suspected rabid animal is beyond the financial means of a poor Filipino family. Although all age groups are susceptible, rabies is most common in children below 15 years old. In 2011, 47.4 % of rabies cases in the Philippines were below 15 years of age. On average, 40 % of PEP regimens are given to children aged 5–14 years, and the majority are male. More than 300,000 people consult for animal bites every year, majority of which require PEP.

Provision of Post Exposure Prophylaxis (PEP) to all rabies exposure is the most effective means of preventing rabies among exposed individuals. PEP should be provided as soon as possible to all rabies exposure.

Another strategy to prevent human rabies is the provision of Pre Exposure Prophylaxis (PrEP) to high risk personnel and schoolchildren aged 5 to 14 in areas where there is high incidence of rabies.

2. POST-EXPOSURE PROPHYLAXIS (PEP)

Post-Exposure Prophylaxis - refers to anti rabies treatment administered after an exposure to potentially rabid animals. It includes local wound care, administration of rabies vaccine with or without Rabies Immunoglobulin (RIG) depending on the category of exposure.

Pregnancy and infancy are not contraindications to PEP with modern culture cell vaccine and RIG. Babies who are born to rabid mothers should be given rabies vaccination as well as RIG as early as possible upon birth. Exposed persons who are present for evaluation or treatment weeks or months after the bite should be managed as if the exposure has occurred recently. However, if the biting animal has remained healthy and alive with no signs of rabies until 14 days after the bite, PEP is no longer recommended. PEP is required for bites by livestock (cows, pigs, horses, goats, etc.) as well as wild animals (monkeys, bats). PEP is not recommended for bite/s of rats, mice, rabbits, snakes and other reptiles, avians, insects and fish.

2.1. Guiding Principles

- The Department of Health (DOH) in consultation with all stakeholders shall be responsible for the development of guidelines on the management of rabies.
- The DOH shall provide augmentation of human rabies vaccines and RIG to all animal bite treatment centers.
- The NRPCP shall be integrated to the regular services of the health facilities. The CHD shall assess the established ABTCs/ABCs.
- Provision of PEP is a shared responsibility of the DOH, Local Government Units, animal bite patients and dog/pet owner.
- There are no absolute contraindications to rabies PEP. Patients allergic to a specific vaccine/RIG or its components should be given the alternative vaccine/RIG.
- RIG shall be given by infiltration and Tissue Culture Vaccine (TCV) by intradermal administration.
- Pre exposure prophylaxis shall be given to high risk individuals.
- Epinephrine and antihistamines should be made available for possible hypersensitivity reactions.
- All clinically significant Adverse Events Following Immunization (AEFI) shall be reported to the AEFI Surveillance and Response System.
- Support services shall be made available at all levels.

2.2. Management of Rabies Exposure

Rabies exposure occurs when saliva from an infected animal comes into direct contact with human mucosa or fresh skin wounds. Rarely, rabies may be contracted by inhalation of virus-containing aerosol or via transplantation of an infected organ. All ABTCs staff must be guided by the the following general guidelines in managing rabies exposures:

- Initiation of post-exposure prophylaxis (PEP) should 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;
- There are no absolute contraindications to rabies PEP. Patients allergic to a specific vaccine/RIG or its components should be given the alternative vaccine/RIG;
- Pregnancy and infancy are not contraindications to treatment with purified cell culture/tissue culture vaccines and RIG;
- Babies who are born to rabid mothers must be given rabies vaccination as well as RIG as early as possible at birth;
- The following are the three (3) categories of exposure to a rabid animal or to an animal suspected to be rabid, each with a corresponding management guidelines:

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Table 5: Categories of Rabies Exposure with Corresponding Management		
Category of Exposure	Type of Exposure	Management
CATEGORY I	Feeding/touching an animal	<ol style="list-style-type: none"> 1. Wash exposed skin immediately with soap and water. 2. No vaccine or RIG needed <p>Pre-exposure prophylaxis may be considered for high risk persons.</p>
	Licking of intact skin (with reliable history and thorough physical examination)	
	Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensils	
	Casual contact (talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms of rabies	
CATEGORY II	Nibbling of uncovered skin with or without bruising/hematoma	<ol style="list-style-type: none"> 1. Wash wound with soap and water. 2. Start vaccine immediately: <ol style="list-style-type: none"> a. Complete vaccination regimen until Day 28 (see Table 1a) if: <ol style="list-style-type: none"> i) biting animal is laboratory proven to be rabid OR ii) biting animal is killed/died without laboratory testing OR iii) biting animal has signs and symptoms of rabies OR iv) biting animal is not available for observation for 14 days b. May omit Day 28 dose if: <ol style="list-style-type: none"> i) biting animal is alive AND remains healthy after the 14-day observation period, OR ii) biting animal died within the 14 days observation period, confirmed by veterinarian to have no
	<p>Minor /superficial scratches/abrasions without bleeding, including those induced to bleed</p> <p>All Category II exposures on the head and neck area are considered Category III and should be managed as such</p>	

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		<p>signs and symptoms of rabies and was FAT-negative</p> <p>RIG is not indicated</p>
CATEGORY III	<p>Transdermal bites (puncture wounds, lacerations, avulsions) or scratches/abrasions with spontaneous bleeding</p> <p>Licks on broken skin or mucous membrane</p> <p>Exposure to a rabies patient through bites, contamination of mucous membranes (eyes, oral/nasal mucosa, genital/anal mucous membrane) or open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation</p> <p>Unprotected handling of infected carcass</p> <p>Ingestion of raw infected meat</p> <p>Exposure to bats</p> <p>All Category II exposures on head and neck areas.</p>	<ol style="list-style-type: none"> 1. Wash wound with soap and water. 2. Start vaccine and RIG immediately: <ol style="list-style-type: none"> a. Complete vaccination regimen until Day 28 (see Table 1a) if: <ol style="list-style-type: none"> i) biting animal is laboratory proven to be rabid OR ii) biting animal is killed/died without laboratory testing OR iii) biting animal has signs and symptoms of rabies OR iv) biting animal is not available for observation for 14 days b. May omit Day 28 dose if: <ol style="list-style-type: none"> i) biting animal is alive AND remains healthy after the 14-day observation period, OR biting animal died within the 14 days observation period, confirmed by veterinarian to have no signs and symptoms of rabies and was FAT-negative.

2.2.1. Local Wound Care

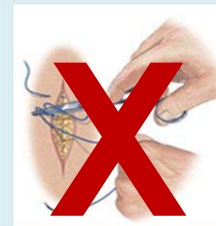
Wash wounds immediately and vigorously with soap/ detergent, and water, preferably for 10 minutes. If soap is not available, the wound should be thoroughly and extensively washed with water.



Apply alcohol, povidone iodine or any antiseptic.



Avoid suturing at all times to prevent the virus from inoculating deeper into the wound.



- i. **Wash wounds immediately** and vigorously with soap/ detergent, and water, preferably for 10 minutes. If soap is not available, the wound should be thoroughly and extensively washed with water.
- ii. Apply alcohol, povidone iodine or any antiseptic.
- iii. Mucous membranes such as eyes, nose or mouth shall be flushed well with water.
- iv. Suturing of wounds should be avoided since it may inoculate the virus deeper into the wounds. Wounds may be coaptated using sterile adhesive strips. If suturing is unavoidable, it should be delayed for at least 2 hours after administration of RIG to allow diffusion of the antibody to the tissues.
- v. Do not apply any ointment, cream or wound dressing to the bite wound.
- vi. The public should be educated in simple local wound treatment and warned not to use procedures that may further contaminate the wounds (e.g. tandok, bato, rubbing garlic on the wounds and other non-traditional practices).
- vii. Antimicrobials are recommended for the following conditions:
 - a. All frankly infected wound
 - b. All category III cat bites
 - c. All other category III bites that are either deep, penetrating, multiple or extensive or located on the hand, face and genital area.
- viii. Anti- tetanus immunization may be given if indicated. History of tetanus immunization (TT/DPT/Td) should be reviewed. Animal bites are considered tetanus prone wounds. Completion of the primary series of tetanus immunization is required

2.2.2. Immunization

Active Immunization:

Active immunization refers to the administration of vaccine to induce protective immune response through antibody and T-cell production in order to neutralize the rabies virus in the body. It induces an active immune response in seven – ten (7-10) days after vaccination which persists for many years provided that primary immunization is completed. The program requires that all ABTCs should use WHO prequalified vaccines.



General Principles:

a. Storage

- a.1.** Vaccines should be stored at +2 to + 8 °C in a refrigerator, not freezer
- a.2.** Once reconstituted, vaccines should be kept in the refrigerator and used within 8 hours

b. Administration Area

- b.1.** Injections should be given on the deltoid area of each arm in adults or at the anterolateral aspect of the thigh in infants.
- b.2.** Vaccine should never be injected in the gluteal area as absorption is unpredictable

Recommended PEP Regimens for ABTCs/ABCs:

a. Intradermal Regimen

To maximize the limited resources of the NRPCP, all Animal Bite Treatment Centers (ABTCs) are required to use only the recommended ID regimen in managing rabies exposures/animal bites. According to WHO, the ID use of Tissue Culture Vaccines can decrease the cost of PEP by as much as 60-80%. ABTCs are also required to administer only vaccines approved by WHO for ID use

Patients with with hematologic conditions where IM injection is contraindicated should receive rabies vaccine by ID route

Immunocompromised patients such as those with HIV infection, cancer/etc and patients with chronic liver disease and those taking chloroquine and systemic steroids should be given standard IM regimen as the response to ID regimen is not optimum for these conditions.

- **Updated 2-site Intradermal Regimen**

This regimen is a modification of the original Thai Red Cross regimen 2- site ID regimen where the Day 90 dose has been transferred to Day 28.

One dose for ID administration is equivalent to **0.1 ml both for PVRV and PCECV**

One dose should be given on each deltoid (or at the anterolateral aspect of both thighs in infants) on **Days 0, 3, 7 and 28**.

Table 6. Updated 2-site Intradermal Regimen

Day of Immunization	PVRV /PCECV	Site of Injection
Day 0	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day 3	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day7	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day 28	0.1 ml	Left and right deltoids or anterolateral thighs in infants

- b. Intramuscular Regimen**

Immunocompromised patients such as those with HIV infection, cancer/etc and patients with chronic liver disease and those taking chloroquine and systemic steroids should be given standard IM regimen as the response to ID regimen is not optimum for these conditions. Vaccination should not be delayed in these circumstances as it increases the risk of rabies.

- **Standard Intramuscular Regimen - Essen**

One dose of vaccine on days 0, 3, 7,14 and 28. Total of 5 doses and 5 visits.

Table 7: Standard WHO Intramuscular Regimen

Day of Immunization	PVRV	PCECV	Site of Injection
Day 0	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 3	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 7	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 14	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 28	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants

Administration

- Injectors should be given on the deltoid area of each arm or at the anterolateral aspect of the thigh in infants.
- Vaccine should never be injected in the gluteal area as absorption is unpredictable.
- Once reconstituted, vaccines should be kept in the refrigerator and used within 8 hours.
- The ID injection should produce a minimum of 3 mm wheal. In the event that a dose of vaccine is inadvertently given subcutaneously or IM, the dose should be repeated intradermally.
- A 1-ml syringe with gauge 26 needle, preferably auto disabled syringe, should be used for ID injection.

Passive Immunization

Rabies Immunoglobulin (RIG) is given in combination with 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 given to patients with Category III exposures. However, immunocompromised individuals such as those with HIV Infection, cancer/transplant patients, patients on immunosuppressive therapy should be given RIG for both CAT II and III exposures. HRIG has a half-life of approximately 21 days while ERIG is 14 days.

Table 8: List of Rabies Immunoglobulins

Generic Name	Preparation	Dose
Human Rabies Immunoglobulin (HRIG)	150 IU/ml, 2 ml/vial	20 IU /kg
Equine Rabies Immunoglobulins (ERIG)	200IU/ml, 5 ml/vial	40 IU/kg
F(ab') ₂ products	200 IU/ml, 5ml/vial	40 IU /kg

Administration

- i. The total computed dose should be infiltrated around and into the wound as much as anatomically feasible, even if the lesion has healed. In case some amount of the total computed dose of the RIG is left after all wounds have been infiltrated, it should be administered deep IM at a site distant from the infiltration site, preferably anterolateral thigh using another needle. The total computed dose should be administered as a single dose
- ii. A gauge 24 or 25 needle, 1 inch length should be used for infiltration. Multiple needle injections into the same wound should be avoided.
- iii. If a finger or toe needs to be infiltrated, care must be taken not to impair blood circulation. Injection of an excessive amount may lead to cyanosis, swelling and pain.
- iv. RIG should not exceed the computed dose as it may reduce the efficacy of the vaccine.
- v. If the computed dose is insufficient to infiltrate all bite wounds, it may be diluted with sterile saline 2 or 3 -fold for thorough infiltration.
- vi. RIG should always be given in combination with rabies vaccine. RIG should be administered at the same time with the first dose of rabies vaccine (Day 0). In case RIG is unavailable on Day 0, it may still be given until 7 days after the first dose of the vaccine(Day 0). 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 rabies CCV/EEV/TCV has already started and interference between active and passive immunization may occur.
- vii. In the event that RIG and vaccine cannot be given on the same day, the vaccine should be given before RIG because the latter inhibits production of neutralizing antibodies induced by vaccination.



- viii. RIG is given only once during the same course of PEP.
- ix. A skin test must be performed prior to ERIG administration using a gauge 26 needle. For skin testing, 0.02 ml of 1:10 dilution solution is infiltrated to raise a bleb 3 mm and read after 15 minutes. A positive skin test is an induration of >6 mm surrounded by a flare/erythema. If initial skin test is positive, repeat skin test on same arm; use distilled water as control on the other arm. The skin test is considered positive if the ERIG skin is positive but the control is negative.
- x. Patients with positive skin test to purified ERIG should be given HRIG. Patient must be observed for at least one hour after injection for any adverse reactions.

Skin testing for hyper sensitivity to equine RIG. Skin testing may detect the rare case of IgE mediated (Type I) hypersensitivity to equine serum protein. However, the majority of reactions to equine RIG result from complement activation, are not IgE mediated, and will not be predicted by skin testing.

There are no scientific grounds for performing a skin sensitivity test prior to administration of ERIG according to WHO. The attending physician should be prepared to manage anaphylaxis which, however rare, could occur at any stage of the ERIG administration.

A negative skin test is not an assurance that no anaphylactic reaction will occur. In case of anaphylactic reaction, adrenaline/epinephrine can be given at 0.5 ml of 0.1 per cent solution (1 in 1000, 1 mg/ml) for adults, and 0.01 ml/kg body weight for children, injected subcutaneously or IM.

If the skin test is positive, HRIG is indicated. If HRIG is not available, equine RIG can still be given but special precaution should be observed.

Situations where Human Rabies Immunoglobulin (HRIG) is preferred

- 1. History of hypersensitivity to equine sera
- 2. Multiple severe exposures especially where the dog is sick or suspected of being rabid
- 3. Symptomatic HIV infected patients

2.3. Management of Previously Immunized Animal Bite Cases

Persons with repeat exposure after having previously received complete primary immunization with Tissue Culture Vaccine (TCV) and persons who were exposed to rabies after completing the Pre- Exposure Prophylaxis against rabies with TCV should be managed as follows:

- 2.3.1. Local wound treatment MUST always be carried out.
- 2.3.2. Patients who have completed the primary immunization should be vaccinated as indicated in Table 9:

Table 9: Schedule of PEP Booster Doses for Previously Immunized Animal Bite Patients

PrEP/PEP History (Regardless of type of TCV and route of administration in previous PrEP/PEP)	Give RIG	MANAGEMENT
Patient received the complete pre-exposure prophylaxis on Days 0, 7 and 21/28 using TCV OR Patient received at least Days 0, 3, 7 of ID/IM dose using TCVs	NO	Give 0.1 ml. ID dose at 1 site each on D0 and D3 OR 1 vial IM dose at 1 site each on D0 and D3
Patient did not complete the 3 doses of PrEP OR Patient received only 1 or 2 ID/IM dose of the PEP	Give if indicated	Give Full Course of PEP

* Patients previously managed using the Nerve Tissue Vaccine (NTV) should be given full course PEP

- 2.3.3. The following patients are considered to have completed the primary immunization:
 - i. Those who have received day 0, 7, 28 of the Pre-Exposure Prophylaxis
OR
Those who have received at least day 0, 3, 7 of the Post-Exposure Prophylaxis; AND
 - ii. Received only the modern TCVs/CCVs but not the Nerve Tissue Vaccines
- 2.3.4. Booster doses may be given ID (0.1 ml. for PVRV or PCECV) or IM (0.5 ml for PVRV or 1.0 ml for PCECV).
- 2.3.5. Patients who have previously received complete primary immunization with rabies vaccine have the advantage that booster doses will rapidly induce a large increase in antibody production (a "secondary response").
Therefore, there is no need to give RIG
- 2.3.6. Patients who have not completed the primary immunization as described above should receive full course including RIG if needed.

Table 10: Management of Previously Immunized Rabies Exposure

Category of Exposure and Management			
Category of Exposure	MANAGEMENT		
	Local Wound Care	Rabies Immunoglobulins (RIG)	Anti-Rabies Vaccine
Category I	YES	NO	NO
Category II	YES	NO	<u>Give Booster dose every exposure</u>
Category III	YES	NO	<u>Give Booster dose every exposure</u>

2.4 Management of Bites by Vaccinated Animals

2.4.1. Definition Of Terms

a. **Vaccinated Animal** -

Dog/cat must be at least 1 year and 6 months old and has updated vaccination certificate from a duly licensed veterinarian for the last 2 years.



b. **Updated vaccination** -

The last vaccination must be within the past twelve months. The immunization status of the dog/cat will not be considered updated if the animal is not vaccinated on the due date of the next vaccination

2.4.2. Management

Patients who were exposed to rabies secondary to bites from vaccinated animals should be managed as follows:

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Table 11: Categories of Rabies Exposure with Corresponding Management

Exposure	Management
ALL Category I exposures	PEP is not recommended
Category II exposure: Provided that: <ol style="list-style-type: none"> 1. Dog/cat is healthy and available for observation for 14 day; AND 2. Dog/cat was vaccinated against rabies for the past 2 year 	PEP may be delayed <i>*If biting dog/cat becomes sick or dies within the observation period, PEP should be started immediately.</i>
A ,Category II exposures where: <ol style="list-style-type: none"> a. AThe dog/cat is proven rabid/sick/ dead with no laboratory examination for rabies/ not available before or during the consultation b. Dog/cat is involved in at least 3 biting incidents within 24 hours c. Dog/cat manifests behaviour changes suggestive of rabies before, during or after the biting incident (please refer to Table 2: Clinical stages and signs of rabies in animal B. All Category III Exposures	GIVE PEP immediately

2.5. Recommendation For PEP Deviations

2.5.1. Delays in Schedule

ABTC/ABC Health personnel are required to strictly follow vaccination schedule to prevent PEP failure. However, in instances when the patient fails to come on the scheduled date for the succeeding dose, the following adjustment in the PEP schedule is recommended:

Table 12: Delays in INTRADERMAL Regimen Schedule and Recommended Actions

Delay in 2nd dose (Day 3 schedule)	
• 1-2 days delay from Day 3 schedule	Give Day 3 dose upon visit and follow the original schedule of Day 7 and Day 28
• 3-4 days delay from Day 3 schedule	Give Day 3 dose upon visit and adjust succeeding doses(day 7 and 28) according to the prescribed interval
• >4 days delay from Day 3 schedule	Restart with a new course
Delay in 3rd dose (Day 7 schedule)	
• <7 days delay from Day 7 schedule	Give Day 7 dose upon visit and give Day 28 dose as originally scheduled
• 7 -14 days delay from Day 7 schedule	Repeat Day 3 dose and adjust subsequent doses and revise according to the prescribed interval
• >14 days delay from Day 7 schedule	Restart with a new course

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Delay in Day 28 dose schedule	Give Day 28 dose upon visit; this may be considered as a booster No need to give RIG again, if already administered
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Table 13. Delays in INTRAMUSCULAR Schedule and Recommended Actions

Delays in Intramuscular Regimen Schedule	Recommended Action
Delay in 2nd dose (Day 3 schedule)	
<ul style="list-style-type: none"> 1-2 days delay from Day 3 schedule 	Give Day 3 dose upon visit and follow the original schedule of Day 7, 14 and Day 28
<ul style="list-style-type: none"> 3-4 days delay from Day 3 schedule 	Give Day 3 dose upon visit and adjust succeeding doses of Day 7, 14 and Day 28 according to the prescribed interval
<ul style="list-style-type: none"> >4 days delay from Day 7 schedule 	Restart a new course
Delay in 3rd dose (Day 7 schedule)	
<ul style="list-style-type: none"> <7 days delay from Day 7 schedule 	Give Day 7 dose upon visit and give Day 28 as originally scheduled
<ul style="list-style-type: none"> 7 -14 days delay from Day 7 schedule 	Repeat Day 3 dose and revise according to the prescribed interval
<ul style="list-style-type: none"> >14 days delay from Day 7 schedule 	Restart with a new course
Delay in 4th dose (Day 14 schedule)	Give Day 14 dose upon visit and Day 28 dose after two weeks
Delay in 5th dose (Day 28 dose schedule)	Give Day 28 dose upon visit No need to give RIG again, if already administered

2.5.2. Shifting of Route of Vaccine Administration

Since no immunogenicity studies have been done regarding change in route of vaccine administration (i.e. shift from IM to ID or vice versa), shifting from one regimen to the other is not recommended.

If shifting is inevitable, vaccination should be restarted from day 0.

2.5.3. Shifting Of Type/Brand Of Vaccines

Shifting from one rabies vaccine brands or types to another is not recommended. In cases where there is unavailability or adverse reactions from the Initial vaccine used, shifting may be warranted using WHO recommended tissue culture vaccine.

2.6 Supportive Management

2.6.1. Anti-Tetanus Immunization

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All animal bite victims should receive anti-tetanus immunization considering that animal bites are tetanus-prone wounds. History of tetanus immunization (TT/DPT/Td/DTaP/Tdap) should be reviewed prior to the giving of the anti-tetanus vaccine. Below is the recommended tetanus vaccine schedule:

Table 14: Guide to Tetanus Prophylaxis in Routine Wound Management

Indication for TT Immunization	Vaccination History			
	Unknown or <3 doses		3 or more Doses	
All Animal Bites	TT/DPT*	TIG/ATS	TT/DPT*	TIG/ATS
< 5 years from last dose	Yes	Yes	No**	No
≥ 5 years from last dose	Yes	Yes	Yes	No

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

2.6.2. Antimicrobials

The most common organism isolated from dog and cat bites is *Pasteurella multocida*. Other organisms include *Staphylococcus aureus*, *Bacteroides* sp., *Fusobacterium* and *Capnocytophaga*.

a. Indications for Antimicrobials

- All Category III cat bites; and
- All other Category III bites that are either deep, penetrating, multiple or extensive or located on the hand, face/genital area.

b. Recommended antimicrobials

- Amoxicillin/clavulanic
Adults – 500 mg p.o. TID
Children – 30-45 mg/kg/day in 3 divided doses
- Cloxacillin
Adults – 500 mg p.o. QID
Children- 10-150-100 mg/kg/day in 4 divided doses
- Cefuroxime axetil
Adults: 500 mg p.o. BID
Children: 10-15 mg/kg/day in two divided doses
- For penicillin-allergic patients:
Adults - Doxycycline
Children –Erythromycin

c. Others

For those instances where there are no obvious signs of infection, amoxicillin as prophylaxis may suffice:

Adults: 500 mg. p.o every 8 hours

Children: 30-45 mg/kg/day in 3 divided doses

2.6.3. Adverse Reactions and its Management

Table 15: Adverse Reactions and its Management		
Reactions	Symptoms	Management
Minor/local	Redness, swelling or induration of injection site	Warm Compress
	Headache, fever, myalgia	Analgesic, anti-pyretic
	Nausea, vomiting	Anti emetic, oral rehydration
Major/systemic	Hypersensitivity Reactions	Give antihistamines, either as a single drug (e.g. diphenhydramine) or in combination (e.g. diphenhydramine plus cetirizine). If the patient's condition does not improve for 48 hours despite combination of antihistamines, a short course (5-7 days) of oral antihistamines plus steroids may be given If patient worsens, requires hospitalization or condition becomes life threatening, may give IV steroids in addition to antihistamines
	Anaphylactic or neuromuscular	Give 0.1 % adrenaline or epinephrine (1:1000 or 1 mg/ml) underneath the skin subcutaneously) or into the muscle (intramuscularly) at a dose of 0.5 ml for adults or 0.01 ml/kg or children, maximum dose of 0.5 ml.

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		<p>Repeat epinephrine dose every 10-20 minutes for 3 doses.</p> <p>Give steroids after epinephrine.</p> <p>Hydrocortisone may be administered by intravenous injection, by intravenous infusion, or intramuscular injection, the preferred method for initial emergency use being intravenous injection.</p> <p>Refer to the next level of care</p> <p>Hydrocortisone sodium succinate Sterile Powder is given at 100 to 500 mg intravenously over a period of 30 seconds (e.g., if dose is 100 mg) to 10 minutes (e.g., for dose 500 mg or more), depending on the specific disease entity being treated.</p> <p>In certain overwhelming, acute, life-threatening situations, administration in dosages exceeding the usual dosages may be justified and may be in multiples of the oral dosages.</p> <p>This dose may be repeated at intervals of 2, 4 or 6 hours as indicated by the patient's response and clinical condition. In general, high dose corticosteroid therapy should be continued only until the patient's condition has stabilized- usually not beyond 48 to 72 hours.</p>
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3. PRE-EXPOSURE PROPHYLAXIS (PrEP)

Pre-Exposure Prophylaxis (PrEP) is rabies vaccination administered **before** an exposure to potentially rabid animals. PrEP may be performed with any of the cell culture vaccines and is recommended for anyone who is at continual, frequent or increased risk of exposure to the rabies virus either as a result of their residence or occupation (for example, laboratory workers dealing with rabies virus and other lyssa viruses, veterinarians and animal handlers). Children often sustain severe bite wounds and have an increased risk of rabies.

3.1. **Benefits of Pre-Exposure Prophylaxis (PrEP)**

- The need for passive immunization (RIG) is eliminated
- PEP requires booster doses only, reducing vaccination from 5 to two doses
- Protection against rabies is possible even if PEP is delayed
- Protection against inadvertent exposure to rabies is possible
- The cost of PEP is reduced

3.2. **Who should Receive PrEP?**

- Health care workers directly involved in care of rabies patients
- Individuals directly involved in rabies control
- Personnel in rabies diagnostic laboratories
- Pet owners and household members
- Animal handlers
- Field workers such as dog vaccinators/catchers
- Veterinarians and veterinary students
- Children 5 to 14 years old living in areas where there is high incidence of rabies.

3.3. Pre-Exposure Prophylaxis Schedule

Table 16: Schedule, Dose and Route of Pre-Exposure Prophylaxis

	PVRV			PCEC		
Schedule/ Route	Day 0	Day 7	Day 21/28	Day 0	Day 7	Day 21/28
Intradermal	0.1 ml	0.1 ml	0.1 ml	0.1 ml	0.1 ml	0.1 ml
Intramuscular	0.5 ml	0.5 ml	0.5 ml	1.0 ml	1.0 ml	1.0 ml

3.4. Routine Booster Schedule For Individual Given Pre- Exposure Prophylaxis:

Not all individual who have completed the PrEP should receive routine booster doses of anti- rabies vaccine. Only high risk individuals whose exposures may not be known are recommended to have routine booster doses.

Table 17: Routine Booster Schedule for Individuals Given Pre- Exposure Prophylaxis (PreP)

Type of Risk	Population at Risk	Recommended Booster Schedule (Without definite exposure)
High Risk (exposures may not be known)	<ol style="list-style-type: none"> Health workers handling rabies cases Workers in rabies laboratories, Veterinarians, Veterinary students, Animal handlers (dog trainers, workers in pet shops, zoos, etc.) 	<p>-1 Booster dose 1 year after primary immunization:</p> <ol style="list-style-type: none"> One (1 site) 0.1 ml ID dose of PVRV or PCEC on D0; OR One (1site) Vial of 0.5 ml PVRV or 1.0 ml PCEC given intramuscularly on D0 <p>-Thereafter, 1 booster, if Ab titers fall below 0.5 IU/ml</p> <p style="text-align: center;">OR</p> <p>- In the absence of serologic testing, 1 booster dose every 5 years</p>
Low Risk (exposures are known)	General Population	No routine booster after primary immunization

4. INFECTION CONTROL

4.1. Injection Safety

A safe injection is defined by the World Health Organization as an injection that:

- Does not harm the recipient
- Does not expose the health staff to any avoidable risk
- Does not result in waste that is dangerous to the community

4.2. Injection Equipment

4.2.1. Auto-Disable (AD) Syringes

Are disposable injection devices that are especially made to prevent re-use and therefore less likely than standard disposable syringes to cause person-to-person transmission of blood-borne diseases. The Program recommends that health workers use AD syringes in their respective ABTCs/ABCs.

4.2.2. Conventional syringes

Plastic syringes with steel needles that are provided usually by the manufacturer in sterile package is recommended.



4.3. Management of Sharps Waste

Used syringes and needles should never be dumped in open areas where people could pick them up, step on them or come in contact with them in any way.



*Even used plastic PET bottles can be used as improvised sharps disposal bin provided it is properly labelled and with proper closure/cap.
Sharps containers should contain disinfectant.*

Used or contaminated sharps are safely disposed through the use of safety boxes or sharp containers. These are puncture-resistant containers where used syringes and needles can be immediately and temporarily stored after use until its disposal.

4.4. Waste Disposal

Safety boxes of sharp containers should be immediately brought to its final disposal. The program recommends use of septic vault, pit burial and waste treatment.

PART B: ESTABLISHMENT OF ANIMAL BITE TREATMENT CENTERS (ABTCs)

1. INTRODUCTION

Animal Bite Treatment Center (ABTC) and Animal Bite Center (ABC) are health facilities manned by trained doctor/s and nurse/s where individuals with rabies exposure are evaluated and managed. It is a facility for administration of PrEP to high risk individuals. ABTC is a government owned/operated while ABC is privately owned/operated bite center.



ABTC/ABC Locator Map

The Department of Health ensures that all Animal Bite Treatment Centers (ABTCs) and Animal Bite Centers (ABCs) provide quality post exposure prophylaxis to all rabies exposures.

As part of the quality assurance system, the DOH certifies ABTCs/ABCs. The certification ensures that the ABTC/ABC meet the standards. A Self Assessment Form is a tool used for DOH Certification. To date there are 384 ABTCs all over the country.

2. GUIDING PRINCIPLES

- ABTC shall be established based on the recommendation of the Center for Health Development (CHD).
- An ABTC/ABC shall be established for every 150,000 population.
- All ABTCs/ABCs shall be manned by a trained physician and nurse by a DOH-accredited training facility.
- All ABTCs/ABCs shall use only FDA approved (RIG) and WHO prequalified vaccines.
- All ABTCs/ABCs shall be certified by DOH and accredited by PhilHealth.
- All ABTCs/ABCs shall maintain a standardized recording and reporting system.
- All ABTCs/ABCs shall have a functional two-way referral system.

3. REQUIREMENTS FOR THE ISSUANCE OF DOH CERTIFICATION FOR THE ABTC/ABC

3.1. Physical Set Up

- Signage that is visible outside the center
- Consultation and wash area with adequate and clean water supply
- Refrigerator with a calibrated thermometer, exclusive for vaccine storage
- Vaccine carrier for temporary storage
- Color coded waste bins and sharp boxes
- Weighing scale
- Organizational Chart
- Clinic Schedule
- Flowchart/ Algorithm

3.2. Manpower

- DOH/CHD trained Medical Doctor and Nurse

3.3. Supplies

- Vaccines and RIG
- Syringes, Dressing Kit, Soap and Gloves
- Emergency drugs for adverse reaction
- IEC Materials

3.4. Recording and Reporting

- Recording and Reporting which includes:
 - a. Rabies Exposure Registry
 - b. PEP Card
 - c. Quarterly/Annual Reports such as Cohort, NRPCP Report Form, Human Rabies Report Forms
 - d. Quarterly PEP Outcome Reporting Form

3.5. Policies and Procedures

- Two way referral system
- Waste management
- Cold Chain management
- NRPCP Manual of Procedures
- All Rabies Exposure/Animal Bites Management Guidelines

PART C: GUIDELINES IN THE PREVENTION AND CONTROL OF CANINE RABIES

1. INTRODUCTION

Dogs are the principal reservoir of rabies in the Philippines. Of the animal rabies cases reported in 2011 85.7% are dogs, 12.7% are cats and 1.6% represents other animals. Rabies in domestic animals like cattle, carabao, pigs, goats and horses has been reported since 1930's but were all traced to bite of rabid dogs.

Canine rabies incidence declined from 1,415 in 2005 to 298 in 2010. For 2011, out of the 2,207 total number of samples submitted for laboratory confirmation, only 415 were confirmed rabies cases. For the past five years from 2007 to 2011, the number and incidence of canine rabies has been on a decreasing trend. However, the number of samples submitted has also been decreasing. Thus it could not be claimed with certainty that the reduction in the number of positive samples is brought about by prevention and control efforts against rabies.

2. ELEMENTS IN THE PREVENTION AND CONTROL OF CANINE RABIES

Canine rabies can be eliminated, as it has been possible/feasible in North America, Western Europe, Japan and many areas in South America. However, canine rabies is still widespread, occurring in over 80 countries and territories, which are predominantly in the developing world. Half of the global human population lives in canine rabies-endemic areas and is considered at risk of contracting rabies. In the Philippines, in more than 97% of all human rabies cases were from rabid dogs.

Control of rabies in dogs includes three basic elements:

2.1. Mass Dog Vaccination

Mass canine vaccination campaigns have been the most effective measure for controlling canine rabies.



2.2. Dog Population Management

Includes the following measures:

- stray dog management through impounding, field control
- (humane euthanasia and disposal)
- surgical sterilization
- non-surgical sterilization
- habitat control

2.3. Dog Movement Control

Border checks and other measures should be implemented to prevent the introduction of rabies into rabies-free areas. Dogs/cats for shipment to provinces should be vaccinated before transport with appropriate health certificate and shipping permit should be issued at the point of embarkation.

3. GUIDELINES ON DOG CONTROL MEASURES

3.1. Mass Dog Vaccination

Mass vaccination of domestic dogs remains the mainstay of canine rabies control.

General guidelines in dog vaccination

Estimation of dog population and evaluation of a mass vaccination campaign should be carried out for strategic planning and management.

- Registration and permanent identification vaccinated dogs is recommended.
- Annual Vaccination against rabies is mandatory.
- At least 70% of dog population in each community should be vaccinated to attain effective herd immunity. It should be done within a short period of three months.
- Coverage required may be higher if dog populations are very dense or lower in areas where movement of most dogs are restricted.



- Political commitment and strong support of national and local government, to the acquisition and government supply of canine vaccines, free delivery of these vaccine and effective coordination and supervision of the campaigns by the health services are among the factors in the success and sustainability of the dog vaccination campaigns.
- In case of a rabies outbreak, all dogs and cats, when presented, should be immunized, regardless of their age, weight or state of health.
- If dogs with current rabies immunization are exposed to a rabid animal, they should be revaccinated immediately, confined and observed for 90 days. Unvaccinated dogs shall be impounded and if unclaimed shall be euthanized.
- All personnel involved in the anti-rabies program are considered high risk and should receive pre-exposure prophylaxis.

3.2. Three Approaches In Mass Vaccination

3.2.1. Comprehensive Approach

The **main purpose** of the comprehensive approach is to eradicate rabies province-wide. The following are the basis for selection of the area for this approach:

- incidence of rabies
- geographic importance and topography
- human population density
- commitment of the LGU counterpart to implement the program.

3.2.2. Site-specific Approach

This approach shall cover specific barangays **within 5 km-radius of provinces with confirmed rabies case**, either human or canine. These areas shall receive secondary allocation of resources as well as the priority attention in the establishment of the major program components, support activities and networking management.

3.2.3. Quick-response Approach

This shall cover barangay **within 5 km. radius in municipalities/ cities or provinces outside of the site-specific and comprehensive areas whenever a single documented and confirmed human and canine rabies occurs**.

Allocation of resources shall be based on the top priority basis and to be taken directly from the buffer stocks available at the LGUs/Region/Bureau of Animal Industry.

3.3. Vaccination Strategies

A single strategy or a combination of strategies can be used for domestic dog vaccination and should be selected on the basis of the setting or known socio-cultural factors. The three strategies for dog vaccination are the following:

- 3.3.1.** Continual vaccination is conducted at fixed vaccination posts in well-recognized sites within the community where dog owners could take their dogs/cats for anti-rabies immunization. These include private or government veterinary clinics. This strategy requires little government resources and effort, however, many owned and all unowned dogs will not be covered thus resulting into low vaccination coverage. Moreover, the coverage will be difficult to measure.
- 3.3.2.** Mobile teams set up temporary vaccination points at a central location within individual villages or cities conveniently located for dog owners (central-point vaccination strategy). This strategy is relatively inexpensive and can achieve the recommended level of coverage if vaccination is provided free-of-charge.
- 3.3.3.** House-to-house campaigns may be required in remote areas. This strategy usually results in a high vaccination coverage of dogs with minimal disruption of the usual community activities, however, it is costly and logistically difficult.
- 3.3.4.** Synchronized campaigns done within a short period of time (i.e. one-day or one-week campaigns covering whole municipalities or states) may be very effective in mobilizing many sectors and the public, because of the limited time for their involvement and higher media and public attention.



3.4. Target Dogs for Vaccination and Annual Vaccination Program

3.4.1. Target dogs for vaccination are those aged three months and above. Only healthy dogs should be vaccinated at age three months and above.

One dose (1ml) is given to the dog regardless of the weight of the animal, then a repeat vaccination is done yearly for continuous protection.

Those that were vaccinated when they were less than three months old shall be re-vaccinated in their fourth month. Studies showed that dogs respond poorly when they are vaccinated earlier than three months of age.



3.4.2. Annual Vaccination Program

Consists of the following:

- Age of First Vaccination- at least three months
- Frequency of Vaccination – Annual for three years
- Route of Vaccination – Subcutaneous and/or Intramuscular

3.5. Animal Vaccines against Rabies

3.5.1. For mass parenteral vaccination campaigns, only inactivated and adjuvanted rabies vaccine should be used.

3.5.2. Potency requirements for animal vaccines.

Inactivated animal vaccines with a potency of less than 1.0 IU per dose, as measured by the NIH test or other recognized pharmacopoeia tests, should not be licensed or released unless an adequately designed experiment has demonstrated a duration of protection of at least 1 year in the species for which the vaccine is to be used.

3.6. Conduct of Dog Vaccination

3.6.1. Pre-Vaccination Activities

a. Planning of vaccination campaigns

Planning of vaccination campaigns at the community level requires the following:

- Communication with local authorities to obtain permission and support.
- Vaccination team members, accompanied by local leaders, should then visit the selected area in order to plan the campaigns in the community.
- The proposed area should be carefully mapped and broken into daily work blocks and further into sub-team blocks, allocating teams to certain areas
- Smaller-scale campaigns (e.g. pilot projects) may be initially conducted to gain experience and subsequently expand to cover larger areas.
- Logistics should be planned carefully and time allowed for purchase of equipment and preparation.
- Before starting, briefing sessions should be conducted.

b. Registration of Dogs and Cats

- Registration is a prerequisite for vaccination by Province City Municipalities and Barangay
- Mandatory annual registration of dogs must be coordinated with the provincial, city or municipal veterinary office by sending the information to the appropriate province, city, municipal barangays
- Private practitioners and other agencies, socio-civic organizations should coordinate registration and vaccination activities with the provincial, city or municipal veterinary offices
- For new/or other type of residents to LGU's, they have one month to register their animal within a certain time period, (ex. one month) depending on the local ordinance
- Registration must be renewed annually
- Collection of Registration fees
 - a. Amount/cost of fee shall be determined by concerned LGU/ thru ordinance

- b. Options on Registration:
 - c. Sharing of registration fees by percentage between barangay and municipality/city/province;
 - d. No sharing if shouldered totally by one unit
 - e. Sharing only on penalties/other fees
- Pre-vaccination Information dissemination - The BRCCC-designated support staff will request the resident to bring the dogs /at the designated vaccination centers. The BRCCC designated recorder should first identify the owner of the dog to be vaccinated.

3.6.2. Actual Vaccination Activities

Suggested time of vaccination is from 9-12 am and 1-4 pm.

Restrainer /Owner of dogs to be vaccinated

- Dog restrainer should assist in restraining stray dogs using catching loop/catching net brought by the vaccination team.
- Let the owner restrain or properly handle their animals. Animals are removed from the cage when handled by the owner.
- Owner to be advised to leash or confine their vaccinated pets in their own yard because the vaccine does not provide instant protection, and protective antibody levels should be reached within 7-10 days after vaccination.

Vaccinator

- Vaccinator shall handle the vaccine properly using styrofoam boxes with coolant or ice to maintain the desired storage requirement while going around the barangay.
- If using multiple dose vaccine, always provide one needle at the vial for aspiration apart from the syringe and needle used for vaccination.
- Administer the vaccine properly either subcutaneously or intramuscularly using the back part with loose skin or the thigh muscle and be sure to give the complete dose requirement.
- Anaphylactic reaction may occur minutes after vaccination. Some dogs suffer such reaction one hour after the shot.

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- While the vaccination is ongoing, BRCC coordinator should go around the barangay on mega phone to encourage residents to have their dogs vaccinated.
- Each vaccinated dog should be issued a certificate of vaccination, a dog tag or registration certificate if warranted by an ordinance.

3.6.3. Post-Vaccination Activities

- **Recording and Reporting**

Vaccinator shall collect and duly accomplish the report on the summary of vaccination, to be submitted immediately to the coordinator, copy to be furnished to the BRCCC chairman, and another copy to be submitted to AHD-BAI.

- **Disposal of vaccination paraphernalia**

Used vials should be collected and returned back to the centers (Regions, BAI) for proper disposal. Used needles, syringes and other paraphernalia must be incinerated or properly disposed in the municipal health/veterinary centers/BAI.

- **Identification of Vaccinated Animals through a Tagging System**

Dog tagging is mandatory but the LGU shall have the option to select the shape and color of the dog tag. The standard vaccination tagging system will include registration number, code bearing the name of the city, municipality and barangay shall be used for identification of vaccinated animals.



2012, Green, bell-shape



2013, Yellow, dog house-shape



2014, Orange, oval



2015, Blue, cross



2016, Red, heart

If possible, these tags shall be distinguishable in shape and color. The dog tag may be made of anodized aluminum and should not be less than 1 X 1 inches and 1.5 mm in thickness. The dog tags shall be distinguished by its color specified for the year as shown below:

- **Standardized forms of Certificate of Vaccination and Central database forms for use of Local Government Units**

A standard certificate of vaccination shall be used by all veterinarians in the LGUs. The certificate shall be issued to the owner upon vaccination of his/her dog/s and shall be enclosed in the registry form of the specific dog registration. All dogs must be registered to be vaccinated. The recommended size of the vaccination certificates should be 4¼ in X 5½ in (¼ of letter size paper).

- **Estimation of vaccination coverage**

Assessment of Dog Immunization Coverage Using Cluster Survey – Post-vaccination questionnaire surveys are used to determine the proportion of vaccinated to unvaccinated dogs in households. During these surveys, dog owners should be asked to produce vaccination certificates to identify vaccinated dogs.

3.7. Personnel Involved In Dog Vaccination

- Vaccination campaigns should be under the overall supervision of veterinarians but other staff will be needed to assist during campaigns such as livestock officers, agricultural extension officers and veterinary assistants
- Private veterinary practitioners are generally involved in vaccination of owned dogs in clinics, but could also be involved in mass vaccination campaigns
- Community-based organizations supporting rabies prevention and control programs
- Barangay health workers/ volunteer
- Non-professional volunteers as vaccinators may need to be authorized by the Provincial/City Veterinary Office or by the Municipal Agriculture Office
- Volunteer veterinarians and veterinary nurses from overseas may be a source of short-term support

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- Veterinary Schools or University staff may support vaccination activities vaccination campaigns

3.8. Estimating Dog Populations

Estimation of dog population is important for more accurate planning of the campaigns, and is useful for assessing dog population management programs and evaluating the effectiveness of the intervention. The options for estimating the number of dogs to vaccinate are as follows:

- Rapid estimates can be made from expert opinion based on historical data of previous campaigns or on registration records if available
- Estimations made in other geographic areas/demographic settings
- Questionnaire surveys

A questionnaire survey is a commonly used census technique for estimating the dog population. It is conducted in the community and can be useful where residents recognize the dogs present in their communities.

A questionnaire Survey is done at the barangays, cities, municipalities, provinces with the Department of Agriculture as lead agency. Implementing Agencies are DILG, LGUs.



Questionnaire surveys can be used to establish the mean number of owned dogs per household and dog: human ratios. These surveys can be conducted before, during or after campaigns (e.g. combined with post-vaccination surveys to estimate the vaccination coverage. Households for interview should be selected randomly. From the household surveys, a national estimate of the owned dog population can then be extrapolated from the total human population or number of households obtained from national population censuses.

Information to be obtained but is not always necessary and priorities should be based on resources available to carry out the surveys.

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- Household Characteristics(name, address, contact number, number of dogs owned)
- Dog Characteristics (name of dog, breed, age/date of birth, sex, Intact/neutered, color/ markings, status of vaccination –date of vaccination)
- Methods are also available to assess the number of roaming dogs - i.e. both owned and unowned dogs, but not accompanied by an owner such as:
 - a. Indicator counts which consist of counting dogs (e.g. males, females and pups) along selected representative routes. Counts can be repeated every year (at the same time of the year) to evaluate changes in population over time (i.e. if the number of dogs has increased or decreased).
 - b. Capture-mark-recapture methods consist of temporarily marking the dogs, e.g. with a dye or distinctive collars and then subsequently recording the proportion of marked animals in the population during a “visual recapture” effort. From the number of dogs marked and the observed ratio of marked to unmarked dogs the total number of street dogs is calculated. Marking can conveniently be done during vaccination campaigns.
 - c. It is important to perform marking and recapture within a time period of a few days in order to minimize mark loss, dog movement and mortality effects. The observations can also be combined with estimates of the number of owned dogs obtained through household questionnaires to estimate the number of unmarked dogs.
 - d. Population estimates can be obtained by extrapolating counts made in a sample (e.g. randomly selected sub-regions) to whole cities. These surveys can also be repeated to detect changes in the number of roaming dogs.

4. DOG POPULATION MANAGEMENT

Dog Population Management includes the following measures:

- stray dog management through impounding, field control (humane euthanasia and disposal);
- surgical sterilization;
- non-surgical sterilization; and
- habitat control

A combination of approaches required for a successful dog population management program. Planning an intervention comprised of these approaches should follow an initial assessment phase and analysis of the local dog population to ensure the approaches are appropriate.

Dog population management shall also incorporate education programs for responsible dog ownership that promotes healthier and safer (vaccinated) dogs and legislative measures on leashing of dogs, mandatory registration, identification and regular rabies vaccination.

4.1. Stray Dog Management

Stray Dog is defined as any dog leaving its owner's place or premise and no longer under the effective control of the owner.

Management of stray dogs includes any of the following:

4.1.1. Impounding

Options on Humane Methods of Stray Dog Catching:

- Use of Pole Nets
- Humane/Animal Friendly Nets
- Traps
- Snare/Catch pole and/or in combination with nets
- Tranquilizer gun
- Tranquilizer Blow Darts
- No Contact Apprehension by photograph and issuance of
- Citation ticket

Needs for opening impounding centers must be carefully evaluated and when an impounding center is required in a given area building and managing it must follow published guidelines.

As an alternative to impounding centres, foster homes for dogs involving dedicated volunteers may be created.

Stray dogs that do not pose potential risk due to health or behavioural problems may be subjected for adoption or sent to animal shelters.

4.1.2. Field Control

Immediate disposal of animals in accordance with the RA 8485 within the vicinity of the capture site or at designated disposal site may be carried out for the following:

- a. Voluntarily surrendered dogs or dogs unclaimed with in three(3) days shall be humanely euthanized OR is subjected for adoption or dogs unclaimed with in three(3) days shall be humanely euthanized;
- b. Animals clearly posing danger to the public due to health or behavioural problems cannot be released back into the community BAI. Animal Welfare Officers in the LGU's are deputized in conducting humane euthanasia for impounded dogs.
- c. Proper disposal of dead animals and carcasses is done through burying,cremation and other approved methods according to existing laws

4.2. Surgical Sterilization through Spaying/Castration

The currently recommended technique for reproductive control is surgical sterilization, **which requires trained personnel, infrastructure, equipment**Appropriate anesthesia and pain managementis recommended to be conducted as early asthree(3) months old and must be conducted by a licensed veterinarian using the most humane and aseptic methods.

4.3. Non- surgical sterilization

- Research is currently being carried out to develop safe and effective methods for **chemical sterilisation or contraception**.
- A non-invasive and inexpensive method is **isolation of females in estrus** which could be implemented by dog owners through education.
- Additional vaccinations and parasite control are often provided alongside sterilization to improve the health of individual dogs, hence enhancing owner

interest in engaging with the intervention, increasing the value of individual dogs which reduces abandonment and population turnover.

4.4. Habitat control

- Garbage should be properly disposed to prevent stray cats and dogs to scavenge them so as not to contribute to the increase in populations of roaming dogs and cats.
- The dog owners should be properly educated about proper waste disposal to prevent the purposeful feeding and careless disposal of waste to pets such as stray cats and dogs and in order to regulate, control, and ensure the proper waste disposal in slaughterhouses and other areas.

5. DOG MOVEMENT CONTROL/ MANAGEMENT

Cross-Border Movement of Dogs requires possession of a health certificate and a proof of rabies vaccination and shipping permit.

5.1. Inter-Provincial Control of Dog Movement

- Permit for movement of dogs for the purpose of breeding, pet, show shall be allowed upon presentation of Valid Rabies Vaccination Certificate and Valid Certificate of registration before the issuance of the veterinary shipping permit regardless of age.
- Animals below three (3) months old cannot be moved. (Refer to Animal Welfare Act on Transport of Animals).
- Mandatory registration of dogs and cats at the point of destination if the animals arrived without certificate of registration may be done in accordance with existing BAI memorandum on shipping of dogs (See annex Memorandum Order)
- Intra-Provincial Movement – is only allowed for pets, breeders upon presentation of the same as above.

5.2. International Dog Movement Control For Import and Export

5.2.1. For export

- BAI Health Certificate/ Export Commodity Clearance is issued based on the presentation of the dog for inspection or
- A Veterinary Health Certificate and a valid vaccination certificate from a private licensed veterinarian is to be presented , Serum for anti-body testing (depending on country requirement) should be done

5.2.2. For Import

- Veterinary Quarantine Clearance to Import is issued by BAI.
- Rabies Vaccination Certificate from Country of Origin is required.
- Imported animals are to be quarantined in the owners premises within thirty days.

Movement of Dogs for slaughter and meat as well as the movement or transportation is not allowed.

PART D: DECLARATION OF RABIES-FREE ZONES

1. INTRODUCTION

The Philippines in its effort to eliminate rabies by the year 2020 has implemented various rabies elimination campaigns focused on mass dog vaccinations and provision of PEP for all rabies exposures which includes Rabies Free Visayas Project and the JICA funded projects in selected island in the country. To facilitate achievement of the goals of Rabies Free Philippines, the DOH, DA and other key partners embarked on island declaration of Rabies-Free areas. The prevention of human rabies shall be sustained, focusing on community efforts involving both veterinary and public health workers.

To support this initiative, a joint Department Order was issued in 2008 by the Department of Health and Department of Agriculture entitled "Guidelines for the Declaring Areas as Rabies Free Zones". The Order was established to provide guidelines for declaring areas as Rabies free.

To date, 9 islands have been declared jointly by the DOH and DA as Rabies Free Zones. These islands include: the provinces of Siquijor, Batanes, Biliran, Camiguin, Marinduque, the island Municipality of Limasawa, Camotes Island, Daang Batayan of Cebu and Apo Island of Negros Oriental.

2. Definition of Terms:

- **Rabies Free Zone/Areas** refers to areas with no confirmed human or animal rabies case, including bats, or indigenously acquired infection by a lyssavirus at any time during the previous two years, in the presence of an adequate surveillance system and import policy and have satisfied all criteria for a rabies-free zones/area declaration.
- **Provisional Rabies-Free Zones/Area** - refers to area that is historically free of rabies where an adequate rabies surveillance is in place to confirm the rabies-free status, an effective import policy has been put into place to ensure maintenance of the rabies free status and has failed to meet the other requirements for the declaration of a rabies-free area/zone.

3. GENERAL GUIDELINES

- Rabies is a notifiable disease and as such shall be the responsibility of the local government units to report human and animal rabies cases promptly.
- An effective system of disease surveillance for humans and animal rabies has been set up and well implemented in the province/city/municipality.
- All regulatory measures for the prevention and control of rabies have been implemented including shipping/transport procedures.
- Accessibility of post-exposure prophylaxis using modern cell culture vaccines are approved and are recommended for both intradermal and intramuscular use.
- Established mechanism should ensure the availability of Human Anti-Rabies Vaccines and Rabies Immunoglobulins, such as inter-local health financing or cost sharing (public-private mix, patient-pet owner).
- Elementary School Curriculum Integration and Instruction on the prevention and control of rabies should be included in the regular health education on the prevention and control of rabies.

4. REQUIREMENTS FOR DECLARATION OF AN AREA AS RABIES FREE

4.1. General Requirements

- a. Local ordinance on the prevention and control of rabies.
- b. Localized comprehensive Rabies Prevention/Control and Elimination Program.
 - i. Presence of effective Rabies Control Committee at all levels of the local government namely: province, city, municipality, barangay.
 - ii. Information, education and communication campaign – Responsible Pet Ownership should be pursued in all the public awareness drives in the provinces, cities, municipalities and barangays. It should be conducted using print, broadcast and other forms of media. Billboards and streamers must be put up in strategic areas.
 - iii. Access to PEP
 - iv. Mass dog vaccination campaigns

4.2. Specific Requirements for Human Rabies-Free Zone Declaration

- a. No case of indigenously acquired infection by a Lyssavirus should be confirmed in any human at anytime for at least two (2) years through monthly zero-case reporting from the Municipal Health Office.

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- b. Presence of a functional surveillance system on rabies, in accordance with the Philippine Integrated Disease Surveillance and Response (PIDSR) Report system which includes the following:
 - i. Functional system of referral for laboratory confirmation of human cases in the regions by FAT or other antigen detection procedures such as Polymerase Chain Reaction (PCR);
 - ii. Surveillance system must involve all levels - health centers, animal bite treatment centers and hospitals – sentinel or non-sentinel sites;
 - iii. Monthly reporting of human rabies should include zero case reporting;
 - iv. The LGU should have at least one staff trained on rabies surveillance to investigate all reported human rabies suspects; and
 - v. The LGUs should conduct immediate case investigation of reported human rabies cases. If the LGU does not have the technical expertise to conduct investigation, the Provincial Health Office or Center for Health Development should provide technical assistance. When a confirmed rabies case is reported in a declared rabies-free area, the LGU should declare an outbreak and conduct an immediate comprehensive response to control the spreads of the disease.
- c. Post-Exposure Prophylaxis must be readily accessible to all animal bite victims and a mechanism is established to ensure availability of human anti-rabies vaccine and rabies immunoglobulin; and
- d. Adequate health education, promotion and advocacy on responsible pet ownership, proper animal bite wound care and adherence to treatment protocol, including the integration of rabies prevention and control in the curriculum of Elementary Schools and the annual celebration of the Rabies Awareness Month should be present or carried out.

4.3. Specific Requirements For Animal Rabies Free Zone

- a. No case of indigenously acquired infection by a type 1 Lyssavirus is confirmed in any animal species including bats at anytime during the past two (2) years through monthly zero-case reporting from the Municipal Agriculture Office/ Veterinary Office and monthly reporting of laboratory confirmed cases by all veterinary rabies laboratories – Philippine Animal Health Center (PAHC), Research Institute for Tropical Medicine (RITM), 10 Regional Animal Disease Diagnostic Laboratories (RADDLs), and two (2) accredited provincial rabies laboratories.

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- b. Comprehensive rabies vaccination program in a place for two (2) years as per provisions of the Anti-Rabies Act of 2007 should exist.
- c. Adequate laboratory-based surveillance system is in full operation in Rabies-Free and Provisionally Rabies-Free areas. The system should include the following:
 - i. Functional Rabies laboratories performing Fluorescent Antibody Test (FAT) for Rabies diagnosis in a minimum of 0.02% of the estimated dog population in their designated catchment areas/zones per year;
 - ii. Functional system of referral for confirmation of cases in the region; and
 - iii. Impounding facility/system for clinically suspect rabid dogs whether or not it is involved in a potential rabies exposure.
- d. Enforcement of control measures to eliminate, destroy and dispose stray dogs as per existing ordinance.
- e. All components of animal rabies prevention and control together with the animal birth control program must be in place.
- f. Effective dog movement control measures i.e. dogs and cats for inter-island transport must have a valid vaccination certificate and can only be transported at least two (2) weeks after vaccination or valid rabies vaccination within last 12 months should be certified by a licensed veterinarian.
- g. Information, education and communication campaign - Responsible Pet Ownership should be pursued in all the public awareness drives in the provinces, cities, municipalities and barangays. It should be conducted using, print, broadcast and other forms of media. Billboards and streamers must be put up in strategic areas.

5. Procedure before Declaration of Rabies Free Zones

5.1. The LGU shall request for evaluation as Rabies Free zone with the following requirements:

- a. Letter request for evaluation addressed to the Regional Director of the Center for Health and Development; Letter request addressed directly to the DOH Central Office shall be referred back to the CHD Regional Director;
- b. Profile of the areas (to include area demographics);
- c. Status of rabies (Human and Animal) for the past five (5) years;
- d. Report of the last human rabies case;

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- e. Copy of the local ordinances and programs in the prevention and control of rabies;
 - f. Area accomplishment for the past two years to include dog vaccination coverage; and
 - g. Surveillance Report both human and canine rabies for the past five (5) years.
- 5.2.** CHD to conduct initial validation and evaluation of the area.
- 5.3.** Should the area fulfil the requirements for declaration of Rabies-free Zone, the CHD will submit report to National Center for Disease Prevention and Control (NCDPC), and shall request for National evaluation.
- 5.4.** Upon receipt of the report, NCDPC will review and conduct national validation with the CHD Regional Coordinator.
- 5.5.** The NCDPC upon validation shall recommend to the National Rabies Committee (NRC) for a joint evaluation with the DA.
- 5.6.** The DOH and DA shall recommend the approval of the area and submit recommendation to their respective Secretaries.
- 5.7.** Upon approval of the two Secretaries the Local Chief Executive shall be informed through the CHD.

6. Sustaining Rabies-Free Zones/ Areas

To prevent re-introduction of rabies virus in a declared Rabies Free Zone areas the following stakeholders at all levels are recommended to implement the following measures/strategies:

6.1. Local Level

- a. The Governor and City/Municipal Mayors must take charge of the implementation of the Rabies-Free zone guidelines in their respective province/city/municipality and should continue to allocate funds for the procurement of vaccines for animals and humans;
- b. The Barangay Officials must extend full support and cooperation to the "Bantay Rabis Sa Barangay" headed by the Barangay Captain who must continue to take charge of the entry of new dogs and maintain the registry of all dogs in the catchment area;
- c. The Rabies Control Committees in the provinces/cities/municipalities must continue to oversee the implementation of the rabies control program components and assist in the maintenance of the Rabies-Free zones;
- d. Epidemiology and Surveillance Units (ESU) at the municipal, city, provincial and regional levels shall sustain continuous operations of human rabies surveillance under the Philippine Integrated Disease Surveillance and Response System.

6.2. Regional Level

- a. The Regional Rabies Control Committees must regularly supervise and assess the implementation of the Rabies-Free zones in their respective areas;
- b. The Regional Animal Disease Diagnostic Laboratory (RADDL) of the DA-Regional Field Units must continue to conduct routine animal surveillance and must investigate the occurrence of animal rabies; and
- c. RADDLs of DA-RFU shall continue to provide monthly report of animal rabies cases to the National Rabies Committee.

6.3. National Level

- a. The Department of Health (DOH) and Department of Agriculture (DA-BAI), shall continue to support program implementation, activities, monitoring and evaluation, and sustenance of Rabies-free zones/areas using parameters for Rabies-free zones;
- b. The DOH and DA-BAI shall conduct joint periodic monitoring of the Rabies-Free zones;
- c. The DILG Regional/Provincial Directors shall monitor the compliance of the Local Chief Executives and their respective roles as mandated under the Memorandum of Agreement;
- d. The DOH shall provide human anti-rabies immunizing agents to Animal Bite Treatment Centers (ABTCs) through the CHDs and to provide pre-exposure prophylaxis of high risk group like health staff, animal handlers/vaccinators, veterinarians/ diagnosticians and children below 15 years of age in highly endemic areas;
- e. The DOH shall refer to RITM all rabies cases for confirmation when possible;
- f. The National Epidemiology Center (NEC) shall provide monthly report of human rabies cases to the National Rabies Committee; and
- g. The Department of Education shall assist in the development of Health Information and Education materials for school children.

7. Incursions of Rabies

In cases where there is re-introduction of rabies in Rabies Free Zone/Areas the following actions should be done:

- Incursions of rabies shall be reported immediately. Investigation must be conducted and the cases must be confirmed as much as possible;
- Control measures must be instituted immediately such as site-specific mass vaccination of dogs, surveillance, movement control and information campaign;
- Re-evaluation of status shall be conducted 6 months after the last vaccination date by the National Rabies Prevention and Control Committee; and
- Rabies-Free status shall be restored in writing by both the DOH and DA Secretaries.

CHAPTER IV: MANAGEMENT OF HUMAN RABIES

1. INTRODUCTION

Rabies is endemic throughout the world, it is considered fatal once symptoms develop, and requires careful consideration when a potential exposure occurs. Proper medication and supportive care should be given at the right time. The approach to management of rabies normally should be calming to the patient and their families.

Proper diagnosis will lead to proper management. Availability of medications that may be given to a rabies patient should be considered. Confirmed rabies patient should be brought to appropriate health facility who can manage rabies cases.

Since the virus is carried mainly through saliva, proper barrier nursing method is recommended for facility staff and relatives, as it is also for all infectious diseases. In the event that the patient died because of rabies, proper handling of the body should also be considered by health facility staff.

2. CLINICAL MANAGEMENT

2.1. Principles of Management of Human Rabies

Considering the fatal outcome and absence of cure for human rabies once signs and symptoms commence, management should center on ensuring comfort for the patient, using sedation, avoidance of intubation and life support measures.

2.2. Medications

Any of the following medications may be given:

- Diazepam
- Midazolam
- Haloperidol plus Diphenhydramine

MANAGEMENT OF HUMAN RABIES

Table 18: Medications that may be given to a Rabies Patient

Drug	Dosage		Preparation	Remarks
	Pediatric	Adult		
Diazepam	0.3-0.5 mg/kg every 2-4 hours not to exceed 20-40 mg/kg/24 hours	Initial: 10 mg IV at 10-15 minute intervals until a maximum of 30 mg has been given Maintenance: 10 mg 3-4x a day	2, 5, 10 mg/tablet 5 mg/ml (2ml ampule)	
Midazolam	0.1 mg/kg/dose IM, IV or PO every 4-8 hours	P.O.- ½ tablet IM- 10-15 mg IV- 2.5-5 mg To be given every 4-8 hours	15 mg/ tablet 5 mg/ml ampule	
Haloperidol decanoate	0.1 mg/kg IM or IV hourly as necessary Maximum single dose: 5 mg	INITIAL: 5 mg IM/SC every hour for 3 doses at least or until patient is calm MAINTENANCE: 5 mg IM/SC every 4 to 6 hrs and prn		<i>Note: Hypotension and dystonic reactions occur</i>
Diphenhydramine	1-2 mg/kg IV or IM Maximum dose: 50 mg	50-100 mg every 4-6 hours		<i>Note: May cause sedation, especially if other sedating agents are given May cause hypotension</i>

2.3. Supportive care

Patients with confirmed rabies should receive adequate sedation and comfort care in an appropriate medical facility.

- Avoid invasive procedures.
- Provide suitable emotional and physical care.
- Provide and discuss with relatives important information concerning transmission of the disease, and indications for PEP of contacts.
- Communicate gently and compassionately with relatives regarding the patient's prognosis.

3. INFECTION CONTROL

- The virus is not carried in blood and is only intermittently shed in saliva, CNS fluid, urine and within some tissues.
- Patients should be admitted in a quiet, draft-free isolation room.
- Staff taking care of a rabies patient should strictly adhere to proper barrier nursing methods for patient care, as is recommended for all infectious diseases.

MANAGEMENT OF HUMAN RABIES

- Health care workers and relatives coming in contact with the patient should wear proper personal protective equipment (PPE), including gown, gloves, mask and goggles.
- Staff should wear sufficient protection such as gowns, goggles, masks and thick gloves.
- Pre-exposure immunization against rabies of nursing staff and health-care personnel in hospitals may be considered for those who, after careful investigation, are considered most at risk.

4. POSTMORTEM MANAGEMENT OF BODIES OF PATIENTS WHO DIED OF RABIES

- Humans who died of rabies generally present a small risk of transmission to others. Blood does not contain the rabies virus. However, rabies virus may be present in many tissues, such as the central nervous system, salivary glands and muscle and in saliva and urine.
- Procedures in handling of brain or spinal cord, such as using electric saws and drills during necropsies, if done carelessly, can lead to mucous membrane and inhalation exposures. If extremely necessary, perform necropsies with strict infection control measures using proper personal protective equipment (PPE), including gown, gloves, mask and goggles.
- Tissues and body fluids should be disposed of in the same manner as practiced for other infectious diseases such as tuberculosis and hepatitis.
- Disinfect instruments by autoclave or boiling after use.
- Discourage embalming. Early disposal of the human remains by burial or cremation is highly recommended.

CHAPTER V: SURVEILLANCE OF RABIES

1. SURVEILLANCE HUMAN RABIES

1.1. Introduction

Disease surveillance is a systematic collection, analysis and interpretation of data for public health action. This is being undertaken by Regional/Provincial/City/Municipal Epidemiology and Surveillance Unit throughout the country.

The Philippine Integrated Disease Surveillance and Response (PIDSR) of the National Epidemiology Center has classified human rabies as an immediately-notifiable disease, thus it must be reported within 24 hours.

The National Animal Disease Diagnostic Laboratory (NADDL) was established to confirm rabies in animal as part of the surveillance of the Department of Agriculture.

1.2. Case Definition

Suspected Case:	Probable case	Confirmed case:
A person presenting with an acute neurological syndrome (encephalitis) dominated by forms of hyperactivity (furious rabies) or paralytic syndromes (dumb rabies) that towards coma and death, usually by respiratory failure, within 7 to 10 days after the first symptom if no intensive care is instituted.	A suspected case plus history of contact with suspected rabid animal.	A suspected case that is laboratory confirmed
<i>Note: Bites or scratches from a suspected animal can usually be traced back in the patient medical history. The incubation period may vary from days to years but usually falls between 30 and 90 days</i>		

1.3 · Notification

Any person in the community or in a health facility attending to the suspect rabies case should report to the MHO/PHO/ PESU and CHD/RESU within 24 hours of any suspected rabies case by the fastest means possible. Report may be done by telephone or via facsimile or email.

SURVEILLANCE OF RABIES

1.4. Case Investigation And Reporting

The CHD program coordinator together with the RSU staff shall conduct a thorough case investigation. For suspected patients who went home against medical advice, they should be reported to the rabies program coordinator and the RESU for verification and follow-up. Reports of human rabies NOTIFICATION shall be consolidated by the RESU and the NEC describing the distribution of human rabies cases by age, sex, geographic location and time of occurrence. Report should be provided to the program.

1.5. Laboratory Confirmation

To support the declaration of rabies free areas, specimen samples may be collected for confirmation. The reference method for diagnosing human rabies is by performing Polymerase Chain Reaction or viral culture on brain samples taken after death. The diagnosis can also be reliably made from skin samples taken before death. It is also possible to make the diagnosis from saliva, urine and cerebrospinal fluid samples.

Table 19: Specimen, Sample Volume for Laboratory Tests for Human Rabies Suspects

Specimen	Purpose	Test	Sample Volume	Referral Laboratory
Ante/Post Mortem				
Saliva**	Virus Isolation	MIT	1-2 ml in sterile vial	RITM
	Viral RNA detection	RT-PCR	2 ml in sterile vial	
Serum	Antibody detection	RFFIT	2 ml in sterile vial	RITM
CSF***	Antibody detection	RFFIT	1-2 ml in sterile vial	RITM
	Viral RNA detection	RT-PCR		
Post Mortem Only				
Brain (Brain stem and Cerebellum)	Antigen detection	Seller's Test	1square inch of the brain No formalin fixation	RITM, SLH, RADDL ***
	Viral RNA Detection	IFA Test		
	Viral RNA	RT-PCR		
	Virus Isolation	Tissue Culture		
		MIT		

*all specimens must be temporarily stored at -20°C freezer until transport

** it must be done at 4-6 hour-interval

*** It must be paired with serum sample

****RADDL (Regional Animal Disease Diagnostic Laboratory) to facilitate preparation and transport of specimen

1.6. Guidelines on Evaluating Rabies Cases

Reported human rabies shall be evaluated according to the standard case definition as suspected, probable and confirmed case.

2. SURVEILLANCE OF ANIMAL RABIES

Rabies is a notifiable disease both in the national health and veterinary systems in the Philippines.

Surveillance of canine rabies and submission of laboratory reports of suspected cases is essential for management of potential human exposures and for veterinarians to adopt appropriate measures towards animals who were in contact with the suspected animal case.

2.1. Recognition of Rabies in Dogs

Rabies is identified at the community level in various situations:

- Pet or stray dogs and other animals directly noted to have manifestations of rabies
- Dogs or cats that have bitten a person and are being observed for manifestations of rabies

2.2. Notification

If a dog, cat or any animal suspected of rabies died after biting a person or while being observed:

- Report immediately to the local veterinarian or trained personnel on animal disease control from the local government unit.
- The local veterinarian or trained personnel should be informed and should be the one to supervise/ carry out handling and preparation of the dog specimen for laboratory confirmation.
- Submit the dog for laboratory confirmation of rabies.

2.3. Preparation/Handling and Packing of Animal Specimens for Rabies Diagnosis

The animal specimen should preferably be collected by a veterinarian in clinic in order to assure that the precautionary safety measures in handling potentially infectious materials are strictly followed. The basic personal protective equipment (PPE) includes a laboratory gown, examination gloves, face masks and shields and disinfectant for decontamination.

SURVEILLANCE OF RABIES

In the household setting, a clean table or bench is needed for the decapitation of the animal. The following procedures should be followed:

- a. The handler should use gloves or wrap their hands with plastic bags to prevent direct contact with the specimen.
- b. Eye protection such as optical glasses should be used to prevent any tissue splatter on the eyes.
- c. An ordinary butcher's knife or bolo may be used to cut the animal's head.
- d. The head should be cut two (2) inches away from the base in order to include important tissue components of the brainstem.
- e. No attempt should be made to extract the brain tissue because this would cause additional risk to the processor
- f. Place the head of the animal in a leak-proof double household plastic bag. This constitutes the primary container.
- g. Do not put any ice cubes inside this primary container.
- h. No chemical preservative like 10% formalin or alcohol should be used as this will render the specimens inappropriate for examination.

2.4. Storage of Animal Specimens before Transport

- Place the primary container into another household plastic bag (secondary container) with liberal amounts of ice, enough to sustain the cold temperature during transport to the laboratory.
- The two containers must be placed in a styrofoam box or any leak-proof transport container and brought to the nearest rabies diagnostic laboratory.
- Label the transport container as "Rabies Suspect". Affix label with the complete name, address and phone number of both the shipper and the laboratory recipient. The head specimen must be sealed in a plastic bag and labelled "**Handle with Care: Rabies Suspect**". A fully accomplished Referral Form should accompany the sample.
- If the specimen cannot be transported at once, it should be frozen or stored inside a leak-proof Styrofoam or ice box container. Add plenty of ice packs into the container to allow overnight cold storage. Replenish the ice/ice packs as often as needed until it is transported to the laboratory.

2.5. Specimen Transport

During transport, the specimen should be packed with ice to preserve it. The specimen may be sent thru air freight or hand carried to the accredited diagnostic laboratories.

2.6. Disposal of Carcass/ Disinfection

Dispose the carcass by burying or burning in a pit. Disinfect the working area with 10% household bleach (Chlorox) or 3% Lysol. Discourage eating of the meat of the biting animal.

2.7. Laboratory Diagnosis of Rabies in Dogs and Other Animals

The diagnosis of animal rabies is based on laboratory confirmation. Fluorescent Antibody Test (FAT) is the gold standard for laboratory diagnosis for animal rabies. Direct Microscopic Examination (DME) and Mouse Inoculation Test (MIT) may be done in the absence of FAT.

2.8. Laboratory Specimens, Volume of Sample and Corresponding Tests for Animal Rabies

Table 20: Appropriate Specimen, Volume and Corresponding Tests for Animal Rabies Diagnosis

Specimen	Purpose	Test	Volume of Sample	Specimen Preservation while on Transport
Head	Antigen Detection	IFA	Brain Tissue, as appropriate	Ice Cubes/ Dry Ice
Whole Body*	Virus Isolation	MIT		No chemical/ formalin fixation
Salivary Gland	Viral RNA	RT-PCR		
Serum**	Antibody Detection	RFFIT	1- 2 ml in sterile vial	Ice cubes

*Rats, bats, mice, guinea pigs

**May be used to determine the immune status of the biting animal

2.9. Results of Laboratory Examination

The diagnostic laboratory should release the results of the examination to the sender of the specimen. Likewise, DA and DOH provincial coordinators should also be furnished with the results to serve as guide in the institution of appropriate control measures.

SURVEILLANCE OF RABIES

The laboratory diagnosticians should inform the AHD-BAI immediately of all specimens examined positive for rabies. They will also collate all DA-BAI-DOH Form I using the standardized DA-BAI-DOH Form two (2) and should submit the filled-up forms to AHD-BAI on or before the 7th day of the succeeding month.

3. OUTBREAK RESPONSE

The main goal in any disease outbreak is to control the spread of the disease. Rabies can spread very quickly in the dog population through dog bites and will eventually be transmitted to humans.

The control strategies chosen should: (1) protect public and animal health; (2) minimize animal welfare problems; (3) cause the least possible disruption to local communities, the tourism industry and visitors; (4) minimize the burden to the public and (5) minimize damage to the environment.

3.1. Handling Of Dogs / Cats Confirmed/ Suspected to be Rabid

The management of cases of domestic animals exposed to rabies can be difficult because of the lack of immediate perceived threat to human life. The exposure incident obviously could later result in human exposure if the domestic animal would develop rabies.

- Healthy dogs and cats that bite a person should be confined and observed for 14 days. It is recommended that rabies vaccine be not administered during the observation period. Such animal should be evaluated by a veterinarian at the first sign of illness during confinement. Any illness in the animals should be reported immediately to the local veterinary department. If signs suggestive of rabies develop, the animal should be euthanized, its head should be cut off and place in a sealed styrofoam under refrigeration for examination at the diagnostic laboratory.
- Any stray dog or cat that bites a human maybe euthanized immediately and head submitted for rabies examination.
- Other biting animals, which might have exposed a person to rabies, should be reported immediately to the local veterinarian and health authority.
- Management of animals other than dogs, cats, depends on the species, circumstances of the bite, epidemiology of rabies in the area, and the biting animal history, current health status and potential for exposure to rabies.

3.2. Trigger Points for Rabies Outbreak Response

- Laboratory –confirmation of animal rabies
- Human Rabies case

3.3. Outbreak Response

3.3.1. Human Rabies Case

Any health facility who has admitted or received a patient with signs and symptoms consistent with rabies should notify the Provincial/City/ Municipal Health Officer, or the RESU, within 24 hours.

Persons exposed to the human rabies case should be evaluated by the admitting hospital for Post-exposure Prophylaxis, based on the program guidelines. Local health staff should coordinate with animal bite Treatment Center for the provision of Post-exposure Prophylaxis to exposed contacts

The CHD/ NEC immediately after receiving the report should immediately notify Department of Agriculture Regional Office and the Bureau of Animal Industry to trigger outbreak response through immediate notification

For either of the two trigger points for rabies outbreak response, the efforts should be geared for further actions, which are as follows:

- a. Organize the Rabies Outbreak Response Team to be led and supervised by the Provincial Veterinarian. Rabies Control Teams will be composed of the Municipal/City Veterinarian/Agriculture Officer and vaccinators, with barangay workers to assist in the vaccination.
- b. All staff that are likely to come into contact with potentially rabid animals (e.g. dog catchers and veterinarians/vaccinators involved in the rabies control measures on the ground should be assessed for Pre-exposure Prophylaxis, depending on their immunization status, at the nearest Animal Bite Treatment Center.
- c. Control and prevention of rabies should be immediately carried out. Measures to limit the spread of the disease and ensure protection of people should include:
 - i. Declaration of infected areas/places with clear establishment of the boundaries of the infected area/place. Warning signs should be erected on all roads at the boundary of infected areas/places as well as at other boundaries such as railway stations, ports, marinas and airports estuaries;

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- ii. Control of dog movements into and out of infected areas/places to reduce opportunities for potentially infected animals to come in contact with susceptible animals. This can be achieved by encouraging dog owners to confine their dogs and by monitoring movements at designated points;
 - iii. Strict regulations should be imposed against importation (via sea or airports) of animals of unknown vaccination status particularly from areas where rabies is known to be present;
 - iv. The most effective way to reducing the number of susceptible animals in an infected area is through intensive mass dog (and cat) vaccination;
 - v. Take into account the resources required and provide ground staff with appropriate training. Ensure procurement of all necessary supplies. If vaccines are limited you should focus on areas of greatest need first, starting with vaccination in and around outbreaks;
 - vi. A central point strategy is continual vaccination at fixed vaccination posts in well-recognized sites within the community where dog owners could take their dogs/cats for anti-rabies immunization. These include private or government veterinary clinics. This strategy requires little government resources and effort, however, many owned and all unowned dogs will not be covered thus resulting into low vaccination coverage. Moreover, the coverage will be difficult to measure. Door-to door vaccination may be done in areas which are relatively far to the fixed vaccination posts; and
 - vii. Dogs should receive tags or temporary marks at the time of vaccination so that the proportion of dogs vaccinated can be determined shortly after vaccination.
- d. In an outbreak situation, provide owners with vaccination so that the vaccination status of their animals can be determined quickly and so to have specific contact details of dog owners that can be recorded in a central register/database;
- e. Carry out key communication actions and awareness campaigns to provide advice and raise awareness through established channels;

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- f. Inform affected communities about the human health implications of a rabies outbreak;
- g. Provide guidance on dog bite prevention and treatment of bites by suspect rabid animals (including wound washing and seeking immediate medical attention for treatment);
- h. Disseminate information on the status of the outbreak, locations directly affected, control measures and restrictions in place, including requirements for compliance (e.g. compulsory vaccination and confinement of dogs);
- i. Engage dog owners in vaccination programs by bringing dogs to central points or providing support for dog handlers during door-to-door delivery (e.g. by ensuring that dogs are available or assisting handlers/vaccinators);
- j. Provide information on location of animal holding facilities; and
- k. Provide emergency contact phone numbers to report cases or receive answers to questions.

3.3.2. Response to a laboratory-confirmed animal rabies case

- All animal disease diagnostic laboratories which have confirmed an animal rabies case should immediately (within 24 hours) inform the Regional/Provincial/City Veterinarian of the LGU where the animal specimen originated.
- The Regional/Provincial/City Veterinarian of the LGU should inform the animal bite victim bitten by the infected animal, if feasible, and/or the Animal Bite Treatment Center staff where the animal bite victim sought consultation.
- The Animal Bite Treatment Center staff advises the patient on PEP according to PEP guidelines.

3.4. Further Considerations

SURVEILLANCE OF RABIES

- Seizure and detention of animals. If detention pounds are not available locally, temporary holding facilities to confine suspect dogs should be set up within the infected area.
- Do not focus on dog population management as part of the operational response. If required, population management programs can be put in place once the outbreak has been brought under control.
- Indiscriminate elimination campaign of unconfined dogs is not recommended. It is ineffective, unpopular and may increase the risk of rabies spread as dog owners may be encouraged to move their dogs from infected to uninfected areas where no culling is taking place. It also diverts time and resources away from dog vaccination, which is the most effective way of handling the outbreak.
- Culling should be restricted to suspected rabid dogs and unvaccinated contact dogs (i.e. bitten by suspected rabid dogs).

CHAPTER VI: HEALTH PROMOTION

1. INTRODUCTION

Health promotion is the process of empowering people to improve their health and well-being. It is one of the essential elements in the successful implementation of all health programs and requires multi-sectoral actions designed to enhance public awareness to exercise their rights and responsibilities. It is carried out through the five action areas, namely: by building healthy public policy, creating supportive environment, strengthening community action, developing personal skills and reorienting health services complemented with various approaches. These approaches are advocacy, communication and social mobilization (ACSM), Communication for Behaviour Impact (COMBI), Social Marketing and Risk Communication among others.

In view of the varying approaches, the Department of Health (DOH) formulated the National Policy on Health Promotion in 2001, recognizing that despite differences in design and focus of the different health programs, said efforts must always aim to adopt/and or change healthy behaviours.

This chapter is primarily designed to guide health care providers and other stakeholders in the planning and implementation of their health promotion activities that will improve clients' knowledge and health seeking behaviour on rabies **prevention**. Thus, increasing the community's involvement in the **prevention and control of rabies** to ensure support from local officials and other stakeholders' to the National Rabies Prevention and Control Program.

2. OBJECTIVES

- Orient health staff on the importance, guiding principles, key strategies and appropriate health promotion activities;
- Guide health providers and local officials in formulating their respective local health promotion and communication plan; and
- Provide a list of key messages and recommended channels/media as basis in developing local Information, Education and Communication (IEC) materials.

3. POLICIES

- The NRPCP shall intensify health promotion activities of the program
- All involved agencies shall develop relevant IEC materials
- The DOH shall initiate integration of Rabies program into the school curriculum in collaboration with DepEd.

4. STRATEGIES

4.1. Building Healthy Public Policy

It is important for health workers to realize that promotion goes beyond health care. Promotion puts health on the agenda of policymakers in all sectors and at all levels, leading them towards being aware of the health consequences of their decisions and accepting their responsibilities for health.

It requires advocacy for the development and issuance of the following policy instruments to support health like laws, local resolutions and ordinances; executive orders, memorandum circulars; administrative orders and memorandum of agreement.

4.2. Creating Supportive Environment

Creation of a supportive environment could be physical or organizational. Physical environment can be improved or enhanced by making animal bite and treatment centers more accessible to clients. On the other hand, organizational environment can be the creation of coalitions, networks and inter-agency committees to increase the number of people promoting particular health actions where social mobilization is the major action to be undertaken.

4.3. Strengthening Community Action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to eliminate rabies in their respective areas. A concerted effort of the community is necessary in the prevention and control of rabies and initial gains of rabies free provinces should be supported and sustained.

4.4. Developing Personal Skills

In the prevention, control and elimination of rabies, the need for developing personal skills is very important. This can be done by enhancing the capability of health care providers through interpersonal communications training, seminars, briefings/ orientation and provision of IEC materials. Health promotion must be carried out in all possible opportunities and places (e.g. home, school, market, etc.) by different concerned institutions or groups of stakeholders given the mandates and the expertise.

4.5. Re-Orienting Health Services

The responsibility for health promotion in health services is shared among individuals, community, groups, health professionals, health service institutions, and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing preventive and curative services.

Health services need to embrace an expanded mandate that is sensitive and responsive of the cultural differences. This mandate should support the needs of individuals and communities for a healthier life, and should open channels between the health sector and broader social, political, economic, and physical environmental components.

4.6. Strategic Activities

Observance of two important events namely:

- Celebration/Observance of Rabies Awareness Month - March
- Celebration/Observance of WORLD RABIES DAY – September 28

Conceptualization, production/reproduction and distribution of IEC materials.

- Conduct Regional initiatives in the integration of Rabies Program to the DepEd Curriculum such as:
 - a. Networking with the Health and Nutrition Service of the Regional DepEd;
 - b. Enter into MOA between the two regional offices (DOH and DepEd); and
 - c. Conduct of TOT on Rabies Program Integration for selected pilot schools

5. PRACTICAL STEPS IN DESIGNING A COMMUNICATION PLAN

- 5.1. Define the problem.** This involves the identification of factors which cause a gap between the existing and desired behaviours of the target group. It can be a problem in knowledge/information, skill, attitude or resource. Problem identification methods include observation, Knowledge Attitude Practice and Behaviour (KAPB) surveys, group discussions, analysis of records, results of tests and special studies;
- 5.2. Formulate communication objectives.** Objectives are goals to aim for or desire to achieve within a time limit through the use of strategies and resources. It is important to have a clear idea of the health program to be communicated and the action to be taken by the identified target audiences;
- 5.3. Identify/Analyze the audience.** It is very important to know the target audience and study their needs, interests and level of comprehension;
- 5.4. Design effective messages.** A message should awaken the interest of the target audience which are in consonance with their needs and values. Messages on Rabies Campaign should create impact to the target audience. It is very important that the message and its approaches be pretested and revised before these are finalized and disseminated;
- 5.5. Use multiple channels.** Multiple communication channels, both mass and interpersonal media have a complementary effect, and can carry different types of information;
- 5.6. Determine needs and resources.** Like other project activities, development and dissemination of messages require resources. However, if resources are limited, other agencies may be tapped for resource sharing;
- 5.7. Document, monitor, measure and evaluate.** Proper documentation is essential in any activity stated in the HPC plan for Rabies. If it is not documented, it did not happen. It is also important to carry out both outcome and process evaluation. It is best to remember that any kind of evaluation should be guided by the plan's objectives.

National Rabies Prevention and Control Program has its health promotion and communication plan anchored on the guiding principles and five action areas of health promotion. It aims to address the educative and communication concerns to help the program achieve its objectives.

CHAPTER VII: LOGISTICS MANAGEMENT

1. INTRODUCTION

One of the components of a successful program like NRPCP is adequate supply of Cell Culture Vaccine (CCV) and Rabies Immunoglobulin (RIG). Therefore, all ABTCs/ABCs should have adequate supply of human rabies vaccine to give at least first dose of CCV to all animal bite cases but ensure completion of required number of doses including RIG to prevent human rabies.

Supplies of CCV and RIG are procured annually by DOH following the procurement management system. Once the CCV and RIG are delivered, inspected by the Food and Drug Administration (FDA) and DOH inspection committee, these will be allocated and distributed to the Centers for Health Development (CHDs) for distribution to the different provinces/CHOs/ABTCs on a quarterly basis, subject to availability of anti-rabies vaccine. All PHOs/CHOs/ABTCs must submit quarterly utilization and vaccine inventory report to the CHD. The local government units are encouraged to enact and strictly enforce ordinance/s relevant to rabies control and to provide fund allocation for anti-rabies vaccines for bite victims.

These vaccines and RIG require cold chain management. A cold chain is a temperature-controlled supply chain which consists of uninterrupted series of storage and distribution activities. This aims to maintain a given temperature range to ensure the shelf life of vaccines and rabies immunoglobulins from the manufacturer to the person who will receive the vaccine.

2. POLICIES

- 2.1. Human rabies vaccine and rabies immunoglobulin should be stored at a temperature of +2 degrees C to +8 degrees C and **should not be frozen**.
- 2.2. Cell Culture Vaccines and Immunoglobulins which are expired, damaged by heat or freezing should be disposed immediately (until accounting or auditing procedures have been completed) or properly labelled and stored outside the cold chain.
- 2.3. Only diluents specifically made for such anti rabies vaccine and rabies immunoglobulin from the same manufacturer shall be used.
- 2.4. Reconstituted human rabies vaccine vials shall be discarded at the end of 8 hours.
- 2.5. To minimize wastage at the ABTC level the CHDs shall provide only PVRVs to small animal bite centers catering less than two (2) patients per day.
- 2.6. Standards for Cell Culture Vaccine:

The NRPCP introduced the intradermal (ID) use of rabies cell culture vaccines in the country in 1997. The Philippines was among the first

countries to adopt this regimen as recommended by the World Health organization. According to WHO, the ID use of cell culture vaccines can decrease the cost of PEP by as much as 60-80%. However, only a limited number of commercially available rabies vaccines have been proven, to date, as safe and efficacious for PEP when administered by the ID route.

To ensure that patients exposed to rabies seeking treatment in government Animal Bite Treatment Centers receive only CCV that have been proven safe and effective, the program shall utilize CCV in compliance to WHO recommendations and criteria.

3. PROCEDURES

3.1. Vaccine Requirements Human

- Rabies vaccine needs for one course of intradermal regimen:

Table 21: Vaccine Need for Intradermal Regimen

Vaccine	Per vial	Intradermal dose	Number of ID doses per visit	Number of doses per vial	Number of Visits	Number of Vials per patient for a full course of Intradermal administration
Purified Verocell Rabies Vaccine	0.5 ml	0.1 ml	2 doses	5 doses	4	2
Purified Chick Embryo Vaccine (PCEC)	1.0 ml	0.1 ml	2 doses	10 doses	4	1

- **Computation of Human Rabies Vaccine using the Intradermal Regimen and Rabies Exposure Category**

Computation of human rabies vaccine requirements at the national and regional level may be based on the number of Category II and III rabies exposures with consideration of the available resources from the national government and other sources.

LOGISTICS MANAGEMENT

Estimated number of Category II and III exposures expected to require CCV:

Total number of Cases of Rabies Exposures x % of Category II and III Exposures
(based on Program Annual Report)

Number of Category II and III Exposures x No. of Vials required for a full course
of Intradermal Regimen

National Level

FOR PVRV	FOR PCEC
No. Of ID doses required	No. Of ID doses required
<p>Cat II + Cat III = number of patients requiring TCVs/CCVs base on annual report base from previous year</p> <p>No. of patients requiring CCVs X 8 doses = total ID doses required for all patients</p> <p>Sample computation:</p> <p>1,000 Cat II + 1,500 Cat III = 2,500 total number of patients requiring CCVs 2,500 x 8 = 20,000 ID doses required for all patients</p>	<p>Cat II + Cat III = number of patients requiring TCVs/CCVs base on annual report base from previous year</p> <p>No. of patients requiring CCVs X 8 doses = total ID doses required for all patients</p> <p>Sample computation:</p> <p>1,000 Cat II + 1,500 Cat III = 2,500 total number of patients requiring CCVs 2,500 x 8 = 20,000 ID doses required for all patients</p>
No. Of vials required	No. Of vials required
<p>Total ID doses / 5 ID per vial X 1.2* = total number of vials required *(.2 or 20% is the allowable wastage)</p> <p>Sample computation:</p> <p>20,000 ÷ 5 x 1.2 = 4,800 vials required</p>	<p>Total ID doses / 10 ID per vial X 1.2* = total number of vials required *(.2 or 20% is the allowable wastage)</p> <p>Sample computation:</p> <p>20,000 ÷ 10 x 1.2 = 2,400 vials required</p>

Vaccine Requirements at the level of Animal Bite Treatment Centers

Estimated number of Rabies Exposures per Year

Computation of the cell culture vaccine for the Local Government Units (LGU) through the Animal Bite Treatment Centers may be based on the number of Category II and III rabies exposures with consideration of the available resources from the LGU and augmentation from the national government and other sources.

Estimated number of vials to be used by the number of patients per day.

The number of patients with rabies exposures seeking anti-rabies vaccination per day could not be predicted. The risk of rabies infection as a consequence should prevail over wastage of vaccine. Unused doses of vaccine may be provided for pre-exposure prophylaxis of individuals within the area.

The table below shows the estimated number of vials to be opened as based on the number of patients seeking PEP in one day (estimate based on ≤ 10 patients/day only).

Table 22: Estimated Number of Vials to be Open Base on the Number of Patients

Number of patients per day	Number of ID Doses	Number of vials to be opened according to vaccine type	
		PVRV	PCEC
1	2	1	1
2	4	1	1
3	6	2	1
4	8	2	1
5	10	2-3	1-2
6	12	3	2
7	14	3	2
8	16	4	2
9	18	4	2
10	20	4-5	2-3

Vaccine Allocation

The kind of vaccine (PVRV or PCEC) to be allocated to ABTCs must be based on the following factors:

- Number of patients per day; and
- Availability of the vaccine in the local market

Ideally, PCEC should not be given to small ABTCs (with 2 or less patients per day to avoid huge wastage rate (>60%).) PVRV can be given to both small and big ABTCs (with >3 patients per day)

3.2. Rabies Immunoglobulin

Computation of the RIG yearly requirement may be based on the number of Category III rabies exposures with consideration of available resources from the national government, LGUs and other sources.

Computation of Rabies Immunoglobulin Supply:

COMPUTATION	EXAMPLE: For Equine Rabies Immunoglobulin
Number of Category III Exposure x average number of vials of RIG per patient	86,982 patients x 2* vials /patient (for a 26-50 kg patient) = 173,964 vials/year

*No. of vials per patient depends upon the weight of patient. For patients ≤ 25 kgs shall require (1) one vial; ≥ 51 to 75 kgs shall require (3) three vials; >75 shall require (4) four vials.

3.3. Animal Rabies Vaccine

Computation of Animal Rabies Vaccine is based on 10:1 human: dog population ratio. Herd immunity when mass dog vaccination coverage of 70% is reached within a short period of time and yearly vaccination thereafter every two years.

Number of animal rabies vaccine required:

Dog population x 70% coverage x 1 vial/10 dogs
10% of human population or 70% x 1 vial/10 dogs

Example:

National: 89 Million x 10% = 8.9 Million (Estimated dog population)

8.9 Million x 70% coverage x 0.1 vial/dog = 623,000 vial

3.4. Vaccine Wastage

Wastage is defined as loss by use, decay, erosion or leakage or through wastefulness. Vaccine usage is defined as the proportion of vaccine issued and administered.

$$\text{Vaccine Usage Rate} = \frac{\text{Number of doses administered}}{\text{Number of doses supplied}} \times 100$$

Vaccine wastage is the opposite of vaccine usage and is calculated as follows:

$$\text{Vaccine Wastage Rate} = \frac{\text{Number of doses supplied}^* - \text{doses administered}}{\text{Number of doses supplied}} \times 100$$

Example:

Number of doses supplied: For 20 vials of PVRV:
5 doses/vial x 20 doses :100 doses
Number of doses administered: 86 doses

$$\text{Wastage Rate: } \frac{100-86}{100} \times 100 = 14\%$$

**Doses supplied is calculated from stock records for a given time period by adding the starting balance of usable vaccine doses to new doses received during the period and subtracting the ending balance*

Some wastage is unavoidable. It is impossible to get all the doses in a multi-dose vial. A 1 ml-dose vial does not yield 10 doses for PCEC or a 0.5 ml vial does not yield 5 doses for PVRV.

In one day, one vial of vaccine could cover the (2) two ID doses of two patients for PVRV or (2) two ID doses of (4-5) four to five patients for PCECV in one visit. However, there are instances that a lesser number of patients come in one day to consume all the available doses of vials that have been opened within the day.

Unused doses may be used for pre-exposure prophylaxis and may be counted as administered doses to minimize wastage.

Wastage rates higher than 20% may indicate problems such as poor stock management, cold chain failure ,incorrect mixing of freeze-dried vaccine and incorrect dosage.

3.5. Physical Inventory

A regular physical check ensures stock records, and accurate and complete running balances. Regular inspection should be done to check on damaged, expired, heat or cold-exposed vaccines that need to be kept outside of the cold chain and clearly labelled “Damaged/expired vaccine – do not use”.

An inventory report should be properly filled up and submitted to next higher administrative level every quarter.

CHAPTER VIII:
RECORDING AND REPORTING

RECORDING AND REPORTING

1. Introduction

2. Policies

- 2.1. The NRPCP shall utilize the Rabies Exposure Registry and PEP Card as its official recording forms.
- 2.2. Quarterly reports on animal bite cases, cohort analysis and Summary of Human Rabies shall be submitted by all levels to the DOH through channels.
- 2.3. Recording and reporting shall be implemented at all ABTCs/ DOH recognized ABCs in the country
- 2.4. Recording and reporting shall include all animal bite cases categorized according to NRPCP guidelines.
- 2.5. The NRPCP shall adopt the official DOH recording and reporting system.
- 2.6. Records and reports shall verify the accomplishment of the program.

3. Procedures

3.1. Rabies Exposure Registry

The Rabies Exposure Registry is maintained at the ABTC/ DOH recognized ABC. It contains data on personal information, patient history of exposure, post-exposure prophylaxis, and previously immunized patients.

[illegible]

RECORDING AND REPORTING

The ABTC/ABC nurse fills up the registry as follows:

- 3.1.1.1. Registration Number - chronologically assigned to each patient.
- 3.1.1.2. Registration Date- indicated the date of consultation.
- 3.1.1.3. Under Personal Information
 - a. Name of Patient- Write the family name followed by the first name and middle initial
 - b. Address- state complete address, including landmarks or contact numbers (if available)
 - c. Age- Patient's completed age in years
 - d. Sex- Write M for male and F for female
- 3.1.1.4. Under history of Exposure
 - Date-indicate the date when the patient was bitten.
 - Place- indicate the complete address where the patient was bitten.
 - Type of Animal- Write PD if Pet Dog; SD if Stray Dog owned or ownerless freely roaming the community; C if Cat; O if Other than those previously stated.
 - Type of Bite- Write B if Bite and NB if Non Bite to include all non-biting rabies exposure like eating raw meat, splattering, kissing, etc.
 - Site- Indicate the body part/s bitten
- 3.1.1.5. Under Post Exposure Prophylaxis (PEP) Category of Exposure
 - Washing of Bite- Write Y if Yes or N if Not done
 - RIG - indicate the date when the RIG was given
 - Route- indicate the route of injection (Write IM if Intramuscular or ID if Intradermal)
 - Brand- indicate the brand name of TCV/CCV given
 - Under Tissue Culture Vaccine/CCV-indicate the date when the following doses was given

Tissue Culture Vaccine (TCV)	Date Dose was Given
1st Dose	
2nd Dose	
3rd Dose	
4th Dose	
5th Dose	

RECORDING AND REPORTING

3.1.1.6. Outcome

Patients who receive either PrEP or PEP may be classified according to the following outcomes:

Code	Description
Completed (C)	Patient received at least day 0, 3 and 7 doses of PEP or day 0, 7 and 21/28 of PrEP
Incomplete (INC)	Patient with less than 3 doses of either PEP or PrEP
Died (D)	Patient who died of whatever cause while undergoing PEP
None (N)	Category II and III exposures who did not received any TCV dose

3.1.1.7. Status of Biting Animal

After the 14th day of observation period, assess the status of the biting animal. Write A if Alive; D if the animal Died or L if the animal was not available for observation.

3.1.1.8. Under Previously Immunized Patients

- Day 0- indicate the date the dose was given
- Day 3- indicate the date the dose was given

3.1.1.9. Remarks- indicate other significant information if available.

3.2. Post Exposure Prophylaxis Card (PEP CARD)

Each patient receiving post-exposure prophylaxis will be provided with a Post Exposure Prophylaxis Card (PEP Card). This will be properly filled out by the ABTC/ABC Nurse based on the Rabies Exposure Registry data. The front page should clearly state the name and address of the ABTC/ABC. This can also be used as reference in cases of transfer/continuation of treatment and future management by other ABTC/ABC.

3.3. Report of Animal Bites

The Quarterly Report of Animal Bites will be filled out by the ABTC/ABC Nurse. The report on animal bite victims, which includes distribution of animal bite cases as to age, sex, geographic location, site of bite (lower or upper extremity, head/neck, trunk), category of exposure, vaccine and immunoglobulin use is submitted by the Animal Bite Treatment Centers to the Provincial and City

RECORDING AND REPORTING

Coordinators for consolidation and submission to the Regional Rabies Coordinator on a quarterly and yearly basis for program analysis and submitted to the National Rabies Prevention and Control Program Coordinator.

[illegible]

3.4. Summary of Human Rabies

The Summary of Human Rabies will be filled out by the Provincial/ City Medical or Nurse Coordinators. It provides information on patients' personal data, biting history, pre exposure prophylaxis and rabies history of human deaths.

[illegible]

3.5. All reports for submission should be reviewed, analyzed and signed by the ABTC/ABC physician.

CHAPTER IX:
MONITORING, SUPERVISION AND
EVALUATION

1. INTRODUCTION

Monitoring is the routine collection and tracking of key program data over time. Monitoring is a process that helps to identify problems early so that they can be corrected quickly. This requires that data be collected, compiled, and analyzed on a routine basis. Monitoring will provide information about the status and trends of the program that can help:

- Assess whether the program is meeting its targets
- Identify and improve problem areas in the implementation of NRPCP
- Check records and reports
- Ensure most effective and efficient use of resources

Supervision is an essential management tool to ensure the ABTC/ABC staff carry out the program's policies, standards, and procedures correctly, effectively, and efficiently. It is also an opportunity for supervisor to do the following:

- Discuss with ABTC/ABC facility staff important issues related to the program;
- Acknowledge and reinforce good performance;
- Help ABTCs/ABCs staff identify and correct inadequacies or weaknesses in its performance;
- Give feedback and solicit ideas on how to improve program implementation; and
- Provide mentoring to the ABTC/ABC staff.

While monitoring helps look at progress in indicators and helps in knowing if targets are reached, evaluation examines the process in greater depth and helps evaluators understand what the indicators are really telling.

Evaluations are typically conducted at specific time periods (for example, at the end of the year), whereas monitoring happens on a daily, monthly, and quarterly basis.

An evaluation of NRPCP will demonstrate how well the program has met the expected goals and targets.

2. POLICIES

- Monitoring of ABTC/ABC shall be done by Provincial /City/CHD NRPCP Coordinators every quarter. They shall see to it that ABTCs/ABCs follow the standards/directions and technical policies.
- The Provincial/City/CHD/ DOH NRPCP Program Coordinators shall regularly analyze data from quarterly reports and provide feedback of findings with corresponding recommendations to the staff or authorities concerned.
- Continuous advocacy efforts to secure commitment of LGUs to purchase anti rabies vaccine, RIG and other supplies.

3. PROCEDURES

3.1. Monitoring and Supervision Activities for ABTCs

Identify which ABTC/ABC should be visited frequently based on results of previous monitoring and supervisory visits. Use the following guidelines for monitoring and supervisory visits:

- a. Verify records such as PEP cards and Rabies Exposure Registry for accuracy and completeness of data entries.
- b. For PEP card, randomly verify/inspect the card of patients whether schedule of next visits are written at the back of the card while actual date of visit/actual ARV administration are recorded inside the card. Should be consistent with the Rabies Exposure Registry Data.
- c. In the Rabies Exposure Registry, bites due to rats, rabbits, snakes and other reptiles, birds and other avian, insects and fish are not included.
- d. Calculate completion rate of last quarter's total number of registered cases. Verify reasons of non completion of treatment.
- e. Observe ABTC/ABC staff administering ID dose and RIG infiltration if correct dose is given and procedures are done correctly.
- f. Observe ABTC/ABC staff giving correct and relevant health education to the patients,
- g. Interview ABTC staff and patients
- h. Conduct physical inventory of vaccines and other supplies including proper storage.
- i. Compute supplied/distributed drugs and the number of doses given and check the remaining doses/vials in the refrigerator.
- j. Coordinators/supervisors must share relevant information and recommendations arising from the visit in writing preferably in the

MONITORING, SUPERVISION AND EVALUATION

supervisory logbook, with the ABTC/ABC staff concerned. Courses of actions to address deficiencies or mistakes must be thoroughly discussed and solutions agreed upon by the supervisor/coordinator and staff. Make sure the issues and recommendations written have been addressed in the next visit.

The ABTC nurse/physician prepares, analyzes, and submits the Quarterly report on Animal Bite Victims , Quarterly Report of Human Rabies Cases and Quarterly Cohort Analysis

Every ABTC/ABC must seek for certification to ensure that quality rabies exposures management services is implemented in both public (Animal Bite Treatment Centers) and private (Animal Bite Centers) facilities. It provides an assurance to all animal bite cases that these facilities are capable of providing quality, safe, affordable and effective rabies exposures prophylaxis services. Furthermore, certification ensures standardization of the provision of bite exposures management and treatment services through a uniform set of standards.

ANNEXES:

1. Anti Rabies Act of 2007 (RA 9482)
2. Implementing Rules and Regulations of the Anti-Rabies Act of 2007
3. Executive Order No. 84 – Declaring March as the Rabies Awareness Month
4. DILG Memorandum Circular 2011-30 Strict Implementation of the Anti-Rabies Act
5. Joint DA-DOH AO – Guidelines Declaring Areas as Rabies Free Zones
6. DOH AO 2007-0029 – Revised Guidelines on Management of Animal Bite Patients
7. DOH AO 2009-0027 – Amendment to AO 2007-2009 on the Revised Guidelines on Management of Animal Bite Patients
8. DOH AO 2011-0002/DA AO 01,s 2011 - Guidelines for Managing Rabies Exposures Secondary to Bites by Vaccinated Dogs and Cats
9. DOH AO No 2013 0004 – Implementing Guideline on the conduct of Animal Bite Treatment Centers (ABTC) and Animal Bite Centers (ABC) Certification of the National Rabies Prevention and Control Program
10. ABCT/ABC Self Assessment Form

Date 2007-06-22

(RA 9482)

S. No. 2541

H. No. 4654

Republic of the Philippines
Congress of the Philippines

Metro Manila

Thirteenth Congress

Third Special Session

Begun and held in Metro Manila, on Monday, the nineteenth day of February, two thousand seven.

—□—

REPUBLIC ACT No. **9482**

AN ACT PROVIDING FOR THE CONTROL AND ELIMINATION OF HUMAN AND ANIMAL RABIES, PRESCRIBING PENALTIES FOR VIOLATION THEREOF AND APPROPRIATING FUNDS THEREFOR

*Be it enacted by the Senate and House of Representatives
of the Philippines in Congress assembled:*

SECTION 1. *Title.* – This Act shall be known as the “Anti-Rabies Act of 2007”.

SEC. 2. *Declaration of Policy.* – It is the declared policy of the State to protect and promote the right to health of the people. Towards this end, a system for the control, prevention of the spread, and eventual eradication of human and animal Rabies shall be provided and the need for responsible pet ownership established.

SEC. 3. *Definition of Terms.* – For the purpose of this Act, the following terms shall mean:

- (a) *Bitten* refers to an act by which a Dog seizes, cuts or grips with its teeth so that the skin of a person has been wounded, pierced or scratched.
- (b) *Concerned Officials* refer to barangay officials, health workers, police officers or government veterinarians.
- (c) *Direct Supervision* refers to range supervision where physical presence of the veterinarian within the barangay is necessary.

- (d) *Dog* refers to a common quadruped domestic animal belonging to the order carnivora (male or female), scientifically known as *canis familiaris*.
- (e) *Euthanasia* refers to the process of painless death to Dogs and other animals.
- (f) *Impound* refers to seize and hold in the custody of the law.
- (g) *Owner* refers to any person keeping, harboring or having charge, care or control of a Dog including his/her representative.
- (h) *Pound* refers to a public enclosure for stray animals.
- (i) *Public Place* refers to any place open to the public like parks, malls, markets, streets, etc.
- (j) *Rabies* refers to a highly fatal disease caused by a lyssa virus, transmitted mainly through the bite of an infected animal and is characterized by muscle paralysis, hydrophobia and aerophobia, and other neurological manifestations.
- (k) *Rabies transmission* refers to the transmission or passage of the Rabies virus through a bite by an infected animal, or through contamination with virus-laden saliva on breaks in the skin and of mucous membranes such as the eyes, the lips, the mouth, or the genital organs.
- (l) *Rabies Vaccination/Immunoprophylaxis of Humans* refers to the inoculation of humans, with modern day rabies vaccines or Rabies immunoglobulin, by a trained doctor or nurse under the supervision of a qualified medical practitioner.
- (m) *Rabies Vaccination of Dogs* refers to the inoculation of a Dog with a Rabies vaccine by a licensed government or private veterinarian or trained individual under the direct supervision of a licensed veterinarian. The services of the said trained individual shall be limited only to Rabies Vaccination Injection in Dogs and only during government mass vaccination campaigns.
- (n) *Post-exposure Treatment (P.E.T.)* refers to an anti-Rabies treatment administered after an exposure to Rabies, which include local wound care, Rabies vaccine, with or without anti-Rabies immunizing agent.
- (o) *Pre-exposure Prophylaxis (P.E.P.)* refers to Rabies vaccination administered before an exposure to Rabies to those who are at high risk of getting Rabies.
- (p) *Stray Dog* refers to any Dog leaving its Owner's place or premise and no longer under the effective control of the Owner.
- (q) *Veterinary or Human Barbiturates* refer to drugs that depress the function of the central nervous system.

SEC. 4. National Rabies Prevention and Control Program. – It is hereby mandated that there shall be a National Rabies Prevention and Control Program to be implemented by a multi-agency/multi-sectoral committee chaired by the Bureau of Animal Industry of the Department of Agriculture. The program shall be a multi-agency effort in controlling and eliminating Rabies in the country. Among its component activities include: (1) mass vaccination of Dogs; (2) establishment of a central database system for registered and vaccinated Dogs; (3) impounding, field control and disposition of unregistered, Stray and unvaccinated Dogs; (4) conduct of information and education campaign on the prevention and control of Rabies; (5) provision on pre-exposure treatment to high risk personnel and Post Exposure Treatment to animal bite victims; (6) provision of free routine immunization or Pre-Exposure Prophylaxis (P.E.P.) of schoolchildren aged five to fourteen in areas where there is high incidence of rabies as well as the (7) encouragement of the practice of responsible pet ownership. The program shall be implemented by the Department of Agriculture (DA), Department of Health (DOH), Department of the Interior and Local Government (DILG) and Department of Education (DepEd), as well as Local Government Units (LGUs) with the assistance of the Department of Environment and Natural Resources (DENR), Non-Governmental Organizations (NGOs) and People's Organizations (POs).

SEC. 5. Responsibilities of Pet Owners. – All Pet Owners shall be required to:

- (a) Have their Dog regularly vaccinated against Rabies and maintain a registration card which shall contain all vaccinations conducted on their Dog, for accurate record purposes.
- (b) Submit their Dogs for mandatory registration.
- (c) Maintain control over their Dog and not allow it to roam the streets or any Public Place without a leash.
- (d) Be a responsible Owner by providing their Dog with proper grooming, adequate food and clean shelter.
- (e) Within twenty-four (24) hours, report immediately any Dog biting incident to the Concerned Officials for investigation or for any appropriate action and place such Dog under observation by a government or private veterinarian.
- (f) Assist the Dog bite victim immediately and shoulder the medical expenses incurred and other incidental expenses relative to the victim's injuries.

SEC. 6. Responsibilities of Government Agencies. – The following government agencies, which shall jointly implement the National Rabies Prevention and Control Program, shall be tasked to:

A. Department of Agriculture

- (1) Improve and upgrade existing animal Rabies laboratory diagnostic capabilities to ensure better services to the people.
- (2) Ensure the availability and adequate supply of animal anti-Rabies vaccine at all times.
- (3) Undertake free anti-Rabies Vaccination of Dogs giving priority to high risk depressed areas.
- (4) Maintain and improve animal Rabies surveillance system.
- (5) Establish and maintain Rabies free zone in coordination with the LGUs.
- (6) Immediately facilitate for the approval of the sale and use of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs by the DOH and the Philippine Drug Enforcement Agency (PDEA).
- (7) Strengthen the training of field personnel and the Information Education and Communication (IEC) activities on Rabies prevention and control and responsible pet ownership.
- (8) Conduct research on Rabies and its control in coordination with other agencies.
- (9) Formulate minimum standards and monitor the effective implementation of this Act.
- (10) Encourage collaborative activities with the DOH, DepEd, DILG, DENR, NGOs, POs and other concerned sectors.

B. Department of Health

- (1) Ensure the availability and adequate supply of DOH pre-qualified human Anti-Rabies vaccine in animal bite treatment centers at all times and shall coordinate with other implementing agencies and concerned NGOs for this purpose.
- (2) Provide Post-Exposure Treatment at the minimum expense to individuals bitten by animals suspected of being rabid which will consist of the initial vaccine and immunoglobulin dose.
- (3) Provide Pre-Exposure Treatment to high-risk personnel, such as, but not limited to, laboratory staff, veterinarians, animal handlers, vaccinators and other persons working with Rabies virus for free.
- (4) Coordinate with the DA in the development of appropriate health education strategy to inform the public on Rabies prevention and control and responsible pet ownership.
- (5) Develop and maintain a human Rabies surveillance system.
- (6) Encourage collaborative activities with the DA, DepEd, DILG, DENR, NGOs, POs and other concerned sectors.
- (7) Immediately approve the registration of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs in coordination with the PDEA.

C. Department of Education

- (1) Strengthen Rabies education program through school health teaching/curriculum.
- (2) Assist in the Dog mass immunization campaigns in the community.
- (3) Encourage collaborative activities with the DA, DOH, DILG, DENR, NGOs, POs and other concerned sectors.
- (4) Integrate proper information and education on responsible pet ownership in the relevant subjects in the Elementary and High School levels.

SEC. 7. *Responsibilities of the LGUs.* – LGUs, in their respective localities, shall:

- (1) Ensure that all Dogs are properly immunized, registered and issued a corresponding Dog tag for every immunized and registered Dog.
- (2) Strictly enforce Dog Impounding activities and field control to eliminate Stray Dogs.
- (3) Ensure that Dogs are leashed or confined within the premises of the Owner's house or Owner's fenced surroundings.
- (4) Allocate funds to augment the implementation of the National Rabies Prevention and Control Program, particularly on the financing of supplies and human and Dog vaccines needed for immunization.
- (5) Ensure the enforcement of Section 6 of Republic Act No. 8485 or "The Animal Welfare Act of 1998".

(6) Enact additional local ordinances that will support the National Rabies Prevention and Control Program that should include the regulation of treatment locally known as “tandok.”

(7) Prohibit the trade of Dogs for meat.

(8) With respect to cities and first class municipalities, establish and maintain a Dog Pound where Impounded Dogs shall be kept, in accordance with Section 9 herein: *Provided*, That the other municipalities, shall, on their own, establish a Dog Pound or opt to share the expense of establishing and maintaining a Dog Pound with other adjoining municipalities and/or with private animal shelters and control facilities.

(9) Prohibit the use of electrocution as a euthanasia procedure.

(10) Appoint a veterinarian and establish a veterinary office in every province, city and first-class municipality: *Provided*, That the other municipalities shall, on their own, opt to share the expense of having a veterinary office.

(11) Require pet shops to post information regarding Rabies and responsible pet ownership.

(12) For purposes of ensuring the administrative feasibility of implementing the provisions of this Act and subject to paragraph 8 of this Section, the LGU shall collect the fines imposed under Section 11 subparagraphs (1), (3), (4), (5) and (6) hereof.

Any and all fines collected pursuant to this Act shall be used for the enhancement of the National Rabies Prevention and Control Program within the locality concerned, as well as the achievement of the objectives envisioned in this Act.

The DILG shall ensure compliance of these responsibilities by the LGUs.

SEC. 8. Assistance of NGOs and the Academe. – The agencies tasked to implement the anti-Rabies program shall seek the assistance and participation of NGOs in any of the following activities:

- (1) Community mobilization.
- (2) Health education/information dissemination on Rabies and responsible pet ownership.
- (3) Mass anti-Rabies campaign.
- (4) Promotion of the anti-Rabies campaign during pet or any animal shows.
- (5) Surveillance/reporting of Rabies cases in animals and humans.
- (6) Any other activities geared towards the prevention and complete eradication of Rabies.

SEC. 9. Impounding, Field Control and Disposition of Unregistered, Stray and Unvaccinated Dogs. – Unregistered, Stray or unvaccinated Dogs shall be put in Dog Pounds and disposed of, taking into consideration the following guidelines:

- (1) Unregistered, Stray or unvaccinated Dogs shall be impounded and kept in the LGU’s designated Dog Pound.

(2) Impounded Dogs not claimed after three days from the Dog Pound shall be placed for adoption to qualified persons, with the assistance of an animal welfare NGO, when feasible, or otherwise disposed of in any manner authorized, subject to the pertinent provisions of Republic Act No. 8485, otherwise known as the "Animal Welfare Act of 1998".

(3) A fee shall be paid by Owners of Impounded Dogs to the LGU concerned, pursuant to Section 7 hereof.

SEC. 10. Dog Population Control. – In furtherance of the policy of this Act to eradicate Rabies, there is the need to control the Dog population and minimize the number of unwanted Stray Dogs. As such, it is hereby mandated:

(1) That the DA, DOH, DILG, DepEd, LGUs, with the assistance of NGOs and POs shall undertake an educational and promotional campaign on responsible Pet Ownership, including the option of spaying or neutering their Dogs.

(2) That the LGUs shall provide an incentive system whereby Owners of Dogs which have been spayed or neutered will be given a subsidized or discounted pet registration fee.

(3) That Dogs which have been impounded three times shall only be released after having been spayed or neutered, at the expense of the Pet's Owner.

SEC. 11. Penalties. –

(1) Pet Owners who fail or refuse to have their Dog registered and immunized against Rabies shall be punished by a fine of Two thousand pesos (P2,000.00).

(2) Pet Owners who refuse to have their Dog vaccinated against Rabies shall be liable to pay for the vaccination of both the Dog and the individuals Bitten by their Dog.

(3) Pet Owners who refuse to have their Dog put under observation after said Dog has Bitten an individual shall be meted a fine of Ten thousand pesos (P10,000.00).

(4) Pet Owners who refuse to have their Dog put under observation and do not shoulder the medical expenses of the person Bitten by their Dog shall be meted a fine of Twenty-five thousand pesos (P25,000.00).

(5) Pet Owners who refuse to put leash on their Dogs when they are brought outside the house shall be meted a fine of Five hundred pesos (P500.00) for each incident.

(6) An impounded Dog shall be released to its Owner upon payment of a fine of not less than Five hundred pesos (P500.00) but not more than One thousand pesos (P1,000.00).

(7) Any person found guilty of trading Dog for meat shall be fined not less than Five thousand pesos (P5,000.00) per Dog and subjected to imprisonment for one to four years.

(8) Any person found guilty of using electrocution as a method of euthanasia shall be fined not less than Five thousand pesos (P5,000.00) per act and subject to imprisonment for one to four years.

(9) If the violation is committed by an alien, he or she shall be immediately deported after service of sentence without any further proceedings.


SEC. 12. *Implementing Rules and Regulations.* – The DA, in coordination with the DOH, DILG, DepEd, DENR, NGOs and POs shall issue the necessary rules and regulations within sixty (60) days from the effectivity of this Act.


SEC. 13. *Appropriations.* – The amount of One hundred million pesos (P100,000,000.00) necessary to implement the provisions of this Act shall be initially charged against the appropriations of the DOH, DA, DILG and DepEd under the General Appropriations Act. For the LGUs, the requirements shall be taken from their Internal Revenue Allotment and other local funds. Thereafter, such sums as may be necessary for its continued implementation shall be included in the annual General Appropriations Act.

SEC. 14. *Separability Clause.* – In case any provision of this Act is declared unconstitutional, the other provisions shall remain in full force and effect.

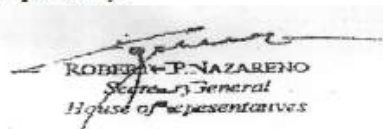
SEC. 15. *Effectivity.* – This Act shall take effect fifteen (15) days after its publication in the *Official Gazette* or in at least two newspapers of general circulation, whichever comes earlier.

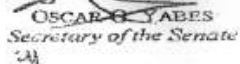
Approved,


JOSE DE VENEZIA JR.
Speaker of the House
of Representatives


MANNY VILLAR
President of the Senate

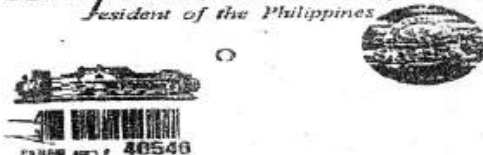
This Act which is a consolidation of Senate Bill No. 2541 and House Bill No. 4654 was finally passed by the Senate and the House of Representatives on February 9, 2007 and February 20, 2007 respectively.


ROBERT P. NAZARENO
Secretary General
House of Representatives


OSCAR G. YABES
Secretary of the Senate

Approved: MAY 25 2007


GLORIA MACAPAGAL-ARROYO
President of the Philippines





Joint DA, DOH, DepEd, DILG Administrative Order No. 01
Series of 2008

**Implementing Rules and Regulations Implementing
Republic Act 9482 An Act Providing for the Control and
Elimination of Human and Animal Rabies, Prescribing Penalties for
Violation Thereof and Appropriating Funds Therefor**

TITLE

Section 1. Title - *This Act shall be known as the Anti-Rabies Act of 2007*

Rule 1. These Implementing Rules and Regulations (IRR) are issued and promulgated pursuant to Sec. 12 of Republic Act 9482. These rules are promulgated to prescribe the procedures and guidelines for the implementation of the Anti-Rabies Act of 2007 to facilitate compliance and achieve the objectives thereof.

DECLARATION OF POLICY AND DEFINITION OF TERMS

Section 2. Declaration of Policy- *It is the declared policy of the state to protect and promote the right to health of the people. Towards this end, a system for the control, prevention of the spread, and eventual eradication of human and animal Rabies shall be provided and the need for responsible pet ownership established.*

Section 3. Definition of Terms- *For the purpose of this Act, the following shall mean:*

- (a) *Bitten refers to an act by which a Dog seizes, cuts or grips with its teeth so that the skin of a person has been wounded, pierced or scratched.*
- (b) *Concerned officials refer to barangay officials, health workers, police officers or government veterinarians.*
- (c) *Direct supervision refers to range supervision where physical presence of the veterinarian within the barangay is necessary.*
- (d) *Dog refers to a common quadruped domestic animal belonging to the order carnivora (male or female), scientifically known as canis familiaris*
- (e) *Euthanasia refers to the process of painless death to Dogs and other animals.*
- (f) *Impound refers to seize and hold in the custody of the law.*
- (g) *Owner refers to any person keeping, harbouring or having charge, care or control of a Dog including his/her representative.*
- (h) *Pound refers to a public enclosure for stray animals.*
- (i) *Public Place refers to any place open to the public like parks, malls, markets, streets, etc.*
- (j) *Rabies refers to a highly fatal disease caused by a lyssa virus, transmitted mainly through the bite of an infected animal and is characterized by muscle paralysis, hydrophobia and aerophobia, and other neurological manifestations.*
- (k) *Rabies transmission refers to the transmission or passage of the Rabies Virus through a bite by an infected animal, or through contamination with virus-laden saliva on breaks in the skin and of mucous membranes such as the eyes, the lips, the mouth, or the genital organs.*
- (l) *Rabies Vaccination/Immunoprophylaxis of Humans refers to the inoculation of humans, with modern day rabies vaccines or Rabies immunoglobulin, by a trained doctor or nurse under the supervision of a qualified medical practitioner.*

- (m) *Rabies Vaccination of Dogs refers to the inoculation of a Dog with Rabies vaccine by a licensed government or private veterinarian or trained individual under the direct supervision of a licensed veterinarian. The services of the said trained individual shall be limited only to Rabies Vaccination Injection in Dogs and only during government mass vaccination campaigns.*
- (n) *Post-exposure Treatment (P.E.T.) refers to an anti-Rabies treatment administered after an exposure to Rabies which includes local wound care, rabies vaccine, with or without anti-Rabies immunizing agent.*
- (o) *Pre-exposure Prophylaxis (P.E.P.) refers to Rabies vaccination administered before an exposure to Rabies to those who are at high risk of getting Rabies.*
- (p) *Stray Dog refers to any Dog leaving its Owner's place or premise and no longer under the effective control of the Owner.*
- (q) *Veterinary or Human Barbiturates refer to drugs that depress the function of the central nervous system.*

Rule 3.1. The acronyms as used in this IRR are as follows:

- (a) ABC – Animal Bite Clinic
- (b) ABTC – Animal Bite Treatment Center
- (c) AHD- Animal Health Division
- (d) BAI- Bureau of Animal Industry
- (e) BFAD- Bureau of Food and Drugs
- (f) CHD – Center for Health and Development
- (g) CHO- City Health Office
- (h) DA- Department of Agriculture
- (i) DA-RFUs- Regional Field Units of the Department of Agriculture
- (j) DECS- Department of Education, Culture and Sports
- (k) DENR- Department of Environment and Natural Resources
- (l) DepED- Department of Education
- (m) DSWD - Department of Social Work and Development
- (n) DILG- Department of Interior and Local Government
- (o) DOH- Department of Health
- (p) IEC- Information, Education and Communication
- (q) IRA- Internal Revenue Allotment
- (r) IRR- Implementing Rules and Regulations
- (s) LGU- Local Government Unit
- (t) LRCC- Local Rabies Control Committee
- (u) MAO – Municipal Agriculture Office
- (v) MHO- Municipal Health Office
- (w) NCDPC- National Center for Disease Prevention and Control
- (x) NGO- Non-Government Organization
- (y) NRPCC- National Rabies Prevention and Control Committee
- (z) OIE – *Office International des Epizooties*
- (aa) PCMVLP- Provincial, City and Municipal Veterinarians' League of the Philippines
- (bb) PDEA- Philippine Drug Enforcement Agency
- (cc) PO- Peoples' Organization
- (dd) PRC – Professional Regulation Commission
- (ee) PTR – Professional Tax Receipt
- (ff) RPO- Responsible Pet Ownership
- (gg) TIN – Tax Identification Number
- (hh) WHO – World Health Organization

Rule 3.2. Other terms used in this IRR are defined hereunder:

- (a) Adoption refers to taking up and making one's own, homeless dogs/pets.
- (b) Animal Bite Treatment Center refers to the government facilities providing PEP and

- (c) Animal control facility refers to a facility that accepts and/or seizes animals for the purpose of caring for them, placing them through adoption, or carrying out law enforcement, whether or not the facility is operated for profit. This includes facilities such as, but not limited to pounds, shelters, animal rescue centers, airport quarantine and animal holding facilities, transportation depots and stations.
- (d) Carcass disposal refers to the acceptable and safe method of getting rid of the dead animals.
- (e) Central database refers to the compilation of information regarding all registered and vaccinated dogs handled by a single entity.
- (f) Committee in this document shall refer to the National Rabies Prevention and Control Committee.
- (g) Dog farming refers to the raising of dogs for meat, fur and other articles intended for human use/consumption.
- (h) Field Control refers to managing the movement of dogs in public places.
- (i) High Risk Personnel refers to people who in the course of their occupation are directly or indirectly exposed to rabies such as but not limited to laboratory staff, veterinarian, animal handlers, and vaccinators.
- (j) High Risk Depressed Areas refers to areas defined and identified by the Committee as such.
- (k) Human rabies high incidence areas refer to areas defined and identified by the Committee as such.
- (l) Information, Education and Communication refers to the approaches to disseminate information on rabies awareness and advocacy to RPO.
- (m) Mandatory Registration refers to the requirement for all dog owners to submit their dogs for registration in the LGU.
- (n) Mass vaccination refers to the inoculation of at least 80% of the unvaccinated dog population within a month in the concerned LGU.
- (o) Neutering refers to the surgical removal under anesthesia of the ovaries and uterus in the female and testicles for the male animals.
- (p) NGO refers to a private, non-stock and non-profit organization formed to provide welfare and development services.
- (q) PO refers to non-profit organization with identifiable leaderships, structures and is membership-based, largely voluntary organizations that operate at the grass-roots level that promote their members interests and are established primarily to serve the needs of a particular sector.
- (r) Pet Owner refers to any person keeping, harbouring or having charge, care or control of a dog including his/her representative.
- (s) Properly immunized dogs refer to dogs inoculated against rabies yearly.
- (t) Rabies Free Zone refers to areas/zones that have been declared by the DA and DOH as free from rabies as recommended by the Committee.
- (u) Rabies Surveillance system refers to the procedures set to monitor and detect occurrence of human or animal rabies cases.
- (v) Responsible pet ownership refers to proper care of pet including veterinary care, vaccinations, de-worming, feeding, shelter and provision of activities to promote health and development.
- (w) “Tandok” refers to a person or the practice of applying traditional remedies in relation to dog bites.

NATIONAL RABIES PREVENTION AND CONTROL PROGRAM

Section 4. *National Rabies Prevention and Control Program. It is hereby mandated that there shall be a National Rabies Prevention and Control Program to be implemented by a multi-agency/multi-sectoral committee chaired by the Bureau of Animal Industry of the Department of Agriculture. The program shall be a multi-agency effort in controlling and eliminating Rabies in the*

country. Among its component activities include: (1) mass vaccination of Dogs; (2) establishment of a central database system for registered and vaccinated Dogs; (3) impounding field control and disposition of unregistered, Stray and unvaccinated Dogs; (4) conduct of information and education campaign on the prevention and control of Rabies; (5) provision on pre-exposure treatment to high risk personnel and Post Exposure Treatment to animal bite victims; (6) provision of free routine immunization or Pre-Exposure Prophylaxis (P.E.P.) of schoolchildren aged five to fourteen in areas where there is high incidence of rabies as well as the (7) encouragement of the practice of responsible pet ownership. The program shall be implemented by the Department of Agriculture (DA), Department of Health (DOH), Department of Interior and Local Government (DILG) and Department of Education (DepEd) as well as Local Government Units (LGUs) with the assistance of the Department of Environment and Natural Resources (DENR), Non-Governmental Organizations (NGOs) and People's Organizations (POs).

Creation of the National Rabies Prevention and Control Committee (NRPCC)

Rule 4.1. There shall be created a National Rabies Prevention and Control Committee (herein referred to as the Committee) chaired by the DA- BAI and vice-chaired by the DOH-NCDPC. The committee members shall be composed of one duly authorized representative for each of the following departments: DA, DOH, DILG and DepEd. One representative each for the following: DENR, NGOs, POs, academe, LGUs, and PCMVLP shall be appointed by the Chairman as members of the committee.

Rule 4.1.1. The Committee may create technical working groups which shall likewise be multi-sectoral or multi agency for the purpose of assisting the committee.

Rule 4.1.2. The DA-BAI shall act as secretariat for the Committee. The secretariat shall be responsible among others in sending of notices, keeping all minutes, records and documents relative to the meetings or deliberations of the committee.

Rule 4.1.3. The Committee shall have regular monthly meetings or as often as maybe necessary to implement the Program.

Rule 4.1.4. The Committee shall establish the appropriate organizational structure and internal rules governing its operation and management to ensure orderly, consistent and full cooperation of its members 15 days after the effectivity of the IRR.

Rule 4.1.5. The Committee shall be primarily responsible for formulating the National Rabies Prevention and Control Program hereinafter, referred to as the Program, and recommend additional rules and regulations as maybe necessary in the implementation thereof.

Rule 4.1.6. The programs initiated by the existing National Rabies Committee and the Rabies Control Consultative Committee created by virtue of a memorandum of agreement between DA, DOH, DILG and DECS (now known as DepEd) dated May 9, 1991 shall whenever possible be integrated/absorbed in the program.

Rule 4.1.7. The Committee shall likewise be responsible for the following:

- a. It shall identify activities, projects and priority areas for rabies elimination.
- b. It shall prepare and recommend the work and financial plan for the Program for inclusion in the respective agency budget proposals under the General Appropriations Act.
- c. It shall identify other sources of funds and authorize receipt of grants/donations to support the implementation of the Program.
- d. It shall prepare and recommend the operational budget of the Committee and its Secretariat for inclusion in the annual appropriations of the DA and DOH.

- e. It shall monitor the activities contained in the Program by the participating agencies and organizations.
- f. It shall recommend and coordinate the conduct of researches on rabies, its prevention, control and eradication in coordination with other agencies.
- g. It shall recommend the rabies-free areas for the joint declaration of the DA and DOH.
- h. It shall conduct a national performance evaluation annually or as deemed necessary and assess if the objectives of the program were achieved. Corollarily, it shall prepare the national annual report.

Component Activities Of The National Rabies Prevention And Control Program

Rule 4.2. The Program shall have component activities including but not limited to:

Rule 4.2.1. Mass Registration and Vaccination of Dogs

- a. The LGUs shall implement the mass registration and vaccination of dogs in accordance with the program set forth by the Committee.
- b. The initial national mass registration and vaccination shall commence not later than March 31, 2008 to coincide with the Rabies Awareness Month and thereafter it shall be held annually.
- c. In all cases, the vaccination of dogs shall be performed by a duly licensed veterinarian or by a trained vaccinator under direct veterinary supervision.
- d. All dogs shall be registered by their owners with their respective LGUs. Owners with vaccinated dogs shall submit record or proof of vaccination signed by a duly licensed veterinarian upon registration.
- e. Transfer of ownership of dogs and its subsequent registration shall be covered by appropriate rules to be set by the Committee.
- f. The Committee shall prescribe the appropriate dog tagging/identification system to be used by the LGU and private practitioners and may impose collection of fees therefor.
- g. Only inactivated rabies vaccines registered and licensed by the BAI and recommended by the Committee shall be used.
- h. Vaccination protocol for special cases shall be issued by the Committee when necessary.
- i. All mass vaccination conducted by NGOs, POs and private entities shall always be coordinated with the respective LGUs.

Rule 4.2.2. Establishment of a central database system for registered and vaccinated dogs

- a. A central database system for registered and vaccinated dogs shall be established by the BAI as depository of records from the data submitted monthly by the LGU Veterinary Services.
- b. The BAI shall collate from the submitted reports of LGUs copy furnished the DA-RFUs, the total registered, vaccinated dogs and other relevant information as basis for policy formulation.

Rule 4.2.3. Impounding, field control and disposition of unregistered, stray and unvaccinated dog

- a. The Committee shall set and establish the standards/guidelines for the impounding, field control and disposition of unregistered, stray, unvaccinated dogs.
- b. A central registry of government and private animal control facilities shall be established by the Animal Welfare Division of the DA-BAI.

Rule 4.2.4. Conduct of information and education campaign on the prevention and control of rabies

- a. Rabies education and Responsible Pet Ownership (RPO) modules as approved by the Committee shall be included in elementary and high school curriculum.
- b. Public lectures on responsible pet ownership and rabies awareness shall be conducted.
- c. The Rabies Awareness Month (March) and the World Rabies Day (28th of September) shall be observed nationwide.
- d. Rabies informational materials shall be made readily available by all concerned agencies.

Rule 4.2.5. Provision on pre-exposure treatment to high risk personnel and Post-Exposure Treatment to animal bite victims

- a. All hired personnel or volunteers of private or government facilities including but not limited to veterinary clinics, hospitals and offices, hospitals with human rabies units, rabies diagnostic laboratories, animal control facilities and all other similar establishments shall receive rabies pre-exposure prophylaxis prior to working.
- b. The Committee in consultation with the DOH shall set the guidelines for the implementation of the PEP including that for the establishment of ABTC and ABCs.
- c. ABTCs shall be established to provide PET to all animal bite victims from all cities and/or municipalities.

Rule 4.2.6. Provision of free routine immunization or Pre-Exposure Prophylaxis (P.E.P) of schoolchildren aged five to fourteen in areas where there is high incidence of rabies

- a. The Committee shall identify areas where there is high incidence of rabies necessitating P.E.P for school children aged five to fourteen.
- b. The Committee shall ensure that the DOH, in coordination with the LGUs, DepEd and DSWD shall provide free routine pre- exposure prophylaxis of schoolchildren aged five to fourteen in those areas identified pursuant to 4.2.6.a.
- c. The Program, through the DOH, shall encourage the inclusion of anti-rabies vaccination among the recommended childhood immunization.

Rule 4.2.7. Encouragement of the practice of responsible pet ownership

- a. All committee members tasked to implement the program shall undertake activities in promoting Responsible Pet Ownership.
- b. Concerned citizens shall report to the proper authorities the presence of stray or abandoned dogs, instances of abuse or irresponsible actions of dog owners such as but not limited to neglect and infliction of harm.

- c. Pet owners shall be provided information on RPO such as grooming, health care, proper nutrition, shelter, and others during registration and vaccination events.

Section 5. Responsibility of Pet Owners.- All Pet Owners shall be required to:

- (a) *Have their Dog regularly vaccinated against rabies and maintain a registration card which shall contain all vaccinations conducted on their dog, for accurate record purposes.*
 - Rule 5(a)1. The pet owner shall keep the LGU issued registration card containing the permanent number, physical characteristics of the dog including but not limited to age, color, sex, breed, distinguishing marks and others.
 - Rule 5(a)2. The registration card shall be presented during annual revaccination and when deemed necessary.
 - Rule 5(a)3. The registration card shall likewise contain all rabies vaccinations conducted on their Dog. The record shall indicate the registration number of the dog, date of vaccination, the attending veterinarian, with the corresponding updated PRC license, TIN and PTR numbers and shall be signed by the same.
- (b) *Submit their Dogs for mandatory registration.*
 - Rule 5(b)1. The pet owner shall renew the registration of their dogs with the LGU Veterinary Services, Municipal Agriculture Offices or appropriate government office annually.
- (c) *Maintain control over their Dog and not allow it to roam the streets or any Public Place without a leash.*
 - Rule 5(c)1. The length of the leash shall not be more than 1.5 meters (5 feet) and the required dog tag shall be attached to the dog collar/harness. Aggressive dogs shall be muzzled in public places.
 - Rule 5(c)2. The Committee shall issue guidelines on the handling of dogs in designated dog activity areas.
 - Rule 5(c)3. The owner shall be responsible for the proper collection and disposal of excreta/feces.
- (d) *Be a responsible Owner by providing their Dog with proper grooming, adequate food and clean shelter.*
 - Rule 5(d)1. Pet owners shall maintain good human-animal relationship and provide good health management program for their dogs.
- (e) *Within twenty-four (24) hours, report immediately any Dog biting incident to the Concerned Officials for investigation or for any appropriate action and place such Dog under observation by a government or private veterinarian.*
 - Rule 5(e)1. The dog shall not be killed or euthanized during the observation period of 14 days from the biting incident.
 - Rule 5(e)2. Should the dog die during the observation period, the pet owner shall immediately submit the dog for rabies laboratory examination.
 - Rule 5(e)3. Unvaccinated dogs bitten by a confirmed rabid animal shall be euthanized immediately and disposed of properly.
 - Rule 5(e)4. Dogs bitten by another dog suspected to be rabid or of unknown status should be confined and maintained under veterinary supervision for 6 months.
 - Rule 5(e)5. If the animal has been vaccinated previously (and its vaccination certificate is available) and can be identified with certainty (e.g. tattoo) it should be revaccinated

immediately and confined for at least 90 days. Post-exposure vaccination of uncertain effectiveness should be discouraged.

- (f) *Assist the Dog bite victim immediately and shoulder the medical expenses incurred and other incidental expenses relative to the victim's injuries.*

Rule 5(f).1. Humans bitten by dogs shall be provided treatment by the appropriate government or private medical practitioner. Animals bitten by dogs shall be provided treatment by the appropriate government or private veterinary practitioner.

Section 6. Responsibilities of Government Agencies. - *The following government agencies, which shall jointly implement the National Rabies Prevention and Control Program, shall be tasked to:*

A. Department of Agriculture

- (1) *Improve and upgrade existing animal rabies laboratory diagnostic capabilities to ensure better services to the people.*

Rule 6A (1).1. It shall be the duty of the DA to ensure and maintain accurate diagnosis by improving and upgrading existing animal Rabies diagnostic laboratories with confirmatory capabilities through the following:

- a. comply with WHO and OIE's minimum standard requirements for the national, regional and satellite rabies diagnostic laboratories.
- b. develop and maintain capable manpower complement for all the rabies diagnostic laboratories. The DA shall allocate funds for the incentives of laboratory personnel under the Magna Carta for public health workers and similar programs.
- c. adopt guidelines drafted by the Committee on Quality Assurance and requirements of rabies diagnostic laboratories.
- d. accredit rabies diagnostic laboratories (by the BAI).
- e. ensure continuous availability of reagents and supplies in the regional laboratories for the diagnosis of animal rabies.
- f. in cooperation with the DOH, shall conduct regular training/refresher courses for personnel of the rabies diagnostic laboratories including laboratory biosafety procedures and proper disposal of specimens and carcasses.

- (2) *Ensure availability and adequate supply of animal anti-rabies vaccines at all times.*

Rule 6A (2).1. The DA may seek assistance from other agencies to augment available dog rabies vaccines to effectively carry out this program.

- (3) *Undertake free anti-Rabies vaccination of Dogs giving priority to high risk depressed areas.*

Rule 6A (3).1. The DA, in coordination with the LGU and other member agencies, shall spearhead mass vaccination in the high risk depressed areas identified by the Committee.

- (4) *Maintain and improve animal rabies surveillance system.*

Rule 6A (4).1. Considering that Rabies is a notifiable disease, the DA shall issue a directive for the compulsory reporting of dogs suspected of being rabid.

Rule 6A (4).2. All owners/operators of animal facilities shall be required by the DA to report incidents of animal rabies in their facilities.

Rule 6A (4).3. The DA shall ensure that laboratory tests are conducted to confirm reports of incidence of rabies.

Rule 6A (4).4. The DA shall direct and ensure that there is a thorough investigation of all incidences of reported dog rabies cases.

- (5) *Establish and maintain Rabies free zone in coordination with the LGUs.*

- Rule 6A (5).1. In collaboration with the DOH, the DA shall establish and maintain Rabies-Free zones in accordance with OIE guidelines for declaration of Free zone.
- (6) *Immediately facilitate for the approval of the sale and use of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs by the DOH and the Philippine Drug Enforcement Agency (PDEA).*
 - (7) *Strengthen the training of field personnel and the Information Education and Communication (IEC) activities on Rabies prevention, control, eradication and responsible pet ownership.*
 - (8) *Conduct research on Rabies and its prevention, control and eradication in coordination with other agencies.*
 - (9) *Formulate minimum standards and monitor the effective implementation of this Act.*
 - (10) *Encourage collaborative activities with the DOH, DepEd, DILG, DENR, NGOs, POs and other concerned sectors.*

B. Department of Health

- (1) *Ensure the availability and adequate supply of DOH pre-qualified human Anti-Rabies vaccine in animal bite treatment centers at all times and shall coordinate with other implementing agencies and concerned NGOs for this purpose.*
 - Rule 6B (1).1. DOH shall set the criteria for human rabies vaccines and immunoglobulins which shall be used in the human anti-rabies vaccination.
 - Rule 6B (1).2. It shall also encourage the LGUs to appropriate funds from Internal Revenue Allotment (IRA) for the purchase of rabies vaccines.
 - Rule 6B (1).3. Augmentation of rabies vaccines to all government ABTCs through the Center for Health Development (CHD) shall be provided by the DOH.
- (2) *Provide Post-Exposure Treatment at the minimum expense to the individuals bitten by the animals suspected of being rabid which will consist of the initial vaccine and immunoglobulin dose.*
 - Rule 6B (2).1. The DOH shall coordinate with the LGUs in the establishment of additional ABTCs in underserved areas in order to make PET more accessible.
 - Rule 6B (2).2. Through the ABTC, the DOH shall provide the initial vaccines and immunoglobulins for animal bite victims.
 - Rule 6B (2).3. The DOH shall also develop and regularly update the guidelines for the management of animal bite and human rabies cases based on recommendations of the WHO, Centers for Disease Control and other international experts, foreign and local literature, updated local data, etc.
 - Rule 6B (2).4. It shall be incumbent upon the DOH to conduct regular training and update of Animal Bite Treatment Center (ABTC) staff. In this connection, it shall develop a quality assurance system to include accreditation and monitoring of all government ABTCs and private rabies treatment center.
- (3) *Provide Pre-Exposure Treatment to high risk personnel such as, but not limited to laboratory staff, veterinarian, animal handlers, vaccinators and other persons working with Rabies for free.*
- (4) *Coordinate with the DA in the development of appropriate health education strategy to inform the public on rabies prevention and control and responsible pet ownership.*
- (5) *Develop and maintain a human rabies surveillance system.*
 - Rule 6B (5).1. The LGU-CHO/MHO shall be directed by the DOH to regularly submit monitoring reports of human rabies cases to CHD.

Rule 6B (5).2. All owners/operators of medical health facilities shall also be required to report all human rabies cases to DOH or CHD.

Rule 6B (5).3. Ensure thorough investigation of all reported human rabies cases.

- (6) *Encourage collaborative activities with the DA, DepEd, DILG, DENR, NGOs, POs and other concerned sectors.*
- (7) *Immediately approve the registration of Veterinary and Human Barbiturate drugs and veterinary euthanasia drugs in coordination with the PDEA.*

C. Department of Education

- (1) *Strengthen Rabies education program through school health teaching/ curriculum.*

Rule 6C (1).1. Include programs for rabies prevention, control and RPO in school activities in all elementary, secondary student councils and campus organizations.

Rule 6C (1).2. Participate actively in rabies prevention and control programs, and training activities initiated by government agencies/NGOs in the community, and as part of their extension/co-curricular activities.

Rule 6C (1).3. Require schools to have special activities to increase awareness on RPO especially during the Rabies Awareness Month in March and World Rabies Day on September 28 of every year.

- (2) *Assist in the Dog mass immunization campaigns in the community.*

Rule 6C (2).1. Participate actively during dog mass vaccination and registration campaign primarily through information dissemination.

- (3) *Encourage collaborative activities with the DA, DOH, DILG, DENR, NGOs, POs and other concerned sectors.*

Rule 6C (3).1. Coordinate with the LGUS, other government agencies and NGOs in the various advocacy activities in schools and communities.

Rule 6C (3).2. Coordinate with the DOH in the PEP of school children.

- (4) *Integrate proper information and education on responsible pet ownership in the relevant subjects in the Elementary and High Schools Levels.*

Rule 6C (4).1. Continuously develop, update and adopt learning packages to support the existing rabies education concepts/contents in the textbooks and other instructional materials.

Rule 6C (4).2. Mobilize school health personnel to supplement and complement classroom instruction on rabies prevention/control messages and RPO to students and parents.

Rule 6C (4).3. Integrate the concepts of rabies prevention, control and RPO in the Alternative Learning System.

Section 7. Responsibilities of the LGUs. – LGUs in their respective localities shall:

- (1) *Ensure that all Dogs are properly immunized, registered and issued a corresponding Dog tag for every immunized and registered Dog.*

Rule 7(1).1. The LGUs shall register and vaccinate all dogs in their jurisdiction annually.

Rule 7(1).2. The LGUs shall adhere to the standard dog tagging system as prescribed by the Committee.

Rule 7(1).3. In the transport of dogs, the LGU shall verify or require registration records as proof of ownership.

- (2) *Strictly enforce Dog Impounding activities and field control to eliminate Stray Dogs.*
 Rule 7(2).1. Establish and maintain dog pounds as prescribed by the Committee.
 Rule 7(2).2. May enter into an agreement with the private service provider for impounding facilities.
- (3) *Ensure that Dogs are leashed or confined within the premises of the Owner's house or Owner's fenced surroundings.*
- (4) *Allocate funds to augment the implementation of the National Rabies Prevention and Control Program, particularly on the financing of supplies and human and Dog vaccines needed for immunization.*
 Rule 7(4).1. The Sanggunian shall allocate funds for the implementation of the LGU Rabies Control Program as prepared by the Local Rabies Control Committee.
 Rule 7(4).2. The LRCC shall source additional resources such as but not limited to the development funds of Legislators for the program.
- (5) *Ensure the enforcement of Section 6 of Republic Act No. 8485 or "The Animal Welfare Act of 1998".*
- (6) *Enact additional local ordinances that will support the National Rabies Prevention and Control Program that should include the regulation of treatment locally known as "tandok".*
 Rule 7(6).1. A model generic ordinance shall be formulated by the Committee for adoption of the LGUs including but not limited to the following provisions: a) registration and vaccination; b) Responsible Pet Ownership; c) regulation of "tandok"; d) control of strays, leashing and confinement; e) establishment and operation of animal control facility; f) dog and dog meat trading, movement and consumption; g) dog population control; h) Information, Education and Communication campaign; i) fund sourcing and generation; j) incentives and penalties; k) appointment of LGU veterinarian and establishment of veterinary office/facilities; and l) any other provisions relevant to the program.
- (7) *Prohibit the trade of Dogs for meat.*
 Rule 7(7).1. Strictly enforce ordinances and other regulations prohibiting the trading of dogs for meat.
 Rule 7(7).2. The trade of dogs shall include but shall not be limited to buying and/or selling of dogs, dog meats and carcasses, dog farming, collecting, and/or slaughtering of dogs for commercial consumption.
- (8) *With respect to cities and first class municipalities, establish and maintain a Dog Pound where Impounded Dogs shall be kept, in accordance with Section 9 herein: Provided, That the other municipalities, shall, on their own, establish a Dog Pound or opt to share the expense of establishing and maintaining a Dog Pound with other adjoining municipalities and/or with private animal shelters and control facilities.*
 Rule 7(8).1. The dog pound shall be established following the standards/guidelines set by the Committee and registered with the AWD as provided by Rule 4.2.3 (a) and (b) within the initial year of the implementation of the Program.
- (9) *Prohibit the use of electrocution as a euthanasia procedure.*
 Rule 7(9).1. Impounded dogs not redeemed nor adopted or have gone beyond the allowable period for stay in the pound shall be euthanized by a method allowed under AO 21 B series of 1999. In no instance shall euthanasia by electrocution be performed.
- (10) *Appoint a veterinarian and establish a veterinary office in every province, city and first-class*

- (11) *Require pet shops to post information regarding Rabies and responsible pet ownership.*
- (12) *For purposes of ensuring the administrative feasibility of implementing the provisions of this Act and subject to paragraph 8 of this Section, the LGU shall collect the fines imposed under Section 11 subparagraphs (1), (3), (4), (5) and (6) hereof.*

Any and all fines collected pursuant to this Act shall be used for the enhancement of the National Rabies Prevention and Control Program within the locality concerned, as well as the achievement of the objectives envisioned in this Act.

The DILG shall ensure compliance of these responsibilities by the LGUs.

Rule 7.1 The DILG shall issue the relevant orders and circulars for the implementation and monitor compliance of the LGUs in support of the Program.

Section 8. Assistance of NGOs and the Academe - The agencies tasked to implement the anti-Rabies program shall seek the assistance and participation of NGOs in any of the following activities:

- (1) *Community mobilization*
- (2) *Health education/information dissemination on Rabies and responsible pet ownership*
- (3) *Mass anti-rabies campaign*
- (4) *Promotion of the anti-rabies campaign during pet or any animal shows*
- (5) *Surveillance/reporting of Rabies cases in animals and humans*
- (6) *Any other activities geared towards the prevention and complete eradication of Rabies*

Rule 8(6).1. Any NGOs, POs, civic organizations and the academe shall ensure that its activities are consistent with and not in conflict with the Program.

Section 9. Impounding, Field Control and Disposition of Unregistered Stray and Unvaccinated Dogs- Unregistered, stray or unvaccinated dogs shall be put in Dog pounds and disposed of, taking into consideration the following guidelines:

- (1) *Unregistered, stray or unvaccinated dogs shall be impounded and kept in the LGU's designated dog pound.*
- (2) *Impounded dogs not claimed after three days from the dog pound shall be placed for adoption to qualified persons, with the assistance of an animal welfare NGO, when feasible, or otherwise disposed of in any manner authorized, subject to the pertinent provisions of Republic Act No. 8485, otherwise known as the "Animal Welfare Act of 1998".*

Rule 9(2).1. Any animal impounded which is not reclaimed by its owner within 72 hours shall be deemed to be abandoned and shall be disposed of by the LGU through adoption or euthanasia. Provided however, that the said animal shall be euthanized immediately if :

- (a) it is dangerous to retain;
- (b) it is suffering from pain or discomfort;
- (c) it is diagnosed with a contagious and highly communicable disease either to humans or animals.

Rule 9(2).2. In the event that an impounded dog is suspected with rabies it shall be isolated and observed accordingly and upon death must be submitted for laboratory examination.

Rule 9(2).3. The pound operator shall follow appropriate methods for the disposal of euthanized animals as prescribed by the Committee.

- (3) *A fee shall be paid by owners of impounded dogs to the LGU concerned, pursuant to Section 7 hereof.*

Rule 9(3).1. To defray expenses in the operation of the pound, the operator shall be authorized to charge fees from the prospective foster owner upon adoption of the dog.

Section 10. Dog Population Control - In furtherance of the policy of this Act to eradicate Rabies, there is the need to control the dog population and minimize the number of unwanted stray dogs. As such, it is hereby mandated:

- (1) *That the DA, DOH, DILG, DepEd, LGUs, with the assistance of NGOs and POs shall undertake an educational and promotional campaign on responsible Pet Ownership, including the option of spaying or neutering their dogs.*
- (2) *That the LGUs shall provide an incentive system whereby Owners of Dogs which have been spayed or neutered will be given a subsidized or discounted pet registration fee.*
- (3) *That Dogs which have been impounded three times shall only be released after having been spayed or neutered, at the expense of the Pet's Owner.*

Section 11. Penalties

- (1) *Pet Owners who fail or refuse to have their Dog registered and immunized against Rabies shall be punished by a fine of Two Thousand pesos (P2,000.00).*
- (2) *Pet owners who refuse to have their Dog vaccinated against Rabies shall be liable to pay for the vaccination of both the Dog and the individuals bitten by their Dog.*
- (3) *Pet owners who refuse to have their Dog put under observation after said Dog has Bitten an individual shall be meted a fine of Ten Thousand Pesos (P10,000.00).*
- (4) *Pet Owners who refuse to have their Dog put under observation and do not shoulder the medical expenses of the person Bitten by their Dog shall be meted a fine of Twenty five thousand pesos (P25,000.00).*
- (5) *Pet Owners who refuse to put a leash on their Dogs while they are brought outside the house shall be meted a fine of Five hundred pesos (P500.00) for each incident.*
- (6) *An impounded Dog shall be released to its Owner upon payment of a fine of not less than Five hundred pesos (P500.00) but not more than One thousand pesos (P1,000.00).*
- (7) *Any person found guilty of trading Dogs for meat shall be fined not less than Five thousand pesos (P5,000.00) per Dog and subjected to imprisonment for one to four years.*
- (8) *Any person found guilty of using electrocution as a method of euthanasia shall be fined not less than Five thousand pesos (P5,000.00) per act and subject to imprisonment for one to four years (1 – 4 years).*
- (9) *If the violation is committed by an alien, he or she shall be immediately deported after service of sentence without any further proceeding.*

Section 12. Implementing Rules and Regulations. – *The DA, in coordination with the DOH, DILG, DepEd, DENR, NGOs, POs shall issue the necessary rules and regulations within sixty (60) days from the effectivity of this Act.*

Section 13. Appropriations. – *The amount of One hundred million pesos (P100,000,000.00) necessary to implement the provisions of this Act shall be initially charged against the appropriations of the DOH, DA, DILG and DepEd under the General Appropriations Act . For the LGUs, the requirements shall be taken from their Internal Revenue Allotment and other local funds.*

Thereafter, such sums as may be necessary for its continued implementation shall be included in the annual General Appropriations Act.

Rule 14. Transitory provision. - The Committee may from time to time, recommend the issuance of additional administrative orders in the pursuit of the objectives of the Anti-Rabies Act of 2007.

Rule 15. Non-exclusivity Clause. - All existing rules and regulations, policies, procedures and standards not inconsistent with this Order shall continue to be in full force and effect.

Rule 16. Repealing Clause. - All laws, decrees, executive issuances, rules and regulations inconsistent with this Act are hereby repealed or modified accordingly.


Rule 17. Separability Clause. - In case any provision of this Act is declared unconstitutional, the other provisions shall remain in full force and effect.

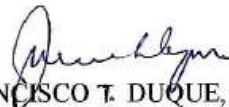
Rule 17.1 The Legal Services of the DA, DOH, DepEd and DILG shall review the relevant Departmental Issuances to determine any amendments.

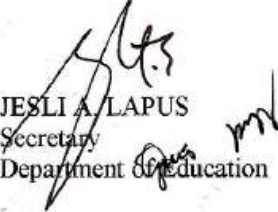
Rule 18 Effectivity. - This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in at least two newspapers of general circulation, whichever comes earlier.

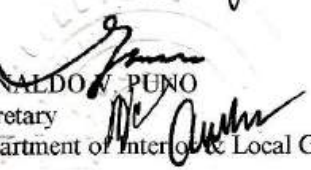
Rule 18.1 These IRR shall take effect fifteen (15) days after publication in a newspaper of general circulation.

APPROVED,


ARTHUR C. YAP
Secretary
Department of Agriculture


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


JESLI A. LAPUS
Secretary
Department of Education


RONALDO W. PUNO
Secretary
Department of Interior and Local Government

EXECUTIVE ORDER NO. 84 - DECLARING MARCH AS THE

RABIES AWARENESS MONTH, RATIONALIZING THE CONTROL MEASURES FOR THE PREVENTION AND ERADICATION OF RABIES AND APPROPRIATING FUNDS THEREFOR

WHEREAS, rabies is a dangerous disease of dog transmissible to humans through the bite of an infected animal;

WHEREAS, approximately 560,000 bite cases are reported every year;

WHEREAS, rabies accounts for the loss of approximately 300-400 Filipino lives every year and causes much agony and suffering to victims and their families before death;

WHEREAS, the disease can be prevented through mass immunization of pet dogs and responsible pet ownership;

WHEREAS, leashing of dogs and control of stray dogs are important complementary strategies in the control and eradication of rabies;

WHEREAS, information and education on rabies prevention measures, first aid for dog bites, and other relevant facts concerning rabies are critical for its eradication;

WHEREAS, the failure to eradicate rabies in the country greatly affects the public health and safety of the Filipino people;

NOW, THEREFORE, I, JOSEPH EJERCITO ESTRADA, President of the Philippines, by virtue of the powers vested in me by law, do hereby declare that the month of March every year shall henceforth be known as the Rabies Awareness Month, and order:

Section 1. A massive information drive on rabies shall be held nationwide every year in the month of March, complemented by a mass immunization of dogs in key areas nationwide and that the vaccines shall be provided for free to the public.

Sec. 2. During the Rabies Awareness Month, the cooperating agencies of the Department of Agriculture - Bureau of Animal Industry (DA-BAI), Department of Health - Communicable Disease Control Service (DOH-CDCS), Department of Education, Culture and Sports (DECS), and the Department of Interior and Local Government (DILG) - Provincial Veterinary Office shall conduct seminars, fora, radio and television plugs, symposiums and other information campaigns in coordination with one another.

The DA-BAI shall procure sufficient number of vaccines, and vaccination paraphernalia to cover the key areas during the mass immunization of dogs nationwide;

Sec. 3. There is hereby created a National Rabies Prevention and Control Committee (NRPCC) to be composed of representatives from DA-BAI, DOH-CDCS, DECS, DILG and NGO (Philippine Veterinary Medical Association [PVMA], Veterinary Practitioners Association of Philippines [VPAP] and the Philippine Society of Veterinary Public Health [PSVPH]) to formulate policies and coordinate implementation of the national rabies prevention and control program (NRPCP). A Rabies Control Section shall be created at the BAI which shall be responsible for the implementation and monitoring of the NRPCP.

Sec. 4. All concerned government agencies, including local government units, shall immediately report to the BAI any occurrence of the diseases in their respective areas of jurisdiction. They shall provide all necessary assistance to the BAI-NRPC Task Force operating within their jurisdictions. Further, in case a local government unit is declared as a rabies-infected area by the DA-BAI, five (5) percent of the contingency fund allocated from its Internal Revenue Allotment may be used for the procurement of vaccines and vaccination paraphernalia necessary for the control of rabies in their respective areas.

Sec. 5. Subject to government accounting and auditing procedures, the amount of forty million pesos (PHP 40,000,000.00) shall be allocated for the rabies awareness month every fiscal year to cover the cost of the rabies vaccines and the cost of the printing of information materials as well as the cost of the radio and television plugs, and logistical expenses for the information and immunization campaigns. The Department of Budget and Management shall allocate from the lump sum appropriations of the General Appropriations Act the necessary amount. Funding for the succeeding year shall be included in the budget proposal of the Department of Health.

Sec. 6. This Executive Order shall take effect immediately.

DONE in the City of Manila, this 13th day of March, in the year of Our Lord, nineteen hundred and ninety nine.



March 3, 2011

MEMORANDUM CIRCULAR
NO. 2011-30

TO : ALL PROVINCIAL GOVERNORS, CITY MAYORS, MUNICIPAL MAYORS,
THE ARMM REGIONAL GOVERNOR, DILG REGIONAL DIRECTORS AND
OTHERS CONCERNED

SUBJECT : STRICT IMPLEMENTATION OF THE ANTI-RABIES ACT OF 2007
(REPUBLIC ACT NO. 9482)

In furtherance of the policy of the State to protect and promote people's right to health, Republic Act No. 9482 (The Anti-Rabies Act of 2007) was approved into law, defining among others, the roles and responsibilities of concerned offices, such as, the Department of Agriculture, Department of Health, Department of Education, the local government units, the assistance and participation of NGOs and academe, and this Department, in establishing a system of control, prevention, spread, and eventual eradication of human and animal rabies by the year 2011.

- The following, are general requirements of RA No. 9482
 1. Formulation of National Rabies Prevention and Control Program, to include activities on:
a) dog mass vaccination; b) establishment and maintenance of pounding areas for stray and unvaccinated dogs; c) encouragement for responsible pet ownership; and d) establishment and maintenance of central database system for vaccinated and registered dogs;
 2. Creation of corresponding Multi-Sectoral Committee to undertake such program;
 3. Appointment of Veterinary Officer and the Creation of a Veterinary Office in every province and city, in conformity with the Local Government Code of 1991; and
 4. Establishment and maintenance of a Dog Pound in every city and 1st class municipalities, for impounding of stray and unvaccinated dogs, provided however, that other adjoining municipalities may form themselves to establish and maintain a Dog Pound.
- To ensure compliance of the above requirements, Section 7 of the Act provides the following functions of the local government units:
 1. Ensure that all dogs are properly immunized, registered and issued a corresponding dog tag for every immunized and registered Dog;
 2. Strictly enforce dog impounding activities and field control to eliminate stray dogs;
 3. Ensure that Dogs are leashed or confined within the premises of the owner's house or owner's fenced surroundings;
 4. Allocate funds to augment the implementation of the National Rabies Prevention and Control Program, particularly on the financing of supplies and human and Dog vaccines needed for immunization;
 5. Ensure the enforcement of Sec. 6 of Republic Act No. 8485 or "The Animal Welfare Act of 1998".

6. Enact additional local ordinances that will support the National Rabies Prevention and Control Program that should include the regulation of treatment locally known as "tandok";
7. Prohibit the trade of dogs for meat;
8. With respect to cities and first class municipalities, establish and maintain a Dog Pound where Impounded Dogs shall be kept, in accordance with Sec. 9 herein: *Provided*, That the other municipalities, shall, on their own, establish a Dog Pound or opt to share the expense of establishing and maintaining a Dog Pound with other adjoining municipalities and/or with private animal shelters and control facilities;
9. Prohibit the use of electrocution as a euthanasia procedure;
10. Appoint a veterinarian and establish a veterinary office in every province, city and first-class municipality: *Provided*, That the other municipalities shall, on their own, opt to share the expense of having a veterinary office; and
11. Require pet shops to post information regarding rabies and responsible pet ownership;

• **Penalties and sanctions pursuant to Section 11 of the Act**

1. Pet owners who fail or refuse to have their dog registered and immunized against Rabies shall be punished by a fine of Two Thousand (P 2,000.00) Pesos;
2. Pet owners who refuse to have their dog vaccinated against Rabies shall be liable to pay for the vaccination of both the dog and the individuals bitten by their dog;
3. Pet owners who refuse to have their dog put under observation after said dog has bitten an individual shall be meted a fine of Ten Thousand (P 10,000.00) Pesos;
4. Pet owners who refuse to have their dog put under observation and do not shoulder the medical expenses of the person bitten by their dog shall be meted a fine of Twenty-Five Thousand Pesos (P 25,000.00);
5. Pet owners who refuse to put leash on their dogs when they are brought outside the house shall be meted a fine of Five Hundred (P 500.00) Pesos for each incident;
6. An impounded dog shall be released to its owner upon payment of a fine of not less than Five Hundred (P 500.00) Pesos, but not more than One Thousand (P 1,000.00) Pesos;
7. Any person found guilty of trading dog for meat shall be fined not less than Five Thousand (P 5,000.00) Pesos per dog and subjected to imprisonment for one to four years;
8. Any person found guilty of using electrocution as a method of euthanasia shall be fined not less than Five thousand pesos (P5,000.00) per act and subject to imprisonment for one (1) to four (4) years; and
9. If the violation is committed by an alien, he or she shall be immediately deported after service of sentence without any further proceedings.

Toward this end, all Provincial Governors, City Mayors and Municipal Mayors, are hereby advised for the full compliance of the requirements of RA 9482, and to give emphasis on the prohibition of the trade of dog meat, as setforth in Section 7 (7) of the above-said law.

DILG Regional Directors and Field Officers shall ensure the widest dissemination of this Circular within their respective areas of assignments, and submit Quarterly Compliance Report by local government units, initial update report to reach the Office of the Secretary, through the Bureau of Local Government Supervision, on or before March 31, 2011.



Jesse M. Robredo
JESSE M. ROBREDO
 Secretary



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
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August 15, 2008

MEMORANDUM CIRCULAR

No. 2008 - 0053


FOR: ALL UNDERSECRETARIES, ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS, CENTERS FOR HEALTH DEVELOPMENT, SERVICES AND SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS & HOSPITALS, PRESIDENT OF THE PHIL. HEALTH INSURANCE CORPORATION AND EXECUTIVE DIRECTORS OF PHIL. NATIONAL AIDS COUNCIL, THE PHIL. INSTITUTE OF TRADITIONAL AND ALTERNATIVE HEALTH CARE, NATIONAL NUTRITION COUNCIL, POPULATION COMMISSION, AND OTHERS CONCERNED

SUBJECT: Joint Department Administrative Order No. 01 between the Department of Health and Department of Agriculture entitled "Guidelines for Declaring Areas as Rabies-Free Zones" dated March 10, 2008

Attached for your information and guidance is a copy of Joint Department Administrative Order No. 01 between the Department of Health and Department of Agriculture entitled "Guidelines for Declaring Areas as Rabies-Free Zones" dated March 10, 2008.

Dissemination to all concerned is requested.

BY AUTHORITY OF THE SECRETARY OF HEALTH


MARIO C. VILLAVERDE, MD, MPH, MPM, CESO II
Undersecretary of Health



March 10, 2008

**JOINT DEPARTMENT ADMINISTRATIVE ORDER No. 01
Series of 2008**

SUBJECT: GUIDELINES FOR DECLARING AREAS AS RABIES-FREE ZONES

I. BACKGROUND/RATIONALE

Rabies is a fatal disease in developing countries where animal rabies immunization, prevention and control of dogs are inadequate. More than half of the estimated global number of Human Rabies deaths occurs in Asia and most commonly human rabies deaths are caused by dog bites.

The Philippines ranks among the top ten countries worldwide with the highest incidence of Human Rabies deaths. The annual mortality rate from rabies is 5-8 per million population; thus, approximately 300-500 Filipinos die of rabies every year or one person per day. Human and animal rabies is region wide in distribution. In 2005, the top 4 regions with the number human rabies deaths are Region VI (39), Region III (35), Region V (30) and Region VII (27). Of the 100,000 animal bite victims, 69% involve are children below 15 years old.

In 2005, the animal rabies incidence was calculated at 17.5 per 100,000 dog population and the regions with high incidence of animal rabies are Region VI (253), Region III (249), Region X (154), NCR (153), Region I (142), Region IV (122) and Region VII (69).

To facilitate achievement of the goals and objectives, the DA, DOH and other key partners shall embark on zonal/island declaration of Rabies-Free areas. The prevention of human rabies shall be sustained, focusing on community efforts involving both veterinary and public health workers.

This Order is hereby established to provide the guidelines for declaring zones/areas as Rabies-Free by which the DA, DOH and other concerned institutions and agencies that will administer programs and activities on the control, prevention and elimination of Rabies through effective management and better coordination among key stakeholders at the national and local levels.

II. DECLARATION OF POLICIES

These operational guidelines shall be guided by the following legal mandates and policies:

- A. Republic Act 9482 or the Anti-Rabies Act of 2007 – An Act Providing for the Control and Elimination of Human and Animal Rabies, Prescribing penalties for Violation Thereof and Appropriating Funds Therefor.
- B. Memorandum of Agreement entered into by the Secretaries of the Department of Agriculture, Health, Education, Culture and Sport and the Interior and Local Government on May 8, 1991.
- C. Executive Order No. 84 – Declaring March as the Rabies Awareness Month, Rationalizing the Control Measures for the Prevention and Eradication of Rabies and Appropriating Funds Thereof.
- D. Batas Pambansa Blg. 97 – An Act Providing for the Compulsory Immunization of Livestock, Poultry and Other Animals Against Dangerous Communicable Diseases.
- E. WHO Technical Report Series 931 (WHO Expert Consultation on Rabies) – 9. Rabies-Free and rabies-free countries or areas.
- F. DOH Administrative Order No. 2005-0023 (Implementing Guidelines for Formula One for Health as framework for Health reforms) C2. c.i. undertake Disease-Free Zone initiative – “Areas where diseases such as malaria, filariasis, schistosomiasis, **rabies**, leprosy and vaccine-preventable diseases are major health problems shall be targeted for initiative campaigns to eliminate these diseases as public threats.”
- G. DOH Administrative Order 2007-0036 (Guidelines on the Philippines Integrated Disease Surveillance and Response (PIDSR) Framework) VIII.A. 1.b.1. Immediately notifiable diseases/syndrome or event (i. Rabies)

III. GOALS AND OBJECTIVES

A. Goal: To declare Philippines as a Rabies-Free Country by 2020

B. General Objectives:

- 1. To declare provinces, cities, municipalities and islands as rabies-free zones.
- 2. To maintain and sustain the rabies-free status of the provinces, cities, municipalities and islands declared as rabies-free zones.

C. Specific Objectives:

- 1. To identify provinces, cities, municipalities and islands eligible for declaration as rabies-free zones.
- 2. To provide technical and logistic assistance to Local Government Units (LGUs) on how to attain/achieve and maintain the Rabies- Free Zone/Area status.
- 3. To validate and confirm the rabies-free status of eligible provinces, cities, municipalities and islands, base on the criteria set by the Department of Health and the Department of Agriculture-Bureau of Animal Industry.

IV. SCOPE AND COVERAGE

This issuance shall apply to all sectors, to include public and private, National Government Agencies (NGAs), Local Government Units (LGUs), local and international Non-Government Organizations (NGOs) and People's Organization (POs) and the community involve in the prevention, control and elimination of human and animal rabies.

V. DEFINITION OF TERMS

- A. Animal birth control – shall refer to the methods to manage animal populations through reproductive control measures such as neutering;
- B. Dog ecology - shall refer to the study of the relation of dogs to the environment, human populations and to each other, including the population density and behavior;
- C. Impounding – refers to the process of capturing and confining stray animals;
- D. Rabies-Free Zone/Area – refers to area with no confirmed human or animal rabies case, including bats, or indigenously acquired infection by a lyssavirus at any time during the previous two years, in the presence of an adequate surveillance system and import policy and have satisfied all criteria for a rabies-free zone/area declaration;
- E. Provisional Rabies-Free Zone/Area – refers to area that is historically free of rabies where an adequate rabies surveillance is in place to confirm the rabies-free status, an effective import policy have been put into place to ensure maintenance of the rabies free status and has failed to meet the other requirements for the declaration of a rabies-free area/zone.
- F. National Rabies Prevention and Control Program refers to the program with the ultimate objective of controlling Rabies in the country implemented by the Department of Agriculture (DA) and the Department of Health (DOH) in collaboration with the Department of Education, Department of Interior and Local Government (DILG), Local Government Units (LGUs), Non-Governmental Organizations (NGOs), People's Organizations (POs) and the academe;
- G. Veterinary groups-refers to animal health practitioners responsible for the health and welfare of animals;
- H. Dog bite– refers to an act by which a dog seizes, cuts and grips with its teeth its victim so that the skin of the victim has been wounded, pierced or scratched;
- I. Responsible Pet Ownership- refers to giving proper care to pets by providing vaccinations against rabies at 3 months of age and every year thereafter; providing clean, comfortable and proper shelter; providing enough exercise, care and proper nutrition; keeping pets within their own backyard where they are free from contact with infected dogs and keeping them on leash when taken for a walk; and bringing the pet for regular health consultation with the veterinarian.

VI. IMPLEMENTING GUIDELINES ON DECLARING AREAS/ZONES AS RABIES-FREE

A. GENERAL GUIDELINES:

1. Rabies is a notifiable disease and as such shall be the responsibility of the local government units to report human and animal rabies cases promptly.

2. The Office International de Epizooties (OIE) (World Organization for Animal Health) and the World Health Organization requires that no indigenous acquired rabies infection has been confirmed in man and any animal species during the past two (2) years.
3. An effective system of disease surveillance for humans and animal rabies has been set up and well implemented in the province/city/municipality.
4. All regulatory measures for the prevention and control of rabies have been implemented including shipping/transport procedures.
5. Accessibility of post-exposure treatment using modern cell culture vaccines approved and recommended for both intradermal and intramuscular use.
6. Established mechanism to ensure availability of Human Anti-Rabies Vaccines and Rabies Immunoglobulins such schemes as inter-local health financing or cost sharing (public-private mix, patient-pet owner).
7. Regular health education and advocacy activities on Rabies Prevention and Control to include Elementary School Curriculum Integration and Instruction on the prevention and control of rabies.

GENERAL REQUIREMENT FOR THE DECLARATION OF RABIES- FREE ZONE/AREA:

1. Local ordinance on the prevention and control of rabies.
2. Localized comprehensive Rabies Prevention/Control and Elimination Program.
3. **Animal Rabies:**
 - a. No case of indigenously acquired infection by a type 1 lyssavirus confirmed in any animal species including bats at anytime during the previous two (2) years through monthly zero-case reporting from the Municipal Agriculture Office/Veterinary Office and monthly reporting of laboratory confirmed cases by all veterinary rabies laboratory – Philippine Animal Health Center (PAHC), Research Institute for Tropical Medicine (RITM), 10 Regional Animal Disease Diagnostic Laboratories (RADDLs), and 2 accredited provincial rabies labs.
 - b. Existing comprehensive rabies vaccination program in place for 2 years as per provisions of the Anti-Rabies Act of 2007.
 - c. Adequate laboratory-based surveillance system is in full operation in Rabies-Free and Provisionally Rabies-Free areas. The system should include the following:
 - i. Functional Rabies laboratories performing Fluorescent Antibody Test (FAT) for Rabies diagnosis in a minimum of 0.02% of the estimated dog population in their designated catchment areas/zones per year;
 - ii. Functional system of referral for confirmation of cases in the region; and
 - iii. Impounding facility/system for clinically suspect rabid dogs whether or not it is involved in a potential rabies exposure.
 - d. Enforcement of control measures to eliminate, destroy and dispose stray dogs as per existing ordinance.

-
- e. All components of animal rabies prevention and control together with the animal birth control program must be in place.
 - f. Presence of effective Rabies Control Committee at all levels of the local government namely: province, city, municipality, barangay.
 - g. Effective dog movement control measures i.e. dogs and cats for inter-island transport must have a valid vaccination certificate and can only be transported at least two (2) weeks after vaccination or valid rabies vaccination within last 12 months certified by a licensed veterinarian.
 - h. Information, education and communication campaign – Responsible Pet Ownership should be pursued in all the public awareness drives in the provinces, cities, municipalities and barangays. It should be conducted using print, broadcast and other forms of media. Billboards and streamers must be put up in strategic areas.

4. Human Rabies:

- a. No case of indigenously acquired infection by a lyssavirus confirmed in any human at anytime during the previous two (2) years through monthly zero-case reporting from the Municipal Health Office;
- b. Adequate surveillance system on rabies in accordance with the Philippines Integrated Disease Surveillance and Report System is functional:
 - i. Functional system of referral for laboratory confirmation of human cases in the regions by FAT or other antigen detection procedures such as Polymerase Chain Reaction (PCR)
 - ii. Surveillance system must involve all levels - health centers, animal bite treatment centers and hospitals – sentinel or non-sentinel sites
 - iii. Monthly reporting of human rabies to include zero case reporting;
 - iv. The LGU should have at least one staff trained on rabies surveillance to investigate all reported human rabies suspects;
 - v. The LGUs should conduct immediate case investigation of reported human rabies cases. If the LGU does not have the technical expertise to conduct investigation, the Provincial Health Office or Center for Health Development should provide technical assistance. When a confirmed rabies case is reported in a declared rabies-free area, the LGU should declare an outbreak and conduct an immediate comprehensive response to control the spread of the disease.
- c. Post-Exposure Treatment must be readily accessible to all animal bite victims and a mechanism is established to ensure availability of human anti-rabies vaccine and rabies immunoglobulin.
- d. Presence of adequate health education, promotion and advocacy on responsible pet ownership, proper animal bite wound care and adherence to treatment protocol, including the integration of rabies prevention and control in the curriculum of Elementary Schools and the annual celebration of the Rabies Awareness Month.

C. Recovery Process:

1. Incursions of rabies shall be reported immediately. Investigation must be conducted and the cases must be confirmed.
2. Control measures must be instituted immediately such as site-specific mass vaccination of dogs, surveillance, movement control and information campaign.
3. Re-evaluation of status shall be conducted 6 months after the last vaccination date by the National Rabies Prevention and Control Committee.
4. Rabies-Free status shall be restored in writing by both the DA and DOH secretaries.


VII. IMPLEMENTING MECHANISM TO SUSTAIN RABIES-FREE ZONES/AREAS

- A. The Governor and City/Municipal Mayors must take charge of the implementation of the Rabies-Free zone guidelines in their respective province/city/municipality and must allocate funds for the procurement of vaccines for animals and humans.
- B. The Barangay Officials must extend full support and cooperation to the **"Bantay Rabis Sa Barangay"** headed by the Barangay Captain who must take charge of the entry of new dogs and maintain the registry of all dogs in the catchments area.
- C. The Rabies Control Committees in the provinces/cities/municipalities must oversee the implementation of the rabies control program components and assist in the maintenance of the Rabies-Free zones.
- D. The DA/DOH Regional Rabies Control Committees must supervise and assess the implementation of the Rabies-Free zones in their respective areas.
- E. The Regional Animal Disease Diagnostic Laboratory (RADDL) of the DA-Regional Field Units (DA-RFU) must continue to conduct routine animal surveillance and must investigate the occurrence of animal rabies. In addition, the RADDL of DA-RFU shall provide monthly report of animal rabies cases to the National Rabies Committee.
- F. The Epidemiology and Surveillance units (ESU) at the municipal, city, provincial and regional levels shall be responsible in the continued operations of human rabies surveillance under the Philippines Integrated Disease Surveillance and Report System. The National Epidemiology center shall provide monthly report of human rabies cases to the National Rabies Committee.
- G. The Department of Agriculture – Bureau of Animal Industry (DA-BAI) and the Department of Health (DOH), shall initiate the program implementation activities, monitoring and evaluation, and declaration of Rabies-free zones/areas using parameters for Rabies-free zones.
- H. The DA-BAI and DOH must conduct a joint periodic monitoring of the Rabies-Free zones.
- I. The DILG Regional/Provincial Directors must monitor the compliance of the Local Chief Executives and their respective roles as mandated under the Memorandum of Agreement.
- J. The DOH shall provide human anti-rabies immunizing agents to Animal Bite Treatment Centers (ABTCs) through the CHDs and to provide pre-exposure treatment of high risk group like health staff, animal handlers/vaccinators, veterinarians/diagnosticians and children below 15 years of age in highly endemic areas.
- K. The Department of Education shall assist in the development of Health Information and Education materials for school children.
- L. The RITM Rabies Laboratory of the DOH shall serve as the reference center for rabies diagnosis in humans using different techniques (PCR, FAT and MIT).

The provisions of the National Rabies Prevention and Control Program Manual of Operation, National Rabies Committee CY 2001 and any other issuances inconsistent herewith are hereby rescinded.

IX. EFFECTIVITY

This order shall take effect immediately.


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


ARTHUR C. YAP
Secretary of Agriculture

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DEPARTMENT OF AGRICULTURE
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September 21, 2007

ADMINISTRATIVE ORDER

No: 2007- 0029

SUBJECT: Revised Guidelines on Management of Animal Bite Patients

I. BACKGROUND/RATIONALE

Rabies is a fatal disease in developing countries where animal immunization and control of dogs are inadequate. In view of the 100% case fatality of human rabies, the prevention of rabies infection after exposure is of utmost importance. The Department of Health, having committed itself to the prevention of human deaths due to rabies, provides vaccines for post exposure treatment through the Animal Bite Treatment Centers (ABTCs) to high risk exposed patients.

Over the last five years, many studies have been conducted by both local and foreign researchers focusing on changes in treatment modalities. The World Health Organization has also issued new recommendations related to rabies management. Based on the available information, the guideline on animal bite management is revised in order to provide more cost effective strategies for rabies prevention and control. The guidelines in the management of animal bite cases are being updated every five years to integrate updated global recommendations. The first revision was done in 1997 and then in 2002.

Disease free zones initiative has identified as one of the strategies of FOURmula One for Health to reduce public health threats alongside with enhanced health promotion and surveillance. The initiatives aim to "mop up" diseases as leprosy, schistosomiasis, filariasis, **rabies** and malaria. This would entail doing stratification of areas according to burden of disease, validation of status of potential disease-free areas, and identification of appropriate intervention based on these stratification

II. OBJECTIVE

To provide new policy guidelines and procedure to ensure an effective and efficient management for eventual reduction if not elimination of human rabies, and to increase voluntary pre-exposure coverage among high risk group such as animal handlers, field workers, health staff working in the rabies unit, rabies diagnostic laboratory staff, and children below 15 years old living in endemic areas.

III. COVERAGE

To ensure consistency in the management of animal bite patients, government health care workers at all levels as well as private practitioners in the country are hereby encouraged to adopt these guidelines.

IV. DEFINITION OF TERMS

- A. Post exposure treatment – anti-rabies treatment administered after an exposure (such as bite, scratch, lick etc) to potentially rabid animals. It includes local wound care, administration of rabies vaccine with or without Rabies Immune Globulin (RIG) depending on category of exposure.
- B. Pre exposure prophylaxis – rabies vaccination administered before an exposure to potentially rabid animals. This is usually given to those who are at high risk of getting rabies such as veterinarians, animal handlers, staff in the rabies laboratory and hospitals handling rabies patients etc
- C. Immunocompromised host – as far as response to rabies vaccination is concerned, this refers to patients receiving immunosuppressive drugs such as systemic steroids (not topical or inhaled) and chemotherapeutic drugs for cancer, patients taking chloroquine, AIDS and HIV infected patients. These patients are expected to have lower immune response to immunization.
- D. Active Immunization – refers to the administration of a vaccine to induce protective immune response.
- E. Passive Immunization – refers to the administration of pre-formed antibodies (immune globulins or passive immunization products) to provide immediate protection. These antibodies come from either human or animal source.
- F. Vaccine Potency – refers to the amount of acceptable active ingredients in a rabies vaccine which is expected to provide at least minimum protection.
- G. Incubation Period – the period from the time of exposure up to the appearance of first clinical symptoms of rabies. It is extremely variable ranging from 4 days to 7 years; but generally 20 to 90 days.
- H. Prodromal Period – lasts for 10 days with non-specific manifestations, which include fever, sorethroat, anorexia, nausea, vomiting, generalized body malaise, headache and abdominal pain. Parasthesia or pain at the site of the bite is due to viral multiplication at the spinal ganglion just before it enters the brain
- I. Observation Period – animal observation for 14 days from the time of bite until the appearance of expected symptoms of rabies
- J. Rabid Animal – biting animal with clinical manifestation of rabies and/or confirmed laboratory findings

- K. Suspected Rabid Animal – biting animal with a potential to have rabies infection based on unusual behavior, living condition like stray dogs, endemicity of rabies in the area and no history of immunization.

V. GENERAL GUIDELINES

- A. Department of Health shall be responsible for the management of animal bite victims including provision of human rabies vaccine.
- B. Rabies Control Program shall be integrated to the regular health services provided by local health facilities of bite victims, as a measure.
- C. Post exposure vaccination shall be shared and carried out by the Department of Health and Local Government Units.
- D. Funding requirements needed for operational systems should be secured prior to the implementation of this policy.
- E. Advocacy through information dissemination and training of health workers shall be conducted at all levels.
- F. Collaboration among government agencies, non-government and private organizations to ensure successful implementation shall be strengthened.

VI. SPECIFIC GUIDELINES AND PROCEDURE

A. Management of Potential Rabies Exposure

1. Initiation of post-exposure treatment (PET) should 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.
2. There are no absolute contraindications to rabies PET. Patients allergic to a specific vaccine/RIG or its components should be given the alternative vaccine/RIG.
3. The following are three (3) categories of exposure to a rabid animal or to an animal suspected to be rabid, each with corresponding management guidelines.

B. Immunization

1. Active Immunization

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1.1 Administration

Vaccine is 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 one year or more provided primary immunization is completed.

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1.2 Types of Rabies Vaccines and Dosage

The types of anti-rabies vaccines available in the Philippines include: a) Purified Vero cell Rabies Vaccine (PVRV) – 0.5 ml/vial; b) Purified Chick Embryo Cell Vaccine (PCECV) – 1.0 ml/vial

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Table 2. WHO and DOH approved rabies vaccines

Generic Name	Preparation	Dose
Purified Vero Cell Rabies Vaccine (PVRV)	0.5 ml/vial	ID - 0.1 ml IM - 0.5 ml
Purified Chick Embryo Cell Vaccine (PCECV)	1 ml/vial	ID – 0.1 ml IM – 1.0 ml

The above mentioned vaccines are considered to be highly immunogenic and safe. For active immunization, any of the two vaccines may be administered either intramuscularly (IM) or intradermally (ID). The potency of vaccine for intramuscular use should be at least **2.5 IU/IM dose** and for intradermal use should be at least **0.5 IU/ID dose** as evidenced by batch testing performed by a WHO-recognized National Regulatory Authority or National Control Laboratory. The potency of the vaccine batch should be provided by the manufacturer.

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Rabies Vaccine Criteria

Only rabies vaccines which satisfy all the following criteria can be used:

- produced by a World Health Organization (WHO) pre-qualified manufacturer;
- have gone through local clinical trials on safety, immunogenicity and efficacy (as evidenced by published clinical trials in peer-reviewed journals and local testing studies);
- have been evaluated by the DOH Rabies Technical Group; AND
- registered with and approved by the Bureau of Food and Drugs (BFAD)

2. Passive Immunization

Rabies Immune Globulins or RIG (also called passive immunization products) are given in combination with 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.

2.1 Human Rabies Immune Globulins (HRIG) derived from plasma of human donors is administered at 20 IU per kilogram body weight. Available preparation is 2ml/vial; 150 IU/ml.

2.2 Highly purified antibody antigen binding fragments [F(ab')₂] produced from Equine Rabies Immune Globulin (ERIG) derived from purified horse serum administered at 40 IU per kilogram body weight. Available preparation is 5 ml/vial; 200 IU/ml.

2.3 Equine Rabies Immune Globulin (ERIG) derived from purified horse serum administered at 40 IU per kilogram body weight. Available preparation is 5ml/vial; 200 IU/ml.

a. Types of Rabies Immune Globulins

Table 3. WHO and DOH approved rabies immune globulins

Generic Name			Preparation	Dose
Human Rabies Immune Globulin (HRIG)			150 IU/ml	20 IU/kg
			2 ml/vial	
F(ab') ₂ products			200 IU/ml	40 IU/kg
			5 ml/vial	

b. Computation and Dosage of Rabies Immune Globulin

HRIG at 20 IU/kg. body weight (150 IU/ml)

$$50 \text{ kg. patient} \times 20 \text{ IU/kg.} = 1000 \text{ IU}$$

$$1000 \text{ IU} \div 150 \text{ IU/ml} = 6.7 \text{ ml.}$$

ERIG/ F(ab')₂ at 40 IU/kg. body weight (200 IU/ml)

$$50 \text{ kg. patient} \times 40 \text{ IU/kg.} = 2000 \text{ IU}$$

$$2000 \text{ IU} \div 200 \text{ IU/ml} = 10 \text{ ml.}$$

c. Rabies Immune Globulin Criteria

All imported RIG introduced for the first time in the Philippines should undergo testing and evaluation by the WHO or WHO-recognized National Regulatory Authority (NRA), or National Control Laboratory (NCL). The tests should include Rapid Fluorescent Focus Inhibition Test (RFFIT) or Mouse Neutralization Test (MNT), pre-clinical safety, pyrogenicity and product purity.

An animal survivorship study may be required. The results of the clinical trials conducted on the product should have been published in a peer-review journal.

The local NRA/NCL should validate the RFFIT, MNT and purity of the product and require local clinical trials on safety. The above requirements are necessary for BFAD registration.

Locally produced RIG should undergo the same evaluation and testing as mentioned above by the local NRA/NCL and the product should be registered with and approved by BFAD before use.

d. Administration:

- 1) The total computed dose of RIG should be infiltrated around and into the wound as much as anatomically feasible, even if the lesion has healed. In case some amount of the total computed dose of RIG is left after all wounds have been infiltrated, it should be administered deep IM at a site distant from the site of vaccine injection (preferably anterolateral thigh) using another needle. The total computed dose should be administered within one day.
- 2) A gauge 23 or 24 needle, 1 inch length should be used for infiltration. Multiple needle injections into the same wound should be avoided.
- 3) A skin test must be performed prior to ERIG/F(ab')₂ administration using a gauge 26 needle. For skin testing, 0.02 ml of 1:10 dilution of solution is infiltrated to raise a bleb 3 mm and read after 15 mins. A positive skin test is an induration >6 mm surrounded by a flare/erythema. If initial skin test is positive, repeat skin test on same arm; use distilled water as control on the other arm. The skin test is considered positive if the ERIG/F(ab')₂ skin test is positive but the control is negative.
- 4) If a finger or toe needs to be infiltrated, care must be taken not to impair blood circulation. Injection of an excessive amount may lead to cyanosis, swelling and pain.
- 5) RIG should not exceed the computed dose as it may reduce the efficacy of the vaccine. If the computed dose is insufficient to infiltrate all bite wounds, it may be diluted with sterile saline 2 or 3 fold for thorough infiltration of all wounds.

- 6) RIG should be administered at the same time as the first dose of vaccine (day 0). In case RIG is unavailable on day 0, it may still be given anytime before the day 7 dose of the vaccine. However if the day 3 and/or day 7 doses of the vaccine have not been given, RIG may still be given anytime.
- 7) In the event that RIG and vaccine cannot be given on the same day, the vaccine should be given before RIG because the latter inhibits the level of neutralizing antibodies induced by immunization.
- 8) RIG is given only once during the same course of PET.

C. Management of Adverse Reactions

Hypersensitivity to ERIG/F(ab')₂ may not be predicted by a negative skin test. Always be ready with adrenaline and antihistamines for treatment of hypersensitivity.

1. Anaphylaxis

- a. Give 0.1% adrenaline or epinephrine (1:1,000 or 1mg/ml) underneath the skin or into the muscle. Adults - 0.5 ml. Children - 0.01ml/kg, maximum of 0.5 ml
- b. Repeat epinephrine dose every 10-20 minutes for 3 doses
- c. Give steroids after epinephrine

2. Hypersensitivity Reactions

- a. Give antihistamines, either as single drug or in combination
- b. If status quo for 48 hrs despite combination of antihistamines, may give short course (5-7 days) of combined oral antihistamines plus steroids
- c. If patient worsens and condition requires hospitalization or becomes life threatening, may give IV steroids in addition to antihistamines

3. Indications for the use of HRIG:

- a. Positive skin test to ERIG/F(ab')₂
- b. History of hypersensitivity to equine sera
- c. Multiple severe exposures (especially where dog is sick or suspected of being rabid) on head and neck area
- d. Symptomatic HIV infected patients
- e. The patient must be asked to wait for at least one hour after injection of ERIG/F(ab')₂ in order to observe for allergic reactions which usually consist of itchiness, rashes or aching joints.

II. Treatment

1. Post-Exposure Treatment

1.1 Local Wound Treatment

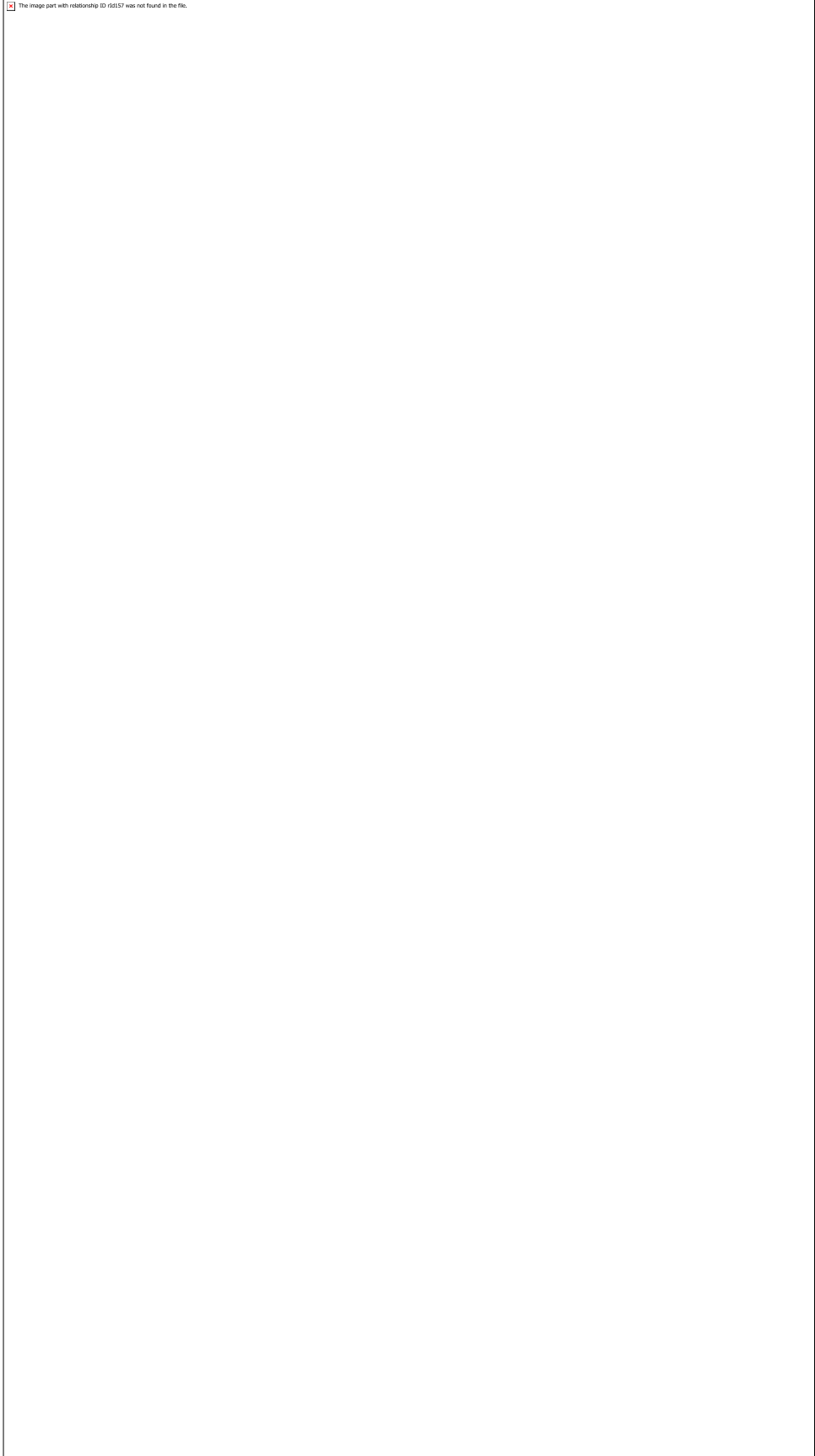
- a. Wounds should be immediately and vigorously washed and flushed with soap or detergent, and water preferably for 10 minutes. If soap is not available, the wound should be thoroughly and extensively washed with water.
- b. Apply alcohol, povidone iodine or any antiseptic.
- c. Suturing of wounds should be avoided at all times since it may inoculate virus deeper into the wounds. Wounds may be coaptated using sterile adhesive strips. If suturing is unavoidable, it should be delayed for at least 2 hrs after administration of RIG to allow diffusion of the antibody to occur through the tissues.
- d. Do not apply any ointment, cream or wound dressing to the bite site because it will favor the growth of bacteria and will occlude drainage of the wound, if any.
- e. Anti-tetanus immunization may be given, if indicated. History of tetanus immunization (TT/DPT/Td) should be reviewed. Animal bites are considered tetanus prone wounds. Completion of the primary series of tetanus immunization is recommended.

Table 4. Guide to Tetanus Prophylaxis in Routine Wound Management

Type of injury	Non-immune Incomplete	Immune*	
		Last Booster > 5 yrs ago	Last Booster < 5 yrs ago
Clean, minor wound	Td/DPT/TT (start active immunization series) ^a	TT/Td	NONE
Tetanus prone	Td/DPT/TT + TIG or ATS	TT/Td	NONE
Neglected wound	Td/DPT/TT + TIG or ATS	TT/Td + TIG or ATS	TT/Td + TIG or ATS

* Immune individual – has received at least 3 doses of DPT or TT

^a 1 dose each on days 0, 1 month and 6 months



1.3 Vaccination

a. General Principles

1. Storage

- Vaccines should be stored at +2 to +8 °C in a refrigerator, not freezer
- Once reconstituted, vaccines should be kept in the refrigerator and used within 8 hours

2. Administration

- Injections should be given on the deltoid area of each arm in adults or at the anterolateral aspect of the thigh in infants.
- Vaccine should never be injected in the gluteal area as absorption is unpredictable

b. Treatment Regimen Schedule

1. Updated 2-Site Intradermal Schedule(2-2-2-0-2)

This regimen is a modification of the original Thai Red Cross 2-site ID regimen where the day 90 dose has been transferred to day 28/30.

- One dose for ID administration is equivalent to 0.1 ml for PVRV and PCECV
- One dose should be given on each deltoid on Days 0, 3, and 7 and 28/30

Table 5. Updated 2-Site Intradermal Schedule

Day of immunization	PVRV/ PCEV	Site of injection
Day 0	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day 3	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day 7	0.1 ml	Left and right deltoids or anterolateral thighs in infants
Day 28/30	0.1 ml	Left and right deltoid or anterolateral thighs in infants
III. One intradermal dose should have at least 0.5 IU vaccine potency.		
IV. The ID injection should produce a minimum of 3 mm wheal. In the event that a dose of vaccine is inadvertently given subcutaneously or IM, the dose should be repeated		
V. A one (1) ml syringe with gauge 28 needle, preferably auto-disable syringe, should be used for ID injection		

- VI. The vaccination schedule should be strictly followed to prevent treatment failure. In certain instances when patient fails to come on the scheduled date for his succeeding dose, the following rules should apply:

Delay in day 3 dose:

- If delay is 1-2 days from day 3 schedule – give day 3 dose upon visit and follow the original schedule of day 7 and 28/30.
- If delay is 3-4 days from day 3 schedule- give day 3 dose upon visit, adjust succeeding doses (day 7 and 28/30) according to the prescribed interval.
- If delay is > 4 days from day 3 schedule – restart a new course

Delay in day 7 dose

- If delay is ≤ 7 days from day 7 schedule - give day 7 dose upon visit, give day 28/30 dose as originally scheduled
- If delay is >7 - 14 days from day 7 schedule – repeat day 3 dose and revise according to the prescribed interval
- If delay is > 14 days from day 7 schedule – restart a new course

Delay in day 28/30 dose – give day 28/30 upon visit; this may be considered as a booster.

If RIG has already been administered, it should not be given again

2. Standard Intramuscular Schedule

- Using the standard IM regimen, one dose is equivalent to 1 vial of 0.5 ml of PVRV or 1.0 ml of PCECV. One (1) dose is given intramuscularly (IM) on days 0, 3, 7, 14 and 28.

Table 6. Standard Intramuscular Schedule

Day of immunization	PVRV	PCECV	Site of injection
Day 0	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 3	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 7	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 14	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 28	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants

- II. Treatment schedule should be strictly followed to prevent treatment failure. In certain instances when patient fails to come on the scheduled date for his succeeding dose, the following rules should be followed:

Delay in day 3 dose:

- If delay is 1-2 days from day 3 schedule – give day 3 dose upon visit and follow the original schedule of day 7, 14 and 28/30
- If delay is 3-4 days from day 3 schedule- give day 3 dose upon visit, adjust succeeding doses (day 7, 14 and 28/30) according to the prescribed interval.
- If delay is > 4 days – restart a new course

Delay in day 7 dose:

- If delay is ≤ 7 days from day 7 schedule - give day 7 dose upon visit, give day 14/28 dose as originally scheduled
- If delay is >7 - 14 days from day 7 schedule – repeat day 3 dose and revise according to the prescribed interval
- If delay is > 14 days from day 7 schedule – restart a new course

Delay in day 14 dose - give day 14 dose upon visit and give day 28 dose after two weeks

Delay in day 28 dose - give day 28 dose upon visit

If RIG has already been administered, it should not be given again

3. Other Treatment Regimen Schedules

These are alternative regimens which are approved by WHO but they cannot replace the important role of RIG in Category III exposures

3.1 Zagreb Regimen Schedule (2-1-1 Intramuscular Schedule)

Table 7. Zagreb Schedule

Day of immunization	PVRV	PCECV	Site of injection
Day 0	0.5 ml	1.0 ml	Left and right deltoids or anterolateral thigh in infants
Day 7	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants
Day 21	0.5 ml	1.0 ml	One deltoid or anterolateral thigh in infants

3.2 Oxford Regimen Schedule (8-site Intradermal Schedule)

Table 8. Oxford Schedule

Day of immunization	PCECV	Number of doses	Site of injection
Day 0	0.1 ml	8	Deltoid (2), anterolateral thigh (2), lower quadrant of abdomen (2), suprascapular region (2)
Day 7	0.1 ml	4	Deltoid (2), anterolateral thigh (2)
Day 30	0.1 ml	1	Deltoid (1)
Day 90	0.1 ml	1	Deltoid (1)

1.4 Post-Exposure Treatment under Special Conditions

- Pregnancy and infancy are NOT contraindications to treatment with purified cell culture vaccines (PVRV, PCECV) and RIG.
- Babies who are born of rabid mothers should be given rabies vaccination as well as RIG as early as possible at birth.
- Alcoholic patients and those taking chloroquine, anti-epileptic drugs and systemic steroids should be given standard IM regimen as the response to ID regimen is not optimum for these conditions. Vaccination should not be delayed in these circumstances as it increases the risk of rabies.
- Immunocompromised individuals (such as those with HIV infection, cancer/transplant patients, patients on immunosuppressive therapy etc.) should be given vaccine using standard IM regimen and RIG for both Category II and III exposures.
- Exposed persons who present for evaluation or treatment weeks or months after the bite should be treated as if exposure has occurred recently. However, if the biting animal has remained healthy and alive with no signs of rabies until 14 days after the bite, no treatment is needed.

- f. Interchangeability of modern rabies vaccine brands or types is not recommended. However, in countries such as the Philippines, Thailand, Sri Lanka, France and Germany it has been practiced for many years without reported untoward events, each time circumstances made it inevitable to interchange vaccine used for administration. Shifting from one vaccine brand to another is not recommended but may be warranted in the following circumstances, provided that it is one of the WHO recommended cell culture vaccines:
 - Hypersensitivity reaction such as generalized rash, anaphylaxis, severe generalized pruritis, severe local reaction at injection site (swelling of entire upper arm)
 - Unavailability of the initial vaccine used.
- g. Since no immunogenicity studies have been done regarding change in route of vaccine administration (i.e. shift from IM to ID or vice versa), shifting from one regimen to another is NOT recommended. As much as possible the initial regimen should be completed. In extreme circumstances that shifting has to be done from IM to ID regimen or vice versa, vaccination should be restarted from day 0 using the new regimen
- h. Bites by rodents, guinea pigs and rabbits do not require rabies post-exposure treatment.
- i. Bites by domestic animals (dog, cat) and livestock (cows, pigs, horses, goats etc) as well as wild animals (bats, monkeys, etc) require PET.

1.5. Post-Exposure Treatment of Previously Immunized Animal Bite Patients

- I. Local wound care MUST always be carried out.
- II. Persons with repeat exposure after having previously received complete primary immunization with tissue culture vaccine should be vaccinated as follows:

Table 9. PET Schedule for Previously Immunized Patients

Interval from last dose	Give
<1 month	no booster
1 month - 6 months	1 booster dose
> 6 Months- 3 years	2 booster doses (D0, D3)
> than 3 years	full course of active immunization, no RIG

- III. The following patients are considered to have completed the primary immunization:
 - a. Those who have received day 0, 7, 28 of pre-exposure prophylaxis
 - b. Those who have received at least day 0, 3, 7 of post-exposure treatment

- IV. Booster doses may be given ID (0.1 ml. for PVRV or PCECV) or IM (0.5 ml for PVRV or 1.0 ml for PCECV).
- V. Patients who have previously received complete primary immunization with rabies vaccine have the advantage that booster doses will rapidly induce a large increase in antibody production (a "secondary response"). Therefore, there is no need to give RIG.
- VI. Patients who have not completed the primary immunization as described above should receive full course including RIG if needed.

2. Pre-Exposure Prophylaxis

a. Benefits

- 1. The need for passive immunization product (RIG) is eliminated
- 2. PET vaccine regimen is reduced from five to two doses
- 3. Protection against rabies is possible if PET is delayed
- 4. Protection against inadvertent exposure to rabies is possible
- 5. The cost of PET is reduced

b. Target population

- 1. Personnel in rabies diagnostic laboratories
- 2. Veterinarians and veterinary students
- 3. Animal handlers
- 4. Health care workers directly involved in care of rabies patients
- 5. Individuals directly involved in rabies control
- 6. Field workers
- 7. It is recommended that children 2-10 yrs old also be immunized because of the increased risk and severity of animal bites in this age group

c. Regimen

- 1. ID regimen – 0.1 ml at one site only for all vaccine types on days 0, 7 and 21/28
- 2. IM regimen - 1 vial of 0.5 ml for PVRV or 1 ml of PCECV given on days 0, 7 and 21/28

- d. One booster dose should be given every one to three years depending on risk of exposure (whether work-related or not).

Table 10. Pre-exposure schedule

Schedule	PVRV			PCECV		
	Day 0	Day 7	Day 21/28	Day 0	Day 7	Day 21/28
Intradermal	0.1 ml	0.1 ml	0.1 ml	0.1 ml	0.1 ml	0.1 ml
Intramuscular	0.5 ml	0.5 ml	0.5 ml	1.0 ml	1.0 ml	1.0 ml

E. Management of Rabies Patients :

Considering the fatal outcome and lack of cure for human rabies once symptoms start, treatment should center on comfort care, using sedation and avoidance of intubation and life-support measures once the diagnosis is certain.

1. Medications – any of the following regimens may be used

- a. Diazepam
- b. Midazolam
- c. Haloperidol plus Diphenhydramine – this regimen has been used at San Lazaro Hospital

Table 12. Dosage of Drugs for Management of Rabies Patients

Drug	Pediatric dose	Adult dose
Midazolam	0.1 mg/kg/dose IV, IM or PO every 4-8 hours	PO - ½ tablet } every 4-8 IM - 10-15 mg } hrs IV - 2.5-5 mg }
		Preparation: 15 mg/tablet, 5 mg/ml Ampule
Diazepam	0.3-0.5 mg/kg every 2-4 hours not to exceed 20-40 mg/kg/24 hours	INITIAL: 10 mg IV, may be requested at 10-15 min intervals until a maximum of 30 mg had been given MAINTENANCE: 10 mg 3-4 x a day Preparation: 2mg, 5 mg, 10 mg tablet; 5 mg/ml ampule (2 ml Ampule)
Morphine	< 50 kg	≥ 50 kg
	Bolus – 0.1mg/kg BW every 2-4 hrs	Bolus – 5-8mg every 2-4 hrs
Haloperidol Decanoate	0.1 mg/kg IM or IV, may repeat hourly as necessary. Maximum single dose: 5 mg.	INITIAL: 5mg IM/SC every hour for 3 doses at least or until patient is calm MAINTENANCE: 5mg IM/SC every 4 to 6 hrs and prn
<i>Note: Hypotension and dystonic reactions may occur</i>		
Diphenhydramine Hcl	1 to 2 mg/kg IV or IM: Maximum dosage, 50 mg.	50-100mg IM every 4 to 6 hrs
<i>Note: May cause sedation, specially if other sedative agents are being used. May cause hypotension.</i>		

2. Supportive care

Patients with confirmed rabies should receive adequate sedation and comfort care in an appropriate medical facility.

- a. Once rabies diagnosis has been confirmed, invasive procedures must be avoided.
- b. Provide suitable emotional and physical support.
- c. Discuss and provide important information to relatives concerning transmission of disease and indication for post-exposure treatment of contacts
- d. Honest gentle communication concerning prognosis should be provided to the relatives.

3. Infection control

- a. Patients should be admitted in a quiet, draft-free, isolation room.
- b. Healthcare workers and relatives coming in contact with patients should wear proper personal protective equipment (PPE) including gown, gloves, mask, goggles

4. Disposal of dead bodies

- a. Humans who have died of rabies generally present a small risk of transmission to others. There is evidence that blood does not contain virus but that the virus is present in many tissues such as the CNS, salivary glands and muscle. It is also present in saliva and urine.
- b. Embalming should be discouraged.
- c. Performing necropsies carelessly can lead to mucous membrane and inhalation exposures.
- d. Wearing protective clothing, goggles, face mask and thick gloves should provide sufficient protection.
- e. Instruments must be autoclaved or boiled after use.
- f. Early disposal of the body by cremation or burial is recommended.

F. Diagnosis:

Table 13. Laboratory Diagnosis for Human Rabies Suspects

Specimen*	Purpose	Test	Volume of Sample	Where
Ante/Post Mortem				
Saliva**	Virus isolation	MIT RT-PCR	1-2 ml in sterile vial	RITM
Serum	Antibody Detection	RFFIT	2 ml in sterile vial	RITM
CSF***	Antibody Detection	RFFIT	1-2 ml in sterile vial	RITM
	Viral RNA detection	RT-PCR		
Post Mortem only				
Brain (brain stem and cerebellum)	Antigen Detection	Seller's Test	1 inch ² of the brain. No formalin fixation	RITM, SLH, RADDL****
	Viral RNA detection	IFA test		
	Viral isolation	RT-PCR		
		Tissue Culture		
		MIT		

* all specimens must be temporarily stored at -20°C freezer until transport.

** It must be done at 4-6 hours interval.

*** It must be paired with a serum sample.

**** RADDL (regional animal disease diagnostic laboratory) - to facilitate preparation and transport of specimen

G. Transmission Via Organ Transplantation :

1. Clinical screening of prospective donors is recommended to include a detailed history, thorough clinical evaluation and analysis of the whole scenario.
2. Physicians responsible for screening donors must maintain a high index of suspicion for rabies.
3. Routine laboratory screening of donors for rabies is not recommended due to a requirement for testing of brain tissue, time constraints and serious consequences of a false positive result.

H. Laboratory Confirmation of Suspected Rabid Animal

1. Seller's test or Negri Body Detection - direct microscopic examination technique using impression smear for the detection of rabies inclusion bodies known as Negri Bodies. The result must be confirmed with MIT or other diagnostic tools. It has low sensitivity and specificity.

2. Immunofluorescent Antibody Test (IFAT) –immunoassay using the monoclonal antibodies specific for rabies virus in an impression smear fixed with acetone. It needs a fluorescent microscope to determine the staining reaction. It is the gold standard in the detection of rabies specific antigen.
3. Mouse Inoculation Test (MIT) –in vivo test to confirm the infectivity of the rabies virus from the inoculum of the sample into a suckling or adult mice. The long post inoculation observation, 21 days, limits the clinical usefulness in the management of animal bite cases.
4. Rabies Fluorescent Focus Inhibition Test (RFFIT) –serologic assay using a cell culture technology to determine the rabies virus neutralizing antibody (VNA) in an immunized or sick individual.
5. Reverse Transcriptase- Polymerase Chain Reaction (RT-PCR) – molecular detection of rabies nucleoprotein in a sample using rabies specific primers. Result should correlate clinically with other diagnostic tools.

I. Collection and Transport of Specimen to Rabies Laboratory

1. Specimen Collection

- a. The animal specimens should preferably be collected by a veterinarian in a clinic in order to assure that the precautionary safety measures in handling potentially infectious materials are strictly followed. The basic personal protective equipment (PPE) includes a laboratory gown, examination gloves, face masks and shields, and a disinfectant for decontamination.
- b. In the household scenario, a clean table or bench is needed for the decapitation of the animal. The following procedures should be followed:
 - I. The handler should use gloves or wrap their hands with plastic bags to prevent direct contact with the specimen.
 - II. Eye protection such as optical glasses or sunglasses should be used to prevent any tissue splatter on the eyes
 - III. An ordinary butcher's knife or bolo may be used to cut the animal's head.
 - IV. The head should be cut 2 inches away from the base in order to include important tissue components of the brainstem.
 - V. **No attempt should be made to extract the brain tissue** because this would cause additional risk to the processor.

- c. Place the head of the animal in a leak proof double household plastic bag. This constitutes the primary container. Do not put any ice cubes inside this container. No chemical preservative like 10% formalin or alcohol should be used as this will render the specimens inappropriate for examination

2. Specimen Transport

- a. Place this primary container into another household plastic bag (secondary container) with liberal amounts of ice, enough to sustain the cold temperature during transport to the laboratory.
- b. The two containers must be put into styrofoam or any leak proof transport container and brought to the nearest laboratory for testing.
- c. If the specimen cannot be transported right away, it can be stored inside a leak proof styrofoam or ice box container. Put plenty of ice/ice packs into the container to allow for overnight cold storage. Replenish the ice/ice packs as often as needed until transport to the laboratory.
- d. Label the transport container as "Rabies Suspect". Affix label with the complete name, address and phone number for both the shipper and the laboratory recipient

J. Disposal of Carcass/Disinfection

- a. Dispose the carcass by burying or burning in a pit. Disinfect the working area with 10% household bleach (chlorox) or 3% lysol.
- b. Do not encourage eating the meat of the biting animal.

Table 14. Appropriate Specimen, Volume, Mode of Transport and Corresponding Tests for Animal Rabies Diagnosis

Specimen	Purpose	Test	Volume of Sample	Transport
Head	Antigen	IFA	Actual tissue	ice cubes or dry ice
Whole body*	Virus isolation	MIT	<i>No chemical or formalin fixation</i>	
Brain Tissue	Viral RNA	RT-PCR		
Salivary Gland				
Serum**	Antibody Detection	RFFIT	1-2 ml in sterile vial	ice cubes

* Rats, bats, mice, guinea pigs

** May be used to ascertain the immune status of the biting animal

K. Management of the Biting Animal

1. The biting animal should be observed for 14 days. Adequate animal care should be provided during the observation period.
2. It is advisable for patients to consult a veterinarian, whenever possible, regarding biting animal management especially when any of the following is observed:
 - a. sudden change of behavior (from mild to vicious temperament or vice versa)
 - b. characteristic hoarse howl
 - c. watchful, apprehensive expression of the eyes, staring, blank gaze
 - d. drooling of saliva
 - e. paralysis or uncoordinated gait of hind legs
 - f. marked restlessness, pacing in cage
 - g. if at large runs aimlessly, biting anything in its way
 - h. depraved appetite, self mutilation
 - i. in some cases, lies quiescent, biting when provoked
 - j. snaps at imaginary objects
 - k. paralysis of lower jaw and tongue; inability to drink
 - l. sudden death without associated signs and symptoms
3. Post Exposure Treatment (PET) may be discontinued if the biting animal remains healthy after the 14 day observation period
4. If the animal dies or gets sick, the head should be submitted to the nearest rabies diagnostic laboratory for testing

L. Dispensing of Human Anti-Rabies Immunizing Agent

The following procedures shall be observed when assessing animal bite patients and dispensing anti-rabies immunizing agents:

1. Assess the victim thoroughly and record in the Municipal/City/Hospital Rabies Surveillance Form (Facility-based form).
2. Decide whether or not to initiate treatment using the Revised Guidelines on the Management of Animal Bite Patients as reference.
3. If the situation warrants immunization (Category II and Category III), the patient should be given the intradermal regimen. The other approved regimens may be used if the ID regimen is not feasible

4. If indicated, the patient shall be provided the required dose of passive immunization products/RIG, if available, preferably ERIG or F(ab)₂.
5. Explain your decision to the patient with particular emphasis on adherence to treatment schedules, if immunization is indicated.
6. Observe courtesy and tactfulness when dealing with patients particularly among individuals who need not be immunized.
7. Give advice on the practice of *Responsible Pet Ownership*.

M. Priorities for Dispensing Vaccines

The following shall be the program's order of priority for dispensing vaccines:

1. Patients bitten by animals found to be positive by IFAT or for "negri bodies" regardless of type of bite exposure
2. Patients with Category III exposure
3. Patients bitten by animals that are not available for observation (stray/slaughtered)
4. Individuals exposed to human rabies patients through bite/non-bite exposure
5. Patients with Category II exposure

VII. Implementing Mechanisms

A. Roles and Responsibilities

1. **Central Office** – National Center for Disease Prevention and Control should be responsible for procurement, allocation and distribution of vaccines and RIG and shall augment vaccine requirements for low- income municipalities with high incidence of rabies..

All Centers for Health Development shall be given allocation every quarter subject to availability of the rabies vaccines.

2. Centers for Health Development

The Centers for Health Development through the Director and the Rabies Control Program Coordinator shall be responsible for distribution of vaccines to the Provincial/City Health Offices.

3. Local Government Units

The Local Government units are encourage to enact and strictly enforce ordinance/s relevant to rabies control and to provide fund allocation for anti-Rabies vaccines for bite victims. The Provincial Rabies Control Coordinators shall distribute the augmented vaccines of Department of Health to established Animal Bite Treatment Center where human anti-rabies immunizing agents (vaccines and RIG) are administered. .



Republic of the Philippines
Department of Health *DOH-01-2*
OFFICE OF THE SECRETARY

June 8, 2009

ADMINISTRATIVE ORDER

No: 2009 – 0027

SUBJECT: Amendment to AO 2007- 0029 regarding the Revised Guidelines on Management of Animal Bite Patients

I. BACKGROUND/RATIONALE

Rabies, present in all continents and endemic in most African and Asian countries, is a fatal zoonotic viral disease, transmitted to humans through contact with infected animals, both domestic and wild. Rabies is estimated to cause at least 55,000 deaths per year worldwide, about 56% of which occur in Asia and 43.6% in Africa, particularly in rural areas on both continents. In the Philippines, although rabies is not among the leading causes of morbidity and mortality, rabies is considered a significant public health problem for two reasons: 1) it is one of the most acutely fatal infections and 2) it is responsible for the death of 200-300 Filipinos annually.

The Department of Health continues to be committed to the fight against rabies and has set the goal of rabies elimination in 2020. An essential part of this strategy is the provision of post-exposure prophylaxis to bite victims and pre-exposure prophylaxis to high risk individuals as mandated by the Anti-Rabies Act of 2007. Pursuant thereto, guidelines for the appropriate as well as cost-effective management of animal bite patients have been issued.

Historically the management of animal bite cases had to be updated every five (5) years and the guidelines revised accordingly to incorporate new and better treatment modalities based on research results. The first revision was made in 1997, the second in 2002 and the 3rd in 2007.

Since the release of the latest guidelines in 2007, new recommendations related to rabies management have been released by the World Health Organization and the US Centers for Disease Control. The Anti-Rabies Act of 2007 and its Implementing Rules and Regulations provided for the provision of pre-exposure prophylaxis among school children from high risk areas. These current guidelines are therefore amended to incorporate these crucial recommendations.

II. OBJECTIVE

To provide updated guidelines and procedures to ensure effective and efficient management of rabies exposures toward eventual reduction, if not elimination, of human rabies

National Rabies Prevention and Control Program Manual of Operations

III. AMENDMENTS IN AO 2007-0029

The following sections of AO 2007-0029 are hereby amended as follows:

1) Section III. COVERAGE (in page 2)

All government health workers at all levels shall adopt these treatment guidelines to ensure standardized and rational management of animal bite patients. Private practitioners in the country are strongly encouraged to adopt these treatment guidelines.

2) Section IV. DEFINITION OF TERMS (in page 2)

A. Post Exposure Prophylaxis (PEP) – formerly post exposure treatment (PET); refers to anti-rabies treatment administered *after* an exposure (such as bite, scratch, lick, etc.) to potentially rabid animals. It includes local wound care, administration of rabies vaccine with or without Rabies Immune Globulin (RIG) depending on category of exposure.

B. Pre exposure prophylaxis – refers to rabies vaccination administered *before* an exposure to potentially rabid animals. This is usually given to those who are at high risk of getting rabies such as veterinarians, animal handlers, staff in the rabies laboratory, hospitals handling rabies patients and **school children from high risk areas**, etc.

3) Section VI.A.3. **Rabies exposure is stratified in three categories with corresponding management guidelines as shown in Table 1.** (in page 4)

Table 1. Categories of Rabies Exposure with Corresponding Management

Category of exposure	Management
<u>CATEGORY I</u>	
a) Feeding/touching an animal	1. Wash exposed skin immediately with soap and water.
b) Licking of intact skin (with reliable history and thorough physical examination)	2. No vaccine or RIG needed
c) Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensils	3. Pre-exposure prophylaxis may be considered for high risk persons.
d) Casual contact (talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms of rabies	

<p><u>CATEGORY II</u></p> <ul style="list-style-type: none"> a) Nibbling of uncovered skin with or without bruising/hematoma b) Minor scratches/abrasions without bleeding c) Minor scratches/abrasions which are induced to bleed d) All Category II exposures on the head and neck area are considered Category III and should be managed as such. 	<ul style="list-style-type: none"> 1. Wash wound with soap and water. 2. Start vaccine immediately: <ul style="list-style-type: none"> a. Complete vaccination regimen until Day 28/30 (see Table 1a) if: <ul style="list-style-type: none"> i) biting animal is laboratory proven to be rabid OR ii) biting animal is killed/died without laboratory testing OR iii) biting animal has signs and symptoms of rabies OR iv) biting animal is not available for observation for 14 days b. May omit Day 28/30 dose if: <ul style="list-style-type: none"> i) biting animal is alive AND remains healthy after the 14-day observation period, OR ii) biting animal died within the 14 days observation period, confirmed by veterinarian to have no signs and symptoms of rabies and was FAT-negative 3. RIG is not indicated
<p><u>CATEGORY III</u></p> <ul style="list-style-type: none"> a) Transdermal bites (puncture wounds, lacerations, avulsions) or scratches/abrasions with spontaneous bleeding b) Licks on broken skin c) Exposure to a rabies patient through bites, contamination of mucous membranes (eyes, oral/nasal mucosa, genital/anal mucous membrane) or open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation. d) Handling of infected carcass or ingestion of raw infected meat e) All Category II exposures on head and neck area 	<ul style="list-style-type: none"> 1. Wash wound with soap and water. 2. Start vaccine and RIG immediately: <ul style="list-style-type: none"> a. Complete vaccination regimen until Day 28/30 (see Table 1a) if: <ul style="list-style-type: none"> i) biting animal is laboratory proven to be rabid OR ii) biting animal is killed/died without laboratory testing OR iii) biting animal has signs and symptoms of rabies OR iv) biting animal is not available for observation for 14 days b. May omit Day 28/30 dose if: <ul style="list-style-type: none"> i) biting animal is alive AND remains healthy after the 14-day observation period, OR ii) biting animal died within the 14 days observation period, confirmed by veterinarian to have no signs and symptoms of rabies and was FAT-negative.

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To ensure compliance to these recommendations and guarantee that animal bite patients seeking treatment in government Animal Bite Treatment Centers receive only TCV that have been proven to be safe and effective, the program shall utilize for its intradermal regimen only tissue culture vaccines that satisfy the following criteria :

1. The vaccine is registered with and approved by the Food and Drug Administration, formerly known as Bureau of Food and Drugs (BFAD);
2. The vaccine has been proven to be safe and efficacious for PEP when administered by the ID route using the schedule recommended by the World Health Organization. Having limited knowledge on and experience with the ID use of all available anti-rabies vaccines in the country, the program shall utilize the WHO list of approved TCV for ID use OR in the case of vaccines not included in the WHO list for ID use, the vaccine must comply with WHO requirements for new rabies vaccines and must have gone through local clinical trials on safety and immunogenicity which are published in peer-reviewed journals;
3. The potency of vaccines for ID use should be at least 0.5 IU/ID dose as evidenced by their lot release certificate. The potency of the vaccine batch should be provided by the manufacturer; AND
4. The product insert must contain the vaccine's approved ID dose and consistent with its Certificate of Registry (CPR) for Disease Control.

5) Section VI.B.2.a. **Types of Rabies Immune Globulins** (in page 6)

Table 3. List of Rabies Immune Globulins provided by the NRPCP to Animal Bite Treatment Centers

Generic Name	Preparation	Dose
Human Rabies Immune Globulin (HRIG)	150 IU/ml at 2 ml/vial	20 IU/kg
Purified Equine Rabies Immune Globulin (pERIG)	200 IU/ml at 5 ml/vial	40 IU/kg

6) Section VI.B.2.d. **Administration** (in page 7)

1. The total computed dose of RIG should be infiltrated around and into the wound as much as anatomically feasible, even if the lesion has healed. In case some amount of the total computed dose of RIG is left after all wounds have been infiltrated, it should be administered deep IM at a site distant from the site of vaccine injection (preferably anterolateral thigh) using another needle. The total computed dose should be administered as a **single dose**.
2. A gauge 23 or 24 needle, 1 inch length should be used for infiltration. Multiple needle injections into the same wound should be avoided.

3. A skin test must be performed prior to ERIG administration using a gauge 26 needle. For skin testing, 0.02 ml of 1:10 dilution of solution is infiltrated to raise a bleb 3 mm and read after 15 minutes. A positive skin test is an induration >6 mm surrounded by a flare/erythema. If initial skin test is positive, repeat skin test on same arm; use distilled water as control on the other arm. The skin test is considered positive if the ERIG skin test is positive but the control is negative.
4. If a finger or toe needs to be infiltrated, care must be taken not to impair blood circulation. Injection of an excessive amount may lead to cyanosis, swelling and pain.
5. RIG should not exceed the computed dose as it may reduce the efficacy of the vaccine. If the computed dose is insufficient to infiltrate all bite wounds, it may be diluted with sterile saline 2 or 3 fold for thorough infiltration of all wounds.
6. RIG should be administered at the same time as the first dose of vaccine (day 0). In case RIG is unavailable on day 0, it may still be given any time before the day 7 dose of the vaccine. However if the day 3 and/or day 7 doses of the vaccine have not been given, RIG may still be given anytime.
7. In the event that RIG and vaccine cannot be given on the same day, the vaccine should be given before RIG because the latter inhibits the level of neutralizing antibodies induced by immunization.
8. RIG is given only once during the same course of PEP.
9. Patients with Positive skin test to purified ERIG should be given HRIG.
10. HRIG is *preferred* for the following:
 - a. History of hypersensitivity to equine sera
 - b. Multiple severe exposures (especially where dog is sick or suspected of being rabid) on head and neck area
 - c. Symptomatic HIV infected patients
11. Patient must be observed for at least one hour after injection of ERIG for immediate allergic reactions.

Section VI.D.1.1.1.e. (in page 9)

Table 4. 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

8) Section VI.D1.1.5.II. **Post Exposure Prophylaxis for Previously Immunized Animal Bite Patients** (in page 15)

Table 9. PEP schedule for previously immunized animal bite patients

PrEP/PEP History (Regardless of type of TCV and route of administration in previous PrEP/PEP)	Give RIG	MANAGEMENT
Patient received the complete pre-exposure prophylaxis on Days 0, 7 and 21/28 using TCV OR Patient received at least Days 0, 3, 7 of ID/IM dose using TCVs	NO	Give 0.1 ml ID dose at 1 site each on D0 and D3 OR 1 vial IM dose at 1 site each on D0 and D3
Patient did not complete the 3 doses of PrEP OR Patient received only 1 or 2 ID/IM dose of the PEP	Give if indicated	Give Full Course of PEP

9) Section VI.D.2.e shall be added – **Routine booster doses are given depending on risk of exposure** (Table 10) (in page 17)

Table 11. Routine booster doses for previously immunized individuals

Involved personnel	Pre-exposure immunization	Serologic testing	Booster dose	
			With exposure	Without definite exposure
All workers in rabies laboratories	Recommended	Every 6 months	1 booster each on Day 0 and Day 3	- no booster if Ab titers ≥ 0.5 IU/ml - 1 booster if Ab titers fall below 0.5 IU/ml - In the absence of serologic testing, 1 booster dose every 5 years is recommended
All veterinarians, veterinary students, animal handlers (dog trainers, workers in pet shops, zoos, etc.)	Recommended	Every 2 years	1 booster each on Day 0 and Day 3	- no booster if Ab titers ≥ 0.5 IU/ml - 1 booster if Ab titers fall below 0.5 IU/ml - In the absence of serologic testing, 1 booster dose every 5 years is recommended
HCW involved in care of rabies patients; individuals involved in rabies control program; field workers, morticians	Recommended	None	1 booster each on Day 0 and Day 3	- 1 booster dose every 5 years
General population	Not Recommended but may be considered as an option in young children and other individuals with risk of exposure	None	1 booster each on Day 0 and Day 3	- None

The following provisions shall be added to section VI (page 23):

N. Injection Safety:

A safe injection is defined by the World Health Organization as an injection that:

- Does not harm the recipient
- Does not expose the health staff to any avoidable risks
- Does not result in waste that is dangerous to the community.

1. Injection Equipment

1. 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.

The program recommends that health workers use AD syringe in their respective ABTC.

2. Conventional Syringes– are plastic syringes with steel needles that are provided usually by the manufacturer in sterile package. The needle may either be fixed to the syringe when it is produced or attached by the health staff just before use.

2. Management of Sharp Waste

Used syringes and needles should never be dumped in open areas where people might pick them up, step on them, or come in contact with them in any way.

The need to better manage used or contaminated sharps is through the use of safety boxes or sharp containers. These are puncture-resistant containers where used syringes and needles can be immediately and temporarily stored after use until its final disposal.

3. Waste Disposal

Collector boxes filled with used syringes and needles should be immediately brought to its final disposal. The program recommends the following methods of disposal:

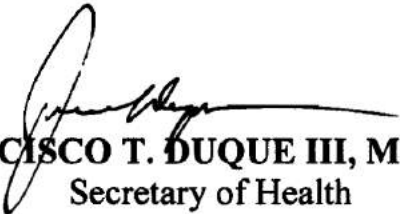
1. Use of septic vault
 2. Pit burial; and
 3. Waste treatment and final disposal to landfill
-

III. REPEALING CLAUSE

Provisions of Administrative Order No. 2007-0029 dated September 21, 2007 “Revised Guidelines on Management of Animal Bite Patients” and Administrative Order No. 2005-0022 “Amendment to A.O. 164s. 2002 dated August 25, 2005 and any other issuances inconsistent herewith are hereby rescinded.

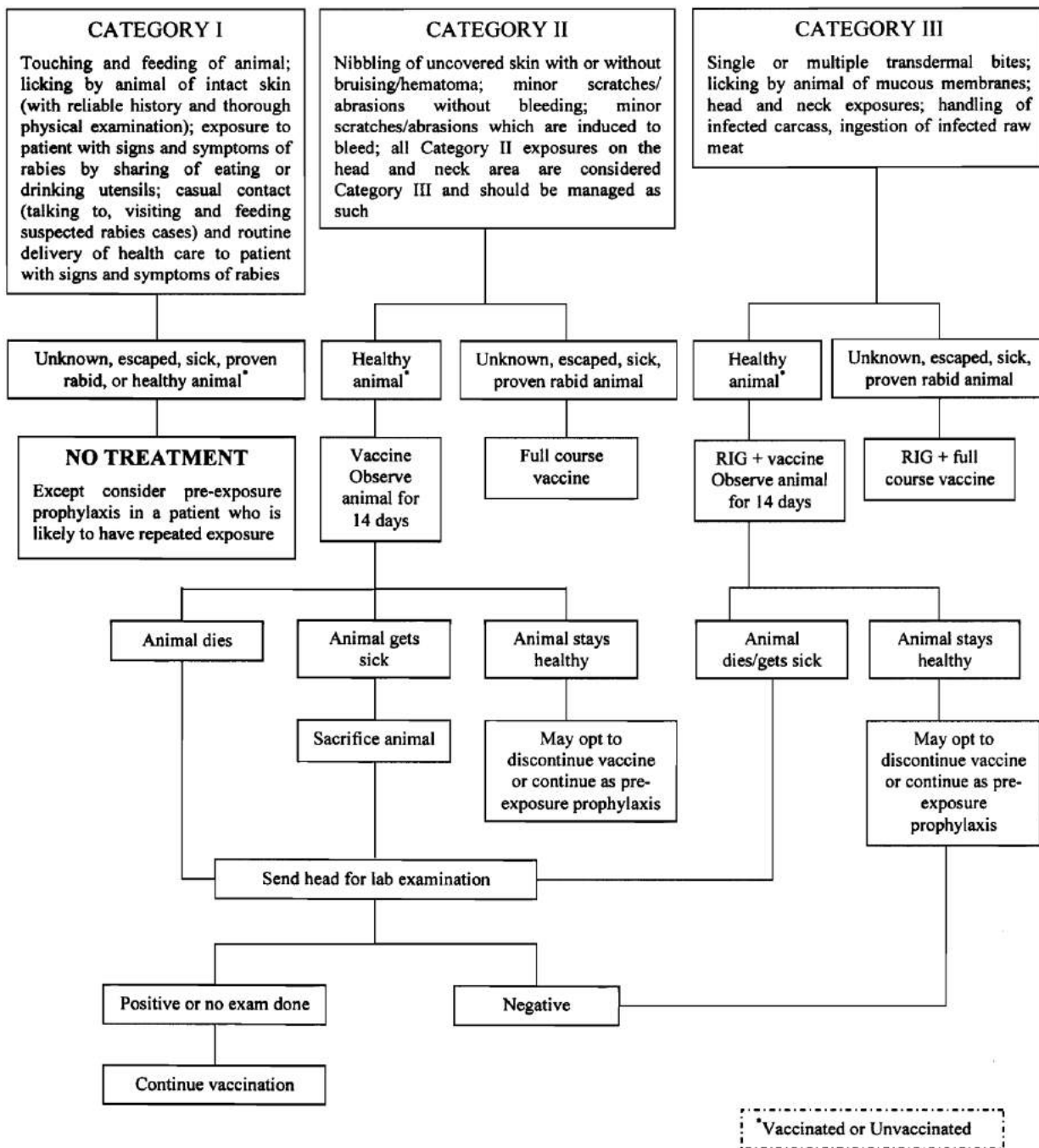
IV. EFFECTIVITY

This order shall take effect immediately.



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

ANNEX A: ALGORITHM OF THE MANAGEMENT OF ANIMAL BITES



SOURCE: Montalban, Cecilia, *et al.* 2005. **Handbook on Rabies and Dog Bites**. Manila: University of the Philippines-Philippine General Hospital Anti-Rabies Unit.

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II. DECLARATION OF POLICIES

These operational guidelines shall be guided by the following legal mandates and policies:

- A. Republic Act 9482 or the Anti-Rabies Act of 2007 – An Act Providing for the Control and Elimination of Human and Animal Rabies, Prescribing Penalties for Violation Thereof and Appropriating Funds Therefor.
- B. Memorandum of Agreement entered into by the Secretaries of the Department of Agriculture, Health, Education, Culture and Sport and the Interior and Local Government on May 8, 1991.
- C. Batas Pambansa Blg. 97 – An Act Providing for the Compulsory Immunization of Livestock, Poultry and Other Animals Against Dangerous Communicable Diseases.
- D. DOH Administrative Order No. 2007- 0029: Guidelines on Management of Animal Bite Patients
- E. DOH Administrative Order No. 2009- 0027: Amendment to AO 2007- 0029 regarding the Revised Guidelines on Management of Animal Bite Patients
- A. WHO Expert Consultation on Rabies. WHO Technical Report Series 931 First Report 2005

III. GOALS AND OBJECTIVES

To provide updated guidelines and procedures to ensure the effective and efficient management of rabies exposures toward eventual reduction, if not elimination, of human rabies

IV. SCOPE AND COVERAGE

All government health workers at all levels shall adopt these Post Exposure Prophylaxis (PEP) guidelines to ensure standardized and rational management of animal bite patients. Private practitioners in the country are strongly encouraged to adopt these guidelines.

V. DEFINITION OF TERMS

- A. Post Exposure Prophylaxis (PEP) – formerly post exposure treatment (PET); refers to anti-rabies treatment administered *after* an exposure (such as bite, scratch, lick, etc.) to potentially rabid animals. It includes local wound care, administration of rabies vaccine with or without Rabies Immune Globulin (RIG) depending on the category of exposure.
- B. Updated rabies vaccination- Dog/cat must be at least 1 yr 6 months old and has updated vaccination certificate from a duly licensed veterinarian for the last 2 years with the last vaccination within the past 12 months.
- C. Rabid Animal – refers to biting animal with clinical manifestation of rabies and/or confirmed laboratory findings of rabies.

VI. GENERAL GUIDELINES

- A. The Department of Health in collaboration with the LGUs shall be responsible for the management of animal bite victims including provision of human rabies vaccine to augment supplies of the LGUs.
- B. The Rabies Control Program shall be integrated with the regular health services provided by local health facilities.
- C. PEP shall be carried out both by the Department of Health and Local Government Units.
- D. The funding requirements to operationalize this issuance shall be secured prior to its implementation.
- E. Advocacy through information dissemination and training of health workers shall be conducted at all levels.
- F. Collaboration among government agencies, non-government and private organizations to ensure successful implementation shall be strengthened.

VII. SPECIFIC GUIDELINES AND PROCEDURES:

A. Categorization of Rabies Exposure:

Table 1. Categories of Rabies Exposure

Category of exposure	Type of Exposure
<u>CATEGORY I</u>	<ul style="list-style-type: none">a) Feeding/touching an animalb) Licking of intact skin (with reliable history and thorough physical examination)c) Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensilsd) Casual contact (talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms of rabies

<u>CATEGORY II</u>	<ul style="list-style-type: none"> a) Nibbling of uncovered skin with or without bruising/hematoma b) Minor scratches/abrasions without bleeding c) Minor scratches/abrasions which are induced to bleed d) All Category II exposures on the head and neck area are considered Category III and should be managed as such
<u>CATEGORY III</u>	<ul style="list-style-type: none"> a) Transdermal bites (puncture wounds, lacerations, avulsions) or scratches/ abrasions with spontaneous bleeding b) Licks on broken skin c) Exposure to a rabies patient through bites, contamination of mucous membranes (eyes, oral/nasal mucosa, genital/anal mucous membrane) or open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation. d) Handling of infected carcass or ingestion of raw infected meat e) All Category II exposures on head and neck area

I. Management

I. PEP is not recommended for all Category I exposures.

II. PEP can be delayed for Category II Exposures provided that ALL of the following conditions are satisfied:

- i. Dog/cat is healthy and available for observation for 14 days**
- ii. Dog/cat was vaccinated against rabies for the past 2 years:**
 - a. Dog/cat must be at least 1 yr 6 months old and has updated vaccination certificate from a duly licensed veterinarian for the last 2 years
 - b. The last vaccination must be within the past 12 months, the immunization status of the dog/cat will not be considered updated if the animal is not vaccinated on the due date of the next vaccination

*** If biting dog/cat becomes sick or dies within the observation period, PEP should be started immediately**

III. PEP should be given immediately for ANY of the following conditions:

- i. The rabies exposure is category III;**
- ii. The dog/cat is proven rabid/sick/ dead with no laboratory exam for rabies/not available before or during the consultation;**
- iii. The dog/cat is involved in at least 3 biting incidents within 24 hours or**
- iv. Dog/cat manifests the following behavior changes suggestive of rabies before, during or after the biting incident:**

Table 2. Clinical Signs of Animal Rabies

Prodromal Stage (usually lasts 2-3 days; sometimes only a few hours)	
<p>A. Changes in attitude/behavior/temperament such as unusual shyness or aggressiveness</p> <ol style="list-style-type: none"> Friendly animal becomes aggressive Solitude Restlessness Snapping at imaginary objects Apprehension Nervousness Anxiety Barking/vocalization at the slightest provocation <p>B. Dilated pupils; become myotic in advance state</p> <p>C. Mydriasis and/or sluggish palpebral or corneal reflexes</p> <p>D. Slight rise in body temperature (slight fever)</p>	
Clinical Rabies	
Furious Stage (usually lasts 1-7 days)	Paralytic (dumb) stage (develops 2-10 days after clinical signs; usually last 2-4 days)
<p>I. Increased response to auditory and visual stimulation such as</p> <ul style="list-style-type: none"> Restlessness Photophobia Hyperaesthesia, Eating unusual objects Aggression Attacking any live or inanimate objects <p>II. Erratic behavior</p> <ul style="list-style-type: none"> Biting or snapping Licking or chewing of wound/bite site If caged, biting of their cage Wandering and roaming Excitability; Irritability; Viciousness <p>III. Self-mutilation</p> <p>IV. Muscular in-coordination and seizures</p> <p>V. Disorientation</p> <ul style="list-style-type: none"> Roams and bites inanimate object and also other animals including man 	<p>Paralysis</p> <ul style="list-style-type: none"> Paralysis may begin at the bite area And progress until entire CNS involvement Following paralysis of the head and neck, the entire body becomes paralyzes Change in tone of vocalization/barking (indicative of laryngeal/pharyngeal paralysis) Hypersalivation or frothing ; drooling/slobbering of saliva (indicative of laryngeal/pharyngeal paralysis) Dysphagia/difficulty/inability to swallow (indicative of laryngeal/pharyngeal paralysis) "Jaw drop"/Dropped jaw due to masseter muscle paralysis (suspects foreign body in mouth or esophagus) Pupil dilation or pupil constriction Protrusion of third eyelid Ataxia, progressive paralysis and cannibalism (terminal stage) Coma and/or respiratory paralysis resulting in death within 2-4 days

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X. EFFECTIVITY

This order shall take effect immediately.



ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health



PROCESO J. ALCALA
Secretary of Agriculture

DEPARTMENT OF AGRICULTURE
In replying pls cite this code :
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A. SELF-ASSESSMENT CYCLE:

This is the cycle in which the facility head shall accomplish the *Self-Assessment Form* (SAF). It is the preliminary step of the certification process that provides an initial assessment of the quality of PEP services rendered by the ABTC/ABC. In this cycle, the facility shall internally assess its own PEP implementation, in accordance to the certification standards written in the SAF.

1. Phases

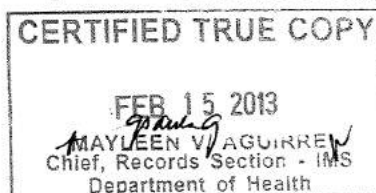
- a. *Self-Assessment Phase* – This is the phase when the staff of the ABTC/ABC headed by a trained physician shall undertake its own assessment based on the standards written in the SAF to facilitate its application for certification.

The SAF contains the following minimum standards:

- i. The ABTC/ABC is adequately equipped to provide quality and safe PEP (refrigerator, vaccines, emergency drugs, water supply, waste disposal and recordings.)
 - ii. The ABTC/ABC provides for the privacy and comfort of its patients and staff,
 - iii. The ABTC/ABC is managed by trained doctors and nurses
 - iv. Rabies exposures are accurately categorized and managed,
 - v. Patients have continuous access to safe and effective modern tissue culture vaccines and rabies immune globulin throughout the duration of their management,
 - vi. PEP is provided by a trained medical doctor and nurse.
 - vii. The training certificate from a DOH recognized training facility is posted prominently in the health facility
 - viii. The ABTC maintain an updated rabies exposure registry.
- b. *Technical Assistance Phase* – This is the phase for provision of technical assistance to the ABTC/ABC by a TA Team composed of the Provincial or City NRPCP Coordinators and DOH Representatives. The Team shall assist the facility to fulfill the standards on ABTC certification and ensure the proper filling-up of the SAF to facilitate their application for ABTC/ABC certification.

2. Procedures:

- a. Any ABTC/ABC shall undergo self-assessment as the preliminary step in the certification process.
- b. The facility shall request for technical support from the TA Team that is at the level of the Province/City. As TA providers, they shall verify the initial findings and validate the contents written by the facility in their SAF.
- c. The self-assessment cycle is completed once the SAF is finally accomplished and is now ready for submission to the CHD.
- d. The self-assessment cycle has no time limit and depends upon the readiness of the facility to conform to the standards of ABTC certification. The TA Team shall assess the readiness of the facility to achieve certification and accreditation.



B. APPLICATION CYCLE (Application for Certification)

This is the step in which interested bite treatment facilities shall express their intention on certification, vis-à-vis, agreeing to the conduct of an external assessment on the quality of their ABTC/ABC services. Application shall be made once the facility has finally completed the SAF; an indication also that the facility is now ready to be certified.

1. Procedures

- a. Any ABTC/ABC facility can apply for certification. The Head of the bite treatment facility shall submit to the respective CHD NRPCP Coordinators a written **Letter of Intention on Certification (LOIC)** expressing their intention to be certified. Only the LOIC shall be submitted to the CHD. The SAF shall remain in the facility and shall be used upon the visit of the certifying team, during the certification proper.
- b. The CHD NRPCP Coordinator/s shall file all the applications received to serve as bases for their coordination with the SS Staff, as invitation to their designated private representative and as itinerary to prioritize their travel.

C. CERTIFICATION CYCLE

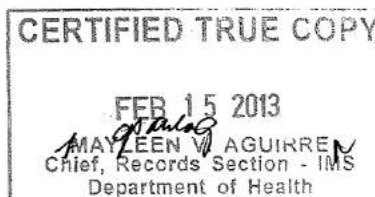
This refers to the actual conduct of the certification process to be undertaken by the ABTC certifying team at the CHD level. In this cycle, the facility shall be externally assessed, based on the standards written in the SAF. The facility is either given the *approval* for ABTC certification or is recommended by the team for a *re-assessment*.

1. Phases

- **Preparatory Phase** – This consists of the necessary coordination with the other members of the certifying team, the logistical preparations and the schedule of visits or itinerary of travel. As head of the team, the CHD NRPCP Coordinators shall facilitate all the requirements for the certification proper. The CHD NRPCP Coordinators shall coordinate with the respective CHD *Sentrong Sigla Staff* concerned on ABTC certification, to synchronize their schedules for the actual certification visits.
- a. **Validation Phase** – this pertains to the actual visit of facilities by the CHD certifying team. The tool to be used by the team is also the SAF, in which they assess the facility's quality of Post Exposure Prophylaxis (PEP) services in accordance to the standards. They shall validate the findings in the SAF, deliberate and agree among themselves, the appropriate rating per criterion. The team shall also use the same rating scale stipulated in the SAF.

2. Procedures

- a. The CHD NRPCP Coordinator shall be the head of the certifying team. The minimum composition of each team shall be three; maintaining an odd number to prevent a neutral decision.



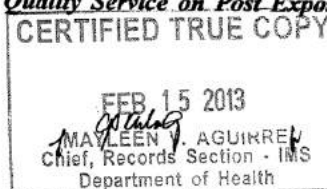
- b. For every facility visited, the team shall validate the findings written by the facility in their SAF. They shall then, give their corresponding rating after coming up with a consensus. The overall decision of whether the facility is certified or for re-assessment shall be made once the entire certification visit is already completed.
- c. The team shall furnish each facility a written response of their final decision about the certification process conducted. They shall provide the facility the **"Summary Report on ABTC/ABC Certification"** that shall briefly describe the visit, the team's rating per standard; and, shall indicate whether the facility is certified or needs re-assessment. The certification of the ABTC/ABC facility will be valid for two years.
- d. *The decision of the CHD certifying team shall remain final and official.* This shall also serve as the basis of approval for the facility's certification.
- e. For those facilities that need re-assessment, the TA Team shall be notified by the certifying team for the same purpose. The CHD NRPCP Coordinator can also be requested to provide technical assistance and be part of the TA Team. However, in his/her capacity to provide technical assistance, the latter shall now abstain from participating in the actual conduct of the re-assessment process, to prevent bias. The facility shall be encouraged to re-apply the soonest possible time.
- f. If a facility is still found to be unfit for certification on three consecutive occasions, a joint monitoring composed of the central, CHD, provincial/city levels shall be scheduled to assist the facility in their certification.
- g. For those facilities that need to be re-certified, upon expiration of their ABTC certificate, the same process/step shall also be undertaken.

D. REGISTRATION AND ISSUANCE CYCLE

The registration and issuance cycle covers the period where the ABTCs, both certified and those for re-assessment are registered in the central registry at the CHD. This cycle is also the time allotted for the preparation of the official ABTC Certificate intended for those qualified facilities. The cycle involves mainly the role of the CHD in the certification process. Registration and issuance of ABTC/ABC certificates are done upon receipt of the summary report from the various CHDs.

1. Procedures

- a. Upon receipt of the summary reports from the CHDs, the NRPCP coordinator shall register the various facilities (whether certified or for re-assessment) in the central registry on ABTC certification. Each facility registered shall be assigned a registration number to easily track their certification status. However, a certification number is assigned only to those facilities that qualify in the ABTC certification. The registry is maintained at the National Center for Disease Prevention and Control (NCDPC), DOH.
- b. For those certified facilities, the CHD shall automatically issue the official quality certificate or the, **"Certificate of Quality Service on Post-Exposure Prophylaxis"**,



duly signed by the CHD Director and dry sealed for authenticity. Likewise, a congratulatory note is attached to encourage the facility in their application for accreditation.

- c. The affectivity of the ABTC certificate shall be for two (2) years upon date of issuance. However, regular monitoring of ABTC implementation and performance shall still be continued in-between, to sustain and safeguard the good quality of PEP services.

VI. IMPLEMENTING MECHANISMS

A. Roles and Responsibilities

The participating agencies in the ABTC certification process are representatives of both public and private sectors. This ensures impartiality in as much as both sectors are represented during the actual certification process. Likewise, there is provision of technical assistance prior to the conduct of certification proper, to facilitate the needs of the facility for compliance with the standards, including those requirements for the availment of the PHIC Animal Bite OPD Benefit Package. The key players and their respective roles are as follows:

1. DOH

a. *The National Center for Disease Prevention and Control (NCDPC)*

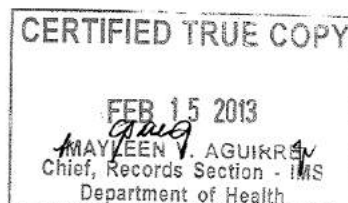
The NCPDC shall:

- a.1. Register all certified ABTCs forwarded by the CHDs. NCDPC shall maintain this official registry of all certified ABTCs, both public and private. They shall be responsible to assign the respective *certification number* per certified ABTC on a chronological basis. Those facilities that did not qualify but are recommended by the CHD certifying team for re-assessment shall also be registered.
- a.2. Prioritize in their monitoring visits those facilities that need re-assessment. This shall be done in joint cooperation with the CHD/PHO/CHO, to analyze the reasons for non-qualification and provide recommendations to improve PEP implementation.

b. *Center for Health Development (CHD)*

The CHD shall:

- b.1. Validate the findings of the facility as stipulated in the SAF. When possible, this shall be done in joint participation of the *Sentrong Sigla* certifiers/assessors, trained on ABTC certification. The CHD NRPCP Coordinators shall be the overall leaders of the certifying team.
- b.2. Exercise impartiality during the certification proper. Since their role is critical in the certification process, they shall function with objectivity at all times and in all ABTCs.



- b.3. Ensure that feedback of the results of the certification process is provided to the respective technical assistance team, particularly, among those facilities that need to be re-assessed. This feedback is important to strengthen the technical assistance that a facility needs, in order to be certified during the re-assessment.
- b.4 Issue the "*Certificate of Quality Service on PEP*" duly signed by the Regional Director and dry sealed for authenticity
- b.5. Quarterly submit to NCDPC an updated list of newly of Certified ABTC/ABC duly signed by the CHD Director. The list shall also include recently delisted ABTCs and ABCs.

c. DOH Representatives

The DOH Representatives shall:

- c.1. Facilitate the submission of all pertinent documents to the Province/City, CHD and vice-versa, in accordance with the set time frame.
- c.2. Participate in the provision of technical assistance together with the Provincial/City NRPCP Coordinators. As members of the technical assistance team, they shall support the areas they represent. However, due to limited Staff at the CHD, they shall also function as certifiers in areas outside their responsibility, or in areas where they did not provide technical assistance.
- c.3. Ensure that the re-assessment be undertaken jointly with the technical assistance team in the event that the facility needs to be re-assessed.

2. Local Government Units (LGU)

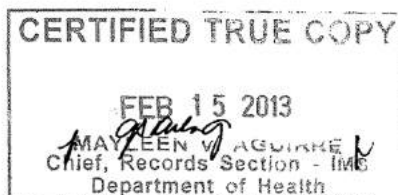
a. Provincial/City NRPCP Coordinators

The Provincial/City Coordinator shall:

- a.1. Provide technical assistance to the ABTCs/ABCs. This covers technical support to the facility in order to cope with the required standards and eventually, be certified. They shall also assist in the proper completion of the SAF, prior to submission to the CHD certifiers that shall serve as the basis for the latter's validation of the ABTC/ABC performance. As the local experts on NRPCP, they shall head the technical assistance team.

B. FUNDING

All expenses to be incurred in the performance of the NRPCP-ABTC certification activity of the public sector shall be borne by the respective CHDs.



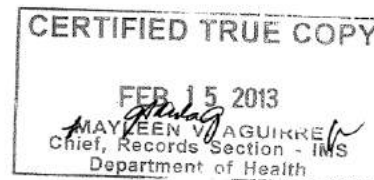
VII. MONITORING AND EVALUATION

Certified bite treatment facilities shall be monitored at least once a year by the CHD to keep track of the overall progress of the NRCP – ABTC certification at the LGU levels. This shall ensure that certified bite treatment facilities continuously comply with the standards set the program even after receiving the certification. The CHD monitoring team shall recommend to the CHD Director the suspension or revocation of the certification depending on the gravity of the deficiencies noted during the monitoring visit/s.

VIII. EFFECTIVITY:

This Order shall take effect immediately.


ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health



DOH / CHD SELF ASSESSMENT TOOL

Facility:					
Major Requirements:				YES	NO
1. Trained Physician and Nurse on Management of Animal Bites from DOH recognized training institution				<input type="checkbox"/>	<input type="checkbox"/>
2. Cold Chain equipment (Refrigerator and Vaccine carrier)				<input type="checkbox"/>	<input type="checkbox"/>
3. Standard recording & reporting system				<input type="checkbox"/>	<input type="checkbox"/>
Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 1	The Animal Bite Treatment Center/ Animal Bite Center provides a safe and effective physical environment to its patients and staff				
Standard 1	The ABTC/ABC is easily located and patients have convenient and safe access to the center				

This standard will be achieved when:

1.1. There is appropriate signage bearing the name of the ABTC/ABC to assist patients accessing the center				
1.2 Physical access is appropriate for the needs of the patients				
1.3 Entrance/exits are clearly marked and free of obstruction and of other hazardous conditions				
1.4 There are resources to inform patients of the daily schedule of the facility				
TOTAL RATING				

Rating Scale

0 – Non Compliant; 1- Incomplete; 2- Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: The Animal Bite Treatment Center/Animal Bite Center provides a safe and effective physical environment to its patients and staff.

Standard 1: The Animal Bite (and) Treatment Center/Animal Bite Center is easily located and patients have convenient and safe access to the center.

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 1	The Animal Bite Treatment Center/Animal Bite Center provides a safe and effective physical environment to its staff and patients				
Standard 2	The ABTC/ABC provides facilities for the comfort and privacy of its patients and staff.				

This standard will be achieved when:

2.1 The ABTC/ABC maintains a clean and health promoting environment within and immediately outside its premises.				
2.2 There are resources and processes to ensure the quality of patient waiting time.				
2.3 The facility is adequately lighted.				
2.4 The privacy of every patient is assured				
TOTAL RATING				

Rating Scale

- 0 – Non Compliant
- 1 – Incomplete
- 2 - Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: The Animal Bite Treatment Center/Animal Bite Center provides a safe and effective physical environment to its patients and staff

Standard 2: The ABTC/ABC provides facilities for the comfort and privacy of its patients and staff.

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 1	The Animal Bite Treatment Center/Animal Bite Center Provides a safe and effective physical environment to its patients and staff				
Standard 3	The ABTC/ABC provides safety to its patients and staff				

This standard will be achieved when:

3.1 The facility has adequate clean water for wound cleaning, personal hygiene, and sanitation purposes				
3.2 The facility maintains appropriate levels of cleanliness and antisepsis of all physical areas, equipment and instruments.				
3.3 General waste, sharps, pathological and infectious waste, pharmaceutical and chemical wastes are appropriately segregated, safely handled and disposed of according to accepted safe disposal practices.				
3.4 There are documented, disseminated, and implemented procedures to identify and address the risks of contamination of patients and staff from sources of infectious diseases.				
TOTAL RATING				

Rating Scale

0 – Non Compliant

1 – Incomplete

2 – Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: The Animal Bite Treatment Center/Animal Bite Center provides a safe and effective physical environment to its patients and staff

Standard 3 The ABTC/ABC provides safety to its patients and staff

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 2	Patients receive appropriate and effective clinical management based on rabies exposure category.				
Standard 4	All patients have continuous access to accurate and reliable animal bite exposure management.				

This standard will be achieved when:

4.1 A physician completes and documents the relevant history for each patient				
4.2 The facility implements policies and procedures for assuring the quality of bite exposure management.				
4.3 If Rabies Vaccine/RIG is not available, policies and procedures for referring patients to another accessible ABTC/ABC are implemented and monitored for effectiveness.				
4.4 Rabies Vaccine / RIG are secured and proper cold chain management is observed.				
TOTAL RATING				

Rating Scale

- 0 – Non Compliant
- 1 – Incomplete
- 2 - Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: Patients receive appropriate and effective clinical management based on rabies exposure category.

Standard 4: All patients have continuous access to accurate and reliable animal bite exposure management.

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 2	Patients receive appropriate and effective clinical management based on rabies exposure category.				
Standard 5	A comprehensive management approach is developed and followed for all patients				

This standard will be achieved when:

5.1 Management of rabies exposure is consistent with Rabies Prevention and Control Program Guidelines.				
5.2 Flow chart of patient management is visible and accessible to expedite the provision of services to patients.				
5.3 A comprehensive evaluation of the patient's progress is documented.				
5.4 Health education is provided to all patients on adherence to management and on responsible pet ownership.				
5.5 Policies and procedures for detecting PEP defaulters and getting them back for management are implemented and monitored for effectiveness.				
TOTAL RATING				

Scale Rating

0 – Non Compliant

1 – Incomplete

2 - Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: Patients receive appropriate and effective clinical management based on rabies exposure category.

Standard 5: A comprehensive management approach is developed and followed for all patients

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal 3	The health staff adheres to clear policies and guidelines on efficient ABTC /ABC operation				
Standard 6	The ABTC/ABC maintains accurate and updated records and reports to all animal bite victims.				

This standard will be achieved when:

6.1 Each patient is uniquely identified throughout the course of management.				
6.2 The facility maintains an updated database of patient records that is accessible to authorized personnel.				
6.3 The facility maintains quarterly reports of both animal and human bite cases.				
6.4 The facility maintains a quarterly inventory of Rabies vaccine/RIG.				
TOTAL RATING				

Rating Scale

- 0 – Non Compliant
- 1 – Incomplete
- 2 – Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: The health staff adheres to clear policies and guidelines on efficient ABTC /ABC operation

Standard 6: The ABTC/ABC maintains accurate and updated records and reports of all animal bite victims.

Item	Criterion	PART I		PART II	
		Evidence by Progress and Achievements	Facility Rating	Certifiers' Comments	Certifiers' Team Rating
Goal IV	The ABTC/ABC Provides quality services with competent manpower to its patient				
Standard 7	The ABTC/ABC has complete manpower complement performing assigned tasks.				

This standard will be achieved when:

7.1 The facility has qualified personnel trained on Animal Bite Management		
7.2 There are personnel responsible for the following		
7.2.1 Diagnosis and Management		
7.2.2 Provision of Rabies Vaccine/RIG		
7.2.3 Logistics Management		
7.2.4 Information Management		
7.2.5 Financial Management		

Rating Scale

- 0 – Non Compliant
- 1 – Incomplete
- 2 – Complete

REMARKS BY THE CERTIFIERS' TEAM

(To be completed if and when there are disparities with the information provided by the facility staff)

Goal: The ABTC/ABC Provides quality services with competent manpower to its patient

Standard 7: The ABTC/ABC has complete manpower complement performing assigned tasks.

OVERALL RATING AND SUMMARY PER GOAL

GOAL	MAXIMUM RATING	TOTAL	
		ABTC RATING	ASSESORS
1	8		
2	8		
3	6		
4	8		
5	8		
6	10		
TOTAL	48		

RATER**REMARKS BY THE CERTIFIERS' TEAM**

(To be completed if and when there are disparities with the information provided by the facility staff)

The decision of the CHD certifying team shall remain FINAL and OFFICIAL

The certification of the facility shall be valid for period of two (2) years but can be revoked at any point in time if for three (3) consecutive occasions seem to be not adhering to the standards.

DOH ABTC / ABC ASSESSMENT TOOL			
Facility:			
Major Requirements:		YES	NO
1. Trained Physician and Nurse on Management of Animal Bites from DOH recognized training institution		<input type="checkbox"/>	<input type="checkbox"/>
2. Cold Chain equipment (Refrigerator and Vaccine carrier)		<input type="checkbox"/>	<input type="checkbox"/>
3. Standard recording & reporting system		<input type="checkbox"/>	<input type="checkbox"/>
Goal 1	The Animal Bite Treatment Center/ Animal Bite Center provides a safe and effective physical environment to its patients and staff		
Standard 1	The ABTC/ABC is easily located and patients have convenient and safe access to the center		
	MEANS OF VERIFICATION		Scoring
1.1. There is appropriate signage bearing the name of the ABTC/ABC to assist patients accessing the center	<ul style="list-style-type: none"> ➤ OFFICIAL NRPCP SIGNAGE INFRONT OF THE CENTER THAT IS READABLE FROM A 50-METERS DISTANCE ➤ DIRECTIONAL SIGNAGE FROM THE MAIN HIGHWAY TO THE ABTC/ABC (IF NEEDED) 		
1.2 Physical access is appropriate for the needs of the patients	<ul style="list-style-type: none"> ➤ PROVISIONS FOR DIFFERENTLY ABLED (eg RAMP, HAND RAILS ETC-IF NEEDED) ➤ NO OBSTRUCTIONS (eg. NO PARKING SIGNS,) 		
1.3 Entrance/exits are clearly marked and free of obstruction and of other hazardous conditions	<ul style="list-style-type: none"> ➤ LABELLED ENTRANCE AND EXIT IS IDENTIFIED W/ NO OBSTRUCTION /CLUTTER 		
1.4 There are resources to inform patients of the daily schedule of the facility	<ul style="list-style-type: none"> ➤ SCHEDULE OF VACCINATION IS POSTED IN CONSPICUOUS PLACE, CLEAR & VISIBLE IN ENTRANCE TO THE FACILITY ➤ SCHEDULE OF VACCINATION IS DISTRIBUTED THROUGH FLYERS OR THROUGH TRI-MEDIA 		

Goal 1	The Animal Bite Treatment Center/Animal Bite Center provides a safe and effective physical environment to its staff and patients		
Standard 2	The ABTC/ABC provides facilities for the comfort and privacy of its patients and staff.		
	MEANS OF VERIFICATION		
2.1 The ABTC/ABC maintains a clean and health promoting environment within and immediately outside its premises.	<ul style="list-style-type: none"> ➤ ACTUAL OBSERVATION(CLEAN, NO MESS OR GARBAGE, NO OFFENSIVE SMELL IN & OUT OF THE PREMISES) ➤ CLEANING SCHEDULE ➤ PERSON IN CHARGE IN CLEANING 		
2.2 There are resources and processes to ensure the quality of patient waiting time.	<ul style="list-style-type: none"> ➤ WELL VENTILATED WAITING AREA W/ CHAIRS ➤ IEC MATERIALS, TV/DVD ➤ Patient's Interview ➤ Actual observation 		
2.3 The facility is adequately lighted.	<ul style="list-style-type: none"> ➤ Observation ➤ Readable newsprint ➤ No shadow while standing 		
2.4 The privacy of every patient is assured	<ul style="list-style-type: none"> ➤ Examination room is secured, curtains or other materials to see to it that the patients are afforded their privacy 		

	➤ Standard room privacy observed	
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Goal	The Animal Bite Treatment Center/Animal Bite Center Provides a safe and effective physical environment to its patients and staff	
3	The ABTC/ABC provides safety to its patients and staff	
	MEANS OF VERIFICATION	
3.1 The facility has adequate clean water for wound cleaning, personal hygiene, and sanitation purposes	<ul style="list-style-type: none"> ➤ Actual Observation (, Clean source of water, soap, and trash can is available) ➤ Wash area (CR, faucet, dipper & pail etc) 	
3.2 The facility maintains appropriate levels of cleanliness and antisepsis of all physical areas, equipment and instruments.	Actual Observation: <ul style="list-style-type: none"> ➤ Instruments used in ABTC shld be soaked in any antiseptic solution; soaking solution is changed every 2 weeks ➤ Presence of alcohol or other antiseptic solution; phenolic type of disinfectants ➤ Sterilizer for instruments 	
3.3 General waste, sharps, pathological and infectious waste, pharmaceutical and chemical wastes are appropriately segregated, safely handled and disposed of according to accepted safe disposal practices.	<ul style="list-style-type: none"> ➤ Waste disposal segregation color coded bin/properly labelled as to sharps, pathologic, gen waste ➤ Safety box/container for sharps ➤ Policies & procedures on proper Waste Disposal 	
3.4 There are documented, disseminated, and implemented procedures to identify and address the risks of contamination of patients and staff from sources of infectious diseases.	<ul style="list-style-type: none"> ➤ Policy on infection control ➤ PreP Vaccination of ABTC/ABC staff ➤ 	

Goal	Patients receive appropriate and effective clinical management based on rabies exposure category.	
4	All patients have continuous access to accurate and reliable animal bite exposure management.	
	MEANS OF VERIFICATION	
4.1 A physician completes and documents the relevant history for each patient	<ul style="list-style-type: none"> ➤ Review of records(ITR- SOAP, RER, PEP Card) ➤ 	
4.2 The facility implements policies and procedures for assuring the quality of bite exposure management.	<ul style="list-style-type: none"> ➤ Algorithm of Categorization ➤ Policies & procedures 	
4.3 If Rabies Vaccine/RIG is not available, policies and procedures for referring patients to another accessible ABTC/ABC are implemented and monitored for effectiveness.	<ul style="list-style-type: none"> ➤ two way referral system ➤ Referral form ➤ Referral Slip ➤ Referral logbook 	
4.4 Rabies Vaccine / RIG are secured and proper cold chain management is observed.	<ul style="list-style-type: none"> ➤ Observation(presence of refrigerator, vaccine carrier, thermometer, updated temp monitoring chart) ➤ Review of Documents(Contingency plan in case of power failure 	

Goal 2	Patients receive appropriate and effective clinical management based on rabies exposure category.	
Standard 5	A comprehensive management approach is developed and followed for all patients	
	MEANS OF VERIFICATION	
5.1 Management of rabies exposure is consistent with Rabies Prevention and Control Program Guidelines.	<ul style="list-style-type: none"> ➤ Document review(RER, ITR, PEP Card) ➤ Patient Interview ➤ Interview Staff 	
5.2 Flow chart of patient management is visible and accessible to expedite the provision of services to patients.	<ul style="list-style-type: none"> ➤ Observation (flow chart) ➤ Patient Interview ➤ Interview Staff 	
5.3 A comprehensive evaluation of the patient's progress is documented.	<ul style="list-style-type: none"> ➤ Progress notes on patients chart ➤ Updated RER 	
5.4 Health education is provided to all patients on adherence to management and on responsible pet ownership.	<ul style="list-style-type: none"> ➤ Review Documents(syllabus of Health Ed) ➤ Observation (Presence of IEC Materials) ➤ Patient Interview ➤ Interview Staff 	
5.5 Policies and procedures for detecting PEP defaulters and getting them back for management are implemented and monitored for effectiveness.	<ul style="list-style-type: none"> ➤ Defaulter tracing mechanism (SMS, phone calls, email etc) ➤ Written policies & procedures ➤ Defaulter logbook ➤ 	

Goal	The health staff adheres to clear policies and guidelines on efficient ABTC /ABC operation	
6	The ABTC/ABC maintains accurate and updated records and reports to all animal bite victims.	
	MEANS OF VERIFICATION	
6.1 Each patient is uniquely identified throughout the course of management.	<ul style="list-style-type: none"> ➤ patient registration number ➤ Look for ITR, RER, PEP Card 	
6.2 The facility maintains an updated database of patient records that is accessible to authorized personnel.	<ul style="list-style-type: none"> ➤ RER, NaRIS ITR ➤ Record-keeping mechanism ➤ 	
6.3 The facility maintains quarterly reports of both animal and human bite cases.	<ul style="list-style-type: none"> ➤ Filed updated Qtrly report (received copy-if emailed indicate date) 	
6.4 The facility maintains a quarterly inventory of Rabies vaccine/RIG.	<ul style="list-style-type: none"> ➤ Vaccine Inventory Report ➤ Updated vaccine stock card ➤ Physical count of vaccines ➤ 	

Goal IV	The ABTC/ABC Provides quality services with competent manpower to its patient
Standard 7	The ABTC/ABC has complete manpower complement performing assigned tasks.

	MEANS OF VERIFICATION	
7.1 The facility has qualified personnel trained on Animal Bite Management	Certificate of training from a DOH accredited training facility	
7.2 There are personnel responsible for the following		
7.2.1 Diagnosis and Management	Physician in charge	
7.2.2 Provision of Rabies Vaccine/RIG	Physician/Nurse	
7.2.3 Logistics Management	Nurse/Pharmacist	
7.2.4 Information Management	Physician/Nurse	
7.2.5 Financial Management	Cashier/Nurse/ Person-in-charge	

SCORING

0 grade in any standard means non provision of certification.

Passing score is equivalent to a total score of 50 points and above.

SUMMARY RATING

Standard	MAXIMUM RATING	TOTAL	
		ABTC RATING	CERTIFIER
1	8		
2	8		
3	8		
4	8		
5	10		
6	8		
7	12		
TOTAL	62		

RATER

RATER

COMMENTS, COMMENDATIONS AND RECOMMENDATIONS BY THE SURVEY TEAM

(To be completed by the survey team only. The survey team must make comments on items where the survey team disagrees or partially disagrees with information provided by the Animal Bite and Treatment Center.)

APPENDICES:

- 1. ABTC Certification**
- 2. List of Animal Bite Treatment Centers**
- 3. List of Rabies Diagnostic Laboratories**
- 4. NEC Surveillance Form**
- 5. NCRPC Form:**
 - a. Accomplishment Report Form**
 - b. Cohort Analysis for PEP**
 - c. Human Rabies Form**
 - d. Rabies Exposure Registry**
 - e. Inventory Form**
 - f. PEP Card**



Republic of the Philippines
Department of Health
National Rabies Prevention and Control Program



CERTIFICATE OF QUALITY SERVICE

Is hereby issued to

Animal Bite Treatment Center

Agham Road, Tayabas City Quezon

**For having complied with the specified standards
of the
Department of Health**

Issued on: **November 7, 2012**

Valid until: **November 7, 2013**

Certificate No. 2012- 04A – 0001

EDGARDO M. GONZAGA, MD, MSc, CESO III
Director IV



DEPARTMENT OF HEALTH
National Center for Disease Prevention and Control-Infectious Disease Office
National Rabies Prevention and Control Program

List of Animal Bite Treatment Centers (ABTC)

Province	Hospital/Clinic	Contact Person	Telephone Number
REGION 1			
Ilocos Norte	Provincial Health Office, Laoag City	Josephine A. Ruedas, MD Luz Catubay, RN	772-11-96
	Gov. Roque Ablan Sr. Memorial Hospital, Laoag City	Dr. Lerma Taylan Linda Labutong	770-03-03
	Batac City Health Office, Batac City	Alicia Agbayani, MD Joan Blas	792-39-15
	Bangui District Hospital, Bangui, Ilocos Norte	Dr. Susana Villaruz Avelina Taggaoa	
	Dingras District Hospital, Dingras, Ilocos Norte	Dr. Ruth Corpuz Ginie Gabriel	784-7383
	Mariano Marcos Memorial Hospital & Medical Center	Dr. Jesus Tomas Silvino Mangasep	792-31-33
Ilocos Sur	Gabriela Silang General Hospital, Tamag, Vigan City	Dr. Trina T. Talaga Ms. Emerlyn Sabugo	0922-8759341 0927-6455098
	Candon City Health Office, Candon City	Dr. Narciso Ramos Jr. Ms. Grace Ragandap Nurse II	742-5008 0928-5024546
	Vigan City Health Office, Vigan City	Dr. Loida Ranches Ms. Elizabeth Quinto Nurse II	0917-6250802 722-6785 09176250802
	Tagudin General Hospital & Capillariasis Center, Tagudin, Ilocos Sur	Dr. Memorena Makiling Ms. Annabelle Lamadrid Nurse I	0918-9259459 09175406930
La Union	Bacnotan District Hospital	Dr. Seves Corpuz - MO-III Lani Balagot Nurse-II	607-4044
	La Union Medical Center, Agoo, La Union	Dr. Glen Ernest Fonbuena – MO-III Genalyn Ancheta - Nurse II	710-1877

	San Fernando City Health Office	Dr. Eduardo S. Posadas Jeanne L. Meredor – Nurse II	888-6915
	Ilocos Training & Reg Medical Center	Estrella Pulido	
	Caba Medicare and Community Hospital	Dr. Nancy Catherine Casila MO- III Jessa Marie Aquino - Nurse-I	708 - 0298
	Naguilian District Hospital	Dr. Olga Estepa – MO-III Ruisa Febe Galinato – Nurse I	609-1018
	Agoo Rural Health Unit	Dr. Roxanne G. Mamaril - MHO Milagros Difuntorum - Nurse II	710-0673
Pangasinan	Pangasinan Provincial Hospital, San Carlos City	Dr. Ma. Victoria de Vera Thelma Bernal	075-532-2603 09275035412
	Western Pangasinan District Hospital, Alaminos City	Dr. Marwin Martinez Marlyn Geminiano	075-552-7129 / 075-551-6408
	San Carlos City Health Office	Dr. Edwin Guinto Clarita Malasan	0919-3911412 075-531-0288
	Dagupan City Health Office	Dr. Leonard Carbonell Fe Belen	075-522-8206
	Region 1 Medical Center- no trained personnel	Dr. Cezar Guico Fe Maramba	075-515-8901 / 075-523-4103
	Alaminos City Health Office	Dr. Ma. Victoria Carambas Pocholo Breboneria	0917-5084154 / 075-551-2956 0919-3418815
	Urdaneta District Hospital, Urdaneta City	Dr. Noel Obedoza Imelda Licudo-DNS	075-568-5114
	Eastern Pangasinan District Hospital, Tayug, Pangasinan	Dr. Roger Peralta III Aileen Tiu	075-572-4339
REGION 2			
CAGAYAN / Tuguegarao City			
Clinic, Provincial Health Office	Cagayan Provincial Capitol	Dr. Cleofe Marie Jean Torres, MO III	Ms. Abad: 0927-2577841

	Cmpd., Tuguegarao City	Dr. Gary Oñate MO III	
Aparri RHU††	Main Municipal Health Office, Aparri RHU -I	Dr. Presentacion Nolasco	0917-6929445
Matilde Olivas D. Hosp** - Camalaniugan ILHZ	Camalaniugan, Cagayan	Dr. Arnold Talla, MHO	
Ballesteros RHU – Northern Cagayan Inter-Local Health Zone	Ballesteros Main Health Center, Centro, Ballesteros, Cagayan	Dr. Loiue Sunico, MHO	Dr. Talla: 09158982810 Mrs. Torres: 0906-4820369
Gonzaga RHU†	Centro, Gonzaga, Cagayan	DR. Exuperio Yuaga MHO	Dr. Sunico 0917-8853132; 0915-5161818
Tuao I RHU*- Piat Interlocal Health Zone			Dr. Yuaga - 09296380980
ISABELA/ Santiago City / Cauayan City		Dr. Nelson Paguirigan COH –I	
Faustino Dy Memorial Hospital	Calamagui, Ilagan, Isabela	Dr. Genaro N. Manalo CHO	078-6222395 (PHO)
Santiago City Health Office	City Hall Compound, San Andres, Santiago City	Dr. Bernadyn Reyes CHO	Dr. Manalo: 0917-5544134; Ms. Castueras: 0917- 5741383
Cauayan RHU- 1	RHU-1, Centro, Cauayan City	Dr. Mary Kristin A. Purugganan Asst.CHO	Dr. Reyes:0918-9365106
Cauayan RHU- 2	Villaluna, Cauayan City	DR. IMELDA GUILLERMO Chief of Hospital	Dr. Purugganan: 0906- 6514425; Ms. Mendoza: 0916-6593703
Milagros District Hospital	National Hi-way, Cabagan, Isabela		
Primo Gaffud District Hospital	Echague, Isabela		
Cauayan District Hospital	Cauayan City		
Roxas District Hospital - MA	Provincial Hi-way, Roxas, Isabela	Dr. Nelson Paguirigan COH –I Ms. Lagrimas Pua, N II	

Gov. Faustino N. Dy Memorial Hospital	Ilagan, Isabela	Ms. Arlene Martinez N III	09176021858
San Mariano RHU*	San Mariano, Isabela	DR. ARLENE LAZARO - MHO	
Ramon RHU*	Ramon, Isabela	DR. LEO GABRIEL - MHO	
NUEVA VIZCAYA			
PHO Clinic	Provincial Capitol Cmpd, Bayombong, Nueva Vizcaya	Dr. Edwin B. Galapon, PHO – II Mr. Edson Dumanay	Mr. Dumanay: 0917-3508003
Nueva Vizcaya Provincial Hospital	National Hi-way, Bambang, Nueva Vizcaya	Dr. Angelica C. Cachola M.O. IV Mr. Martin Luther Norial, N II	
Alfonso Castaneda RHU*		Dr. Annie C. Bawayan - MHO Mrs. Bernadette S. Fangayen, PHN	
QUIRINO			
Quirino Provincial Hospital	Cabarroguis, Quirino	Dr. Herminia Molina Mrs. Leticia Lozano, RN Mr. Essex Danao, PHN	Mrs. Lozano: 0917-5925268
REGION III(CENTRAL LUZON)			
Aurora (3)	Aurora Memorial Hospital	Ms. Dolores E. Suril	09294561456
	Dingalan Community Hospital	Ms. Dawn Paguio	09093342108
	Casiguran Rural Health Unit	Ms. Marissa M. Orcullo	09193453318
Bataan (1)	Bataan General Hospital, Balanga City	Ms. Blenda Pajares	(047) 237 - 1724
Bulacan (7)	Emilio G. Perez Memorial Hospital	Ms. Elisa Velasco	(044) 667 - 2132
	Gregorio del Pilar District Hospital	Ms. Rosario Delos Angeles	(044) 792 - 0119
	Ospital ng Lungsod ng San Jose Del Monte	Dr. Evelyn Policarpio	09163121214
	San Miguel District Hospital	Ms. Gladys May Rueda	(044) 678 - 2070/764 – 0130

	Bulacan Medical Center	Ms. Corazon Cruz	(044) 791 - 0630/662 – 2675
	Baliuag District Hospital	Ms. Marife Tamondong	(044) 766 - 2364
	San Jose del Monte City Health Office	Dr. Betzaida Banaag	(044) 691 - 2584
Nueva Ecija (5)	Nueva Ecija Provincial Health Office EL Joson Cpd, MCH Building, Bitas, Cabanatuan City	Ms. Ma. Teresa Mendoza	09177959338
	Cabanatuan City Health Office City Hall Cpd., Kapt. Pepe Subd. Phase II, Cabanatuan City	Ms. Carolina Gabao	(044) 463 - 5900/600 – 3931
	Science City of Munoz Health Center City Hall Cpd., Poblacion West, Science City of Muñoz	Ms. Felisa Marcelo	(044) 465 - 5921
	San Jose City Health Office A.O. Pascual St., San Jose City	Ms. Marilyn Llorando	(044) 511 - 4219
	Palayan City Health Office Caimito, Palayan	Ms. Briza Gonzales	09175900209
Pampanga (7)	Macabebe District Hospital	Ms. Felicitas Neri	(045) 921 - 2875
	San Luis District Hospital	Ms. Cynthia Sacro	(045) 963 – 2102/4361176
	Diosdado P. Macapagal Memorial Hospital	Dr. Susana Sicat	(045) 900 – 2112/9002172
	Romana Pangan District Hospital	Ms. Ester Mendiola	(045)970-0488
	San Fernando RHU I	Dr. Renely Tungol	(045) 961-3200
	Jose B. Lingad Memorial Regional Hospital	Ms.Ma. Victoria Rivera	(045)963-2279
	Angeles City Health Office	Dr. Hernand Tulud	(045)322-4483/8933628
Tarlac (1)	Tarlac Provincial Health Office	Ms. Cecille Lopez - Zuasula	(045) 982 - 1306
Zambales (5)	Pres. Ramon Magsaysay Memorial Hospital	Dr. Jean Rebutan	(047) 811 - 7213
	San Marcelino District Hospital	Ms. Ruby Duave	(047) 623 - 2302
	Candelaria District Hospital	Ms. Lilia Medina	09178874101

	Ospital ng Sta Cruz	Ms. Ma. Teresa Minimo	09186975514
	Olongapo City Health Office	Dr. Bryan Tubban	(047) 224 - 1628
REGION 4A			
TOTAL (66) CALABARZON Laguna (19)	Sta. Rosa CHO I ABTC Rizal Blvd. Brgy. Market Area, Sta. Rosa City	Dr. Rossana Cunanan, CHO Dr. Catherine Haynes Genoveva Factoriza, PHN III Christine Buela Nurse II	534-1021
	J.P. Rizal Memorial Hosp.ABTC Brgy. Bucal,Calamba City	Dr. Daniel Ching MS III Dennis Lasat, Nurse I HEPO Designate Ms. Angelina Alviar Nurse IV	834-2702
	PPL-Bay Brgy. Maitim, Bay, Laguna	Dr. Peterson Uy, MO III Lucena Ricarte, Nurse I	536-8357
	Laguna Provincial Hospital ABTC J. De Leon St. Sta. Cruz, Laguna	Dr. June Mendoza, MO III Josefina Villanueva, Nurse II Henry Tadle , Nurse I	8081984
	Luisiana Dist. Hosp. ABTC Fabricante St. Luisiana, Laguna	Dra. Ma. Eloisa Inano, MO IV Emma Estrellado, Nurse I	555-4071
	Majayjay Med. Hosp. ABTC Brgy. Talortor, Majayjay, Laguna	Dr. Anthony Borlongan MO IV Ms. Nova Brosas, Nurse II	305-4505
	Nagcarlan Dist. Hospital Baltazar St. Nagcarlan, Laguna	Dr. Herma Formeloza, MO III Ms. Mini Jovellano, Nurse II	563-1016
	Gen. Cailles Mem. Hosp. Tavera, Pakil, Laguna	Dra. Hanna Etherea Maulawin Bradney Go, Nurse I	557-0215
	San Pablo City- CHO Grnd. Floor New City Hall Bldg. A. Mabini St. Ext.5-A	Dra. Ma. Victoria Guia, MD Ms. Jiega Lopez, PHN	562-8111
	Cabuyao RHU I Rosario Village, Brgy. Sala, Cabuyao, La	Dra. Elena Diamante Catherine Mae Buan, RN	531-1183
	San Pedro Rural Health UNIT	Dra. Ma. Consuelo Arrojo Ms. Paz Omalin	520-3748
	Calamba CHO ABTC	Dr. Adelino Labro, MO IV	545-1697

	Brgy. Poblacion, Calamba, City	Ms. Ruby San Diego, Nurse II Mr. Wilmer Suarez Nurse II	
	Panlalawigang Pagamutan ng Laguna Gen. Luna St. San Pablo City	Dr. Jordan Malveda, MO III Ms. Jeryl Marie Amat, Nurse II	562-2788
	Sta. Cruz RHU I ABTC P. Guevarra St. Sta. Cruz, Laguna	Dra. Delia Becina, MHO Ms. Dolores Estellore PHN II Ms. Nina Portes, Nurse I	501-0359
	Liliw RHU ABTC Brgy. Pag-asa, Liliw, Laguna	Dra. Marilou Cordon, MHO Ms. Rachelle Coligado, PHN II	563-3055
	Pagsanjan RHU ABTC Brgy. Poblacion, Pagsanjan, Laguna	Dra. Lyra L. Torres, MHO Ms. Toni Marie Rabago, PHN II	501-3183
	Siniloan RHU ABTC Brgy. Bagumbayan, Siniloan, Laguna	Dra. Girany Fariñas, MHO Ms. Felomena Mendoza, Nurse II	813-0204
	Paete RHU ABTC F. Sario St. Brgy. Maytoong, Paete, Laguna	Dra. Ma. Fe Aguilar- MHO Ms. Evangeline Baes Nurse I	557-2838
	Ospital ng Biñan	Dra. Mirabelle Benjamin CHO Ms. Mary Rose Corencia Nurse	511-3872
CALABARZON RIZAL (13)	Taytay Municipal Health Office ABTC 2 nd Floor Taytay Emergency Hospital J. Asilo St., cor, Sumulong St., Brgy. San Isidro Taytay Rizal	Dr. Arnel Sarmac Charrilyn Reyes - Nurse	658-8573
	Cainta Municipal Health Office ABTC Bonifacio Avenue, Cainta Rizal	Dr. Cristy Corrales Susan Remogat	656-9505
	Angono Municipal Health Office ABTC Brgy. San Isidro, P. Tolentino St., Angono Rizal	Dr. Jose Lozo Ruby Villar	296-7224; 295-3484
	Binangonan Municipal Health Office ABTC Brgy. Calumpang, Binangonan Rizal	Dr. Angelito dela Cuesta Cecilia Salazar	652-5413

	Jalajala Municipal Health Office ABTC Barangay Spcl. District Jalajala Rizal	Dr. Benigno Beltran Abellanora Mariano	401-4879
	Antipolo City Health Office ABTC M. Santos St. Brgy. San Roque, Antipolo City	Dr. Grace Reillo Mae Anne Sangalang	697-0362; 696-4097
	Pililla Municipal Health Office ABTC M. A. Roxas St., Brgy. Bagumbayan, Pililla Rizal	Dr. Aura Paz Nimea Ceralde	654-1093
	Tanay, RHU ABTC – Tanay Rizal	Dr. Rene Luce Norma Galeno	703-2780
	San Mateo, RHU ABTC – San Mateo Rizal	Dr. Anna Sochaco Gioze Valera	
	Rodriguez RHU ABTC - Rizal	Dr. Anna Elvira Perreno Dennis Villanueva	368-0120
	Teresa RHU ABTC Brgy. Bagong Bayan Teresa Rizal	Dr. Menchita Celestra Cessie Cenidoza	
	Cardona RHU ABTC - Cardona Rizal	Dr. Elaida Silao Glenda Campos	664-6898
	Morong RHU ABTC- Morong Rizal	Dr. Normita Pedrosa Juliet Caballero	691 5346
BATANGAS (9)	Batangas Provincial Health Office ABTC Kumintang Ibaba, Batangas City	Dr. Josephine Gutierrez Daisy Dalisay Vivian Hernandez	(043)723-2916/ 723-3285
	Lipa District Hospital ABTC Granja, Lipa City	Dr. Ma.Teresa Flores Felisidad Briones	0918-366-9164
	Batangas City Health Office ABTC P. Burgos St., Batangas City	Dr. Babylyn Gonzales Aileen Cantos	723-3103/ 723-2472
	Tanauan City Health Office ABTC Tanauan City	Dr. Adel Bautista Anne Lorraine Magsino	778-1001 778-1466
	Lipa City Health Office ABTC Inosluban, Lipa City	Dr. Rosario Custodio Amy Cuenca	784-2521
	San Juan RHU,ABTC San Juan, Batangas	Dr. Nestor Alidio Arlene Endaya	575-4058

	Don Manuel Lopez Meml Dist Hospital ABTC Balayan, Batangas	Dr. Julian Laylo Josephine Sanchez Fe Riosa	921-1842
	Calatagan RHU ABTC Poblacion 2, Calatagan Batangas	Dr. Robert Turno Eliza Gomez	213-2018
	Laurel Memorial District Hospital ABTC Brgy. Santor Tanauan City, Batangas	Dr. Felix Werhner Torres Dr. Phil Pangilinan Angelita Patulot	784-0958
CAVITE (9)	Tanza RHU ABTC Daang Amaya, Tanza Cavite	Dr. Ruth Punzalan Ms. Ailyn Salazar	(046)437-1076
	Naic Medicare Hospital ABTC Naic, Cavite	Dr. Clemevina Custodio Ms. Aubeth Borres	4120312
	Alfonso RHU ABTC Alfonso Cavite	Dr. Evangelina Manzo Ms. Teresita L. bendo	5220568
	Gen. Emilio Aguinaldo Medical Hosp ABTC,Trece Martirez City	Dr. Wilfredo Cortez Mr. Aniceto Reyes	8640791
	Dasmarinas RHU I ABTC Dasmarinas Municipal Hall, Cavite	Dr. Ohliva Deocampo Christina Ambion	4160279
	Dasmarinas RHU II ABTC DBB, Dasmarinas Cavite	Dr. Minerva Cazeñas Praxedes Ramirez	4165638
	Tagaytay CHO ABTC Kaybagal South, Tagaytay City	Dr. Rosalinda Mangaya Leah Bayot	4131220 loc 134
	Cavite CHO ABTC Cavite City	Dr. Loida Terrado Teresita Desquitado Mike Ace Monzon	431 0752
	Kawit RHU ABTC Kawit, Cavite	Dr. Edgardo Figueroa Mr. Bryan Lazaro Rouselle Llieta	4341452
QUEZON (16)	Quezon Medical Center ABTC Barangay 11 ; Lucena City	Dr. Emelio Joven: 0921 405 3881 Josephine Dayapan: 0920 405 3191	7102440 loc 257
	Doña Marta District Hospital ABTC	Dr. Arnulfo Imperial: 042 316 5319	3165326

Zone 2, Atimonan Quezon	Lourdes Santayana: 0915 581 9354	
Alabat Island Dist. Hosp ABTC Alabat Quezon	Dr. Teodoro Serrano: 0928 551 4199 Imelda del Moro	3028026
Gumaca District Hosp ABTC Brgy. Sto. Rosario, Gumaca Quezon	Dr. Purita Tullas Lolita Ramos: 0916 564 1847	3176479
Magsaysay District Hosp ABTC Brgy. Magsaysay, Lopez Quezon	Dr. Emma Serdon Loida Guia: 0916 210 1286	3025354 3025437
Guinayangan Medicare Hosp ABTC Brgy. Calimpak, Guinayangan Quezon	Dr. Florencia Vergara: 0917 501 4400 Josefina Manuel	
Unisan Medicare Hosp ABTC Brgy. Ibabang Kalillayan, Unisan Quezon	Dr. Marylen Zubiri: 0920 910 2191 Lilibeth Teng:	0920 347 9059
Candelaria Municipal Hosp ABTC Brgy. Masin Sur, Candelaria Quezon	Dr. Grace Mirando: 0920 918 1369 Gloria Umali: 042 741 1742	
Bondoc Peninsula Dist Hosp ABTC Brgy 8, Catanauan Quezon	Dr. Geneblazo Ma.Cristina Samadan: 0921 962 0585	3158412
San Francisco Municipal Hosp ABTC Brgy. Poblacion, San Francisco, Quezon	Dr. Mario Lopez: 0920 909 4830 Bryan Napeñas: 0919 559 3605	
Mauban Dist. Hosp ABTC Brgy Polo, Mauban Quezon	Dr. Wennie Alcantara Marina Morales	784 0216
Ma. Eleazar Dist Hosp ABTC Brgy. Munting Parang, Tagkawayan Quezon	Dr. Reynaldo Florido Janeth Rocafort: 0910 731 3693	3098324
Claro M. Recto Dist. Hosp. ABTC Brgy. Poblacion 1, Infanta Quezon	Dr. Hilario Mercado Fe Andaya: 0920 613 8332	5352882 5352127
Pagbilao Rural Health Unit ABTC Pagbilao Quezon	Dr. Nathaniel Merene Marvin Martinez	
Tayabas City Health Office ABTC Tayabas City	Dr. Hernan Marquez: 0917 507 4178 Gerald Remallosa: 0920	7130092

		967 4040	
	Lucena City Health Office ABTC Lucena City	Dr. Jaycee Tabernilla John Chua	6602245
REGION 4 B			
MARINDUQUE *Not Active ABTC	DR. DAMIAN J. REYES MEMORIAL HOSPITAL	Lorelie C. Maano	0920-8027772
		Shirley M. Rianzales	0929-83867
	*GASAN RHU	Dr. Arnel Salcedo	0918-6380035
		Ma. Aleli Judith Salva	0919-4101969
	*BUENAVISTA RHU	Dr. Eleanor May Grate	0908-4866947
		Elsa Tan	0949-7975751
	STA. CRUZ RHU I	Dr. Teodulfo Rejano	0920-6140698
	*STA. CRUZ RHU II	Rizalinda Rey	0921-3433088
PUERTO PRINCESA CITY	CITY HEALTH OFFICE	Mary Joy Tianchon	0920-9248517
PALAWAN	NARRA RHU	Dr. Gina Tagyab	09205428528
		Edith Longno	09082762749
	ESPANOLA RHU	Dr. Rhodora Tingson	09194911424
		Catherine Barroma	09084887080
	QUEZON MEDICARE HOSPITAL	Dr. Romulo Robles	09175532807
		Ellen Joy Gabo	09204898816
	RIZAL RHU	Dr. Lazir Penit	09162548252/09189917857
		Rutchell Laborera	No number
	SOUTHERN PALAWAN PROVINCIAL HOSPITAL	Dr. Cirilo Diesmos	09178395158
		Susan dela Cruz	09269344713
	*BATARAZA RHU	Dr. Juan Mabutas (transfer)	No number
		Rowena Ustarez	09196148335
	ROXAS RHU	Dr. Leo Salvino	09195112823

		Merle de Ramos	09203653741
	ARACELI RHU	Dr. Rosalindo Losaria	09065556877
		Maricris Saclet	09068775223
	SAN VICENTE RHU	Dr. Emmanuel Veranda	09088853922
		Elsa Tejada	09209463849
	NORTHERN PALAWAN DISTRICT HOSPITAL	Dr. Ma. Zaida Cagape	09175545819
		Glenn Vyll Enriquez	09268542799
	TAYTAY RHU	Dr. Dan del Rosario	09209459649
		Karen Abis	No number
	EL NIDO RHU	Dr. Cesar Rivera	09178011925
		Shiela Gripon	09178482379
	CUYO DISTRICT HOSPITAL	Dr. Rey Lanzuela	09196880322
		Nanette Lasin	09494525771
	CORON RHU	Dr. Alan Guintapan	09088937202
		Ritchel Bacsa	09088964420
	CULION RHU	Dr. Charlie Tejada	09208746435
		Armando Lagrosa II	09204700687
	CULION SANITARIUM AND GENERAL HOSPITAL	Dr. Neal Vincent Torre	No number
		Aida Ereno	09182479836
	BUSUANGA RHU	Dr. Lisaldeo Moses Princesa	09283393419
		Meleah Custudio	09216680787
	OSPITAL NG PALAWAN	Dr. Susan Zambrano	09285217452
		Erlina Golifardo	09182316187
	PROVINCIAL HEALTH OFFICE	Dr. Mary Ann Navarro	09175877121
		Pamela Garcia	09276351698

		Eileen Grace Macabihag	09296033177/09154244918
		Estela Buncag	09465956566
ROMBLON	ROMBLON PROVINCIAL HOSPITAL	Dra. Noralee Fetalvero	567- 5453
	SIBUYAN DISTRICT HOSPITAL	Dr. Ramon Villanueva	09276787675 rdy1226@yahoo.com
		Del Male	09168352219
	DON MODESTO FORMILLEZA SR. MEMORIAL HOSPITAL	Dr. Irvin Alojado	09192158846
		Bella Lucias RN	09051790110 bgloquias@yahoo.com
	ROMBLON DISTRICT HOSPITAL	Dr. Catalino Gumban	
		Judith Roxas RN	
CALAPAN CITY	CALAPAN CITY RHU	Ms. Enriquetta Perilla	0926-2682338
ORIENTAL MINDORO	ORIENTAL MINDORO PROVINCIAL HOSPITAL	Dr. Rico/ Gina Tolentino	0910-8774769
	PINAMALAYAN COMMUNITY HOSPITAL	Dr. Gonzales/ Sheila Vitto	0928-5058526
	ROXAS	Dr. Leonor Daite	09282361042
OCCIDENTAL MINDORO	SAN JOSE RHC	Evangeline Penaflor Meldie Driza Soriano	
	SABLAYAN RHC	Meneleo Simon, MD Emily Mendoza	
	OCCIDENTAL MDO PROV. HOSP.	Karen Solar, MD Amelita Girao, RN	0915-7493-517
	LUBANG DISTRICT HOSP.	Venmar Sayabal Adelvisa Valerno, RN	0929-9716-250
REGION 5			
Albay	Bicol Regional Teaching and Training Hospital, Legaspi City, Albay (052) 483-0014 local 4280	Sally Macinas/Rommel Madrid, MD	09167404763
	Josefina Belmonte Duran Memorial District Hospital, Ligao City	Estela Zenit, MD	09193237255
	Ziga Memorial District Hospital, Tabaco City	Berlyn Villanueva, MD	09175584996

Camarines Norte	Camarines Norte Provincial Hospital, Daet	Ramon Echano, MD	09065709543
	Labo District Hospital, Labo	Jose Vernon Banal, MD	09065709543
Camarines Sur	Bicol Medical Center, Camarines Sur	Maria Litam, MD	09189057064
	Iriga City Health Office, Iriga City	Jose Gimenez, MD	0997202622 (054) 299-2465
	Naga City Hospital, Naga City	Lunining Luciano, MD	472-0559
	Ragay District Hospital	Milfred Bayot, MD	09285077307
	Libmanan District Hospital	Frana M. Barrios MD	(09165283372
	Bicol Samitarium	Jimmy dela Vina MD	473-2244
	Nabua RHU	Teodora Pornillos, MD	09204590016
Catanduanes	Eastern Bicol Medical center, Virac	Hyde Advincula-Tadoy MD	811-4030
	Pandan District Hospital. Pandan	Rafael Mariano, MD	09207436595
	Viga District Hospital	Nerissa Guerrero, MD	09156284185
	Cataingan District Hospital, Cataingan	Jovan Lim, MD	09204224799
Masbate	Masbate Provincial Hospital, Masbate City	Cynthia Llacer, MD	09184525603
	Ticao District Hospital, San Jacinto	Jesus Camposano	09285208751
	Claveria District Hospital	Glenn Andueza, MD	09204670321
Sorsogon	Dr. Fernando Duran Memorial Hospital, Sorsogon City	Marlon Gapayao, MD	09175874592
	Irosin District Hospital, Irosin	Ludovic Tan, MD	09202187538
	Donsol District Hospital, Donsol	Joseph Chavez, MD	09201544880
	Gubat District Hospital	Franco Lagatuz, MD	09275149299
	Sorsogon City Health Office, Sorsogon City	Ruel Rebutillo, MD	0918-6985412/ 0917-8680633
	Vicente Peralta Mem Hospital	Charlie Bandola, MD	09206096708

REGION 6			
Aklan	Rafael S. Tumbokon Mem'l Hospital, Kalibo, Aklan		
Antique	Angel Salazar Mem'l Hospital, San Jose, Antique		
Capiz	Roxas Memorial Provincial Hospital, Arnaldo Blvd. Roxas City		
	Roxas City Health Office, Bangbang St., Roxas City		
	Bailan District Hospital		
	Iloilo Doctors Hospital		
Iloilo	Iloilo City Health Office		337-5284
	Passi City Health Office		311-5046
	Passi District Hospital, Passi City		311-5453
	Western Visayas Medical Center, Mandurriao, Iloilo City		321-2841 local 190
	Iloilo Provincial Hospital, Pototan		529-7498
	Rep. Pedro Trono Memorial District Hospital, Guimbal		315-5172/ 512-0234
	Ramon Tabiana Mem'l District Hospital, Cabatuan		522-8211
	Federico Ramon Tirador Sr, Mem'l Hospital, Janiuay		317-1319
	Sara District Hospital, Sara		392-0144
	Dr. Ricardo Y. Ladrado Memorial District Hospital, Lambunao		349-1578
	Barotac Viejo District Hospital, Barotac Viejo		362-0300
	Balasan District Hospital, Balasan		397-0169
Negros Occidental	Bacolod City Health Office		434-4098
	Bago City Health Office		461-0118

	Cadiz City Health Office		0919-5741226
	Escalante City Health Office		0920-8811150
	Himamaylan City Health office		388-3504
	Kabankalan City Health Office		471-3069
	La Carlota City Health Office		460-2683
	Sagay City Health Office		0919-3454537
	Silay City Health Office		495-5018
	Silay Provincial Hospital		
	San Carlos City Health Office		0916-3124291
	Talisay City Health Office		0919-4416675
	Sipalay City Health Office		0909-6521275
	Victorias City Health Office		399-3437
	Escalante District Hospital		454-8015
	Kabankalan District Hospital		471-2357
	Don Salvador Benidecto Mem'I Hospital, La Carlota City		460-3360
Guimaras	Guimaras Provincial Hospital, Jordan, Guimaras		581-3331
REGION 7			
Cebu	Provincial Health Office, Cebu Provincial Capitol, Cebu City		032-253-9773
	Cebu City Health Department, Cebu City		032- 232-6969
	Vicente Sotto Memorial Medical Center		
	Danao District Hospital, Danao City		032-200-4482
	Minglanilla District Hospital, Minglanilla, Cebu		032-490-2937
	Lapu- Lapu City Health Office, Lapu-lapu City		032-340-5339

	Mandaue City Health Office, Mandaue City		032-346-0110
	Tuburan Rural Health Unit, Tuburan, Cebu		032-463-9007
	Medellin Rural Health Unit, Madellin, Cebu		032-436-2019
	Bogo City Health, Cebu Province		434-9460
	Malabuyoc District Hospital, Malabuyoc, Cebu		032-516-1495
	Argao District Hospital Hospital, Argao, Cebu		032-367-7500
	Barili District Hospital, Barili, Cebu		032-470-9026
	Toledo City Health Office, Toledo City		032-322-5239
	Bantayan District Hospital,, Bantayan, Cebu		032-352-5231
	Oslob District Hospital, Oslob, Cebu		032-4819985
	Ricardo Maningo District Hosp'l, Camotes, Cebu		(032) 514-3327
Negros Oriental	Negros Oriental Provincial Hospital, Dumaguete City		035-225-9291
	Dumaguete CHO, Dumaguete, City		035-225-2535
	Siaton District Hospital, Siaton, Negros Oriental		035-427-0307
	Bindoy District Hospital, Bendoy, Negros Oriental		035-405-3034
	Canlaon ABTC Negros Oriental		
	La Libertad RHU, La Libertad, Negros Oriental		035-409-4020
	Bayawan District Hospital, Bayawan, Negros Oriental		035-531-0485
	Bais District Hospital, Bais City Negros Oriental		035-407-8317 / 402-3194
Siquijor	Siquijor Provincial Health Office, Siquijor		035-344-2014
Bohol	Garcia Memorial Provincial		038-515-5081

	Hospital, Talibon, Bohol		
	Celestino Gallares Memorial Hospital, Tagbilaran City		038-411-4868/4869
	Emilio del Valle Memorial Hospital, Ubay, Bohol		038-518-0379/0324
	Private (Family Vaccine)		
	<ul style="list-style-type: none"> • Teodoro B Galagar District Hospital, Jagna, Bohol • Cong. Natalio P. Castillo Sr. Memorial Hospital, Loon, Bohol • Carmen Memorial hospital, Carmen, Bohol 		038-525-9510 038-505-9426/9170 038-2382-405
REGION 8			
Tacloban City	Eastern Visayas Regional Medical Center		(053) 523-2809
	Tacloban City Hospital		053) 323-3151
Leyte	Leyte Provincial Hospital, Palo, Leyte		(053) 323-3057
	Ormoc City Health Office		255-2225/4062
	Western Leyte Provincial Hospital		
	Dr. Maniel Veloso Memorial Hospital, Palompon Leyte		
Southern Leyte	Salvacion M Ynigues Memorial Hospital, Maasin		381-2368/2396
	Anahawan District Hospital		
Biliran	Biliran Provincial Hospital, Naval		500-9179
Samar	Samar Provincial Hospital, Catbalogan, Samar		356-1423
	Calbayog City Health Office, Calbayog City		209-2617/2790
Eastern Samar	Eastern Samar Provincial Hospital, Borongan		560-9555
	Oras District Hospital ,Oras Eastern Samar		
	Felipe Abrigo Memorial		271-2180)

	Hospital Guian Eastern Samar		
	Albino Duran Memorial Hospital Balangiga Eastern Samar		(560- 9417)
	Can-Avid District Hospital Can-avid Eastern Samar		(564-6521)
Northern Samar	Northern Samar Provincial Hospital, Catarman		500-9032/9308
	Gamay District Hospital, Gamay Northern Samar		
	Laoang District Hospital		
	Allen District Hospital		
REGION IX (WESTERN MINDANAO)			
Zamboanga City	Zamboanga City Medical Center , Dr. Evangelista St., Sta. Catalina		(062) 990-4769/ 991-0573
	Mindanao Central Sanitarium, Zamboanga City		
	Paragas Memorial Hospital, Zamboanga City		
	Labuan Public Hospital, Brgy. Labuan		(062) 926-0259
Zamboanga del Norte	Dipolog City Health Office, Brgy. Estaka, Dipolog City		(065) 212-3400
	Zamboanga del Norte (ZDN) Medical Center, Brgy. Sicayab, Dipolog City		(065) 212-5080/212-5081/ fax 212-3625
	Dr. Jose Rizal Memorial Hospital, Brgy. Lawaan, Dapitan City		(065) 213-6421
	Sindangan District Hospital, Sindangan		
	Liloy Integrated Hospital, Liloy		
Zamboanga del Sur	Pagadian City Health Office		
	Midsalip Infirmary Hospital		
	Margosatubig Regional Hospital, Margosatubig		(062) 211-5634

	Zamboanga del Sur Medical Center, Pagadian City		
	Mahayag Municipal Hospital		
Zamboanga Sibugay	Zamboanga Sibugay Provincial Hospital, Brgy. Sanito, Ipil		(062) 333-2323
	Olutanga Municipal Hospital, Brgy. Bateria, Olutanga		
	Alicia District Hospital, Alicia		
	Payao Municipal Hospital		
	Kabasaran Pathfinder Municipal Hospital		
Isabela City	Basilan General Hospital, Isabela City, Basilan		
	Isabela City Health Office, Isabela City, Basilan		
	Sulu Sanitarium, Jolo Sulu		
REGION 10			
Bukidnon	Bukidnon Provincial Hospital-Maramag, Maramag, Bukidnon	Dr. Mary Jean Baguio Ms. Chuchi Vicenta Obice	
	Bukidnon Provincial Medical Center, Casisang, Malaybalay City	Dr. Ma. Azalea V. Cordero Ms. Lourdes Ouano	088-2215510 088-2215513
	Manolo Fortich RHU, Manolo Fortich, Bukidnon	Dr. Raymundo N. Ditona, Jr Ms. Ma. Elena Lozarita	
	Malaybalay City Health Office, Malaybalay City	Dr. Melirose S. Detecio Ms. Maila A. Manuel	
	Valencia City Health Office, Valencia City	Dr. Juniver G. Flores Ms. Myrna Q. San Juan	
Misamis Oriental	Misamis Oriental Provincial Health Office	Dr. Patricia B. Lim Ms. Janesse Mae Bernas	
	CLAJAVITA ILHZ (RHU Villanueva), Villanueva, Misamis Oriental	Dr. Marybelle Linog Ms. Patricia Emano	
	GALILEO ILHZ (RHU Alubijid), Alubijid, Misamis Oriental	Dr. Lolita U. Roxas Ms. Xenia C. Apdian	
	MANLUNA ILHZ (MisOr Prov Hosp – Manticao), Manticao,	Dr. Donna Dee M. Acenas Ms. Marife C. De Vera	

	Misamis Oriental		
	MISORET ILHZ (MisOri Prov Hosp – Balingasag), Balingasag, Misamis Oriental	Dr. Elijah Mateo Ms. Tacastacas	
	GBA ILHZ (CHO Gingoog), Gingoog City	Dr. Jasmine Casinillo Ms. Portia A. Cloma	
Misamis Occidental	Misamis Occidental Provincial Hospital, Oroquieta City	Dr. Estefa V. Doyungan Ms. Leonor C. Beltran Ms. Lovely May B. Maghinay	088-5311529; 088-5312243
	Mayor Hilarion A. Ramiro Sr. Regional Teaching and Training Hospital, Maningcol, Ozamiz City	Dr. Mercy L. Senados Ms. Phoebe G. Pangilinan	*trained on July 31-Aug 1, 2012
	Ozamiz City Health Office, Ozamiz City	Dr. Daniel T. Medina Mr. Paul M. Singh	
	Oroquieta City Health Office	Dr. Al Joseph Guantero Ms. Stella Salabas	0922-8429966
Camiguin	Camiguin General Hospital, Mambajao, Camiguin	Dr. Alvin F. Sampilo Ms. Annie Cristy C. Sampilo	
Lanao del Norte	Lanao del Norte Provincial Hospital - Baroy	Dr. Demetrio Opamen Ms. Alma L. Cajita	
	Iligan City Health Office, Iligan City	Dr. Agripina Gaité Ms. Frances	
	Lanao del Norte PH – Kolambugan, Kolambugan, Lanao del Norte	Dr. Glen Fuentes Ms. Juvy M. Yap	
	Lanao del Norte PH – Kapatagan, Kapatagan, Lanao del Norte	Dr. Ms.	
Cagayan de Oro City	Cagayan de Oro City Health Office	Dr. Fe C. Bongcas Ms. Nice J. Bingona Mr. Reagan S. Abbu	
REGION XI			
Davao City	CHO, DC – Mini Forest Health Center (1 st District)	Ma. Rosalita B. Domingo, MD Ms. Evelyn Papa, RN	(082) 224-1182 09177401323
	CHO,DC – Sasa Health Center (2 nd District)	Julinda Acosta, MD Eldy Sombilon, RN	09232234430
	Southern Philippines Medical Center (Family Medicine	Seurinane Sean Espanola, MD Noreen C. Yap, RN	(082) 227-2731

	Department)		
	Southern Philippines Medical Center		
Davao del Sur	Davao del Sur Provincial Hospital, Digos City	Dr. Renato C. Leynes Ms. Nina L. Aninon	09184432325
	Sta. Cruz Rural Health Unit, Sta. Cruz	Loremie Ann M. Lindong, MD Mariel Jay B. Bebanco, RN	
	Malita District Hospital, Malita	Ma. Teresa M. Valencia, MD Mary Grace M. Canada, RN	09103479879 09481374468
	Gregorio Matas District Hospital Kiblawan, Davao Sur	Jealyn Z. Solatorio, RN	
Davao del Norte	Davao del Norte Hospital - Carmen Zone	Maria Fe L. Pastor, MD Edgie Laud B. Espina, RN	09426217671
	Davao del Norte Hospital – Kapalong Zone	Ross Melchor S. Sator, MD Dovie Madonna R. Arrocena, RN	09159007731
	Davao del Norte Hospital – Samal Zone	Catherine M. Valera, MD Gibb Anthony Apat, RN	09177050902
	Panabo City Health Office, Panabo	Emelda T. Bendejo, MD Divine T. Hofilenia, RN	
	Davao Regional Hospital, Tagum City	Julius Jay S. Cabison, MD Grace C. Gabrido, RN	09321401954 09352438543
Compostela Valley Province	Compostela Valley Provincial Hospital, Montevista	Arlene Joy T. Maglana, RN	
	Pantukan District Hospital, Pantukan	Juliet P. Morales, RN	
	Maragusan Municipal Hospital, Maragusan	Luz T. Estipona, MD Ms. Mercedita S. Luayon	
	Laak Municipal Hospital, Laak		
Davao Oriental	Davao Oriental Provincial Hospital, Mati City	Gerard B. Iturralde, MD Josephine P. Dando,, RN	09269486047
	Lupon District Hospital, Lupon	Dr. Ariel D. de la Cruz Gemma P. Cabading, RN	

	Governor Generoso Municipal Hospital	Reden V. Bersaldo, MD Richard Castillon, RN	
	Manay District Hospital	Myrna Young, MD Jenny Ria Patugan, RN	09497229245
	Cateel District Hospital	William A. Agujetas, MD Letecia E. Orcullo, RN	
	Mati City Health Office	Maribeth G. Hiponia, MD Jan Clyde Barnes, RN	09283469220 09305322835
REGION XII (SOCCSKSARGEN)			
	Cotabato Regional Medical Center, Cotabato City		(064) 421-2192
	Cotabato Provincial Hospital, Amas, Cotabato		0928-5078007
	South Cotabato Provincial Hospital, Koronadal City		(083) 552-3141
	Kidapawan City Health Office		(064) 288-1377
	Dr. Amado P. Diaz Provincial Hospital Midsayap, Cotabato		0908-4676455
	General Santos City Hospital		0919-2533901
	Lebak Medicare Community Hospital, Lebak, Sultan Kudarat		0910-3996771
	Polomoloc Rural Health Unit, Polomoloc, South Cotabato		(083) 225-2035
	Tacurong City Health Unit, Tacurong City		
	Sultan Kudarat Provincial Hospital, Isulan, Sultan Kudarat		
	Sarangani Provincial Health Office, Alabel, Sarangani		(083) 508-2285
CORDILLERA ADMINISTRATIVE REGION			
Benguet	Abatan Emergency Hospital, Buguias, Benguet		
	Kapangan Medicare Community Hospital, Kapangan, Benguet		
	La Trinidad RHU, La Trinidad, Benguet		

Apayao	Apayao Provincial Hospital, Kabugao, Apayao		
	Sta. Marcela RHU, Santa Marcela, Apayao		
	Apayao District Hospital, Calanasan, Apayao		
	Conner District Hospital, Conner, Apayao		
	Flora District Hospital, Flora, Apayao		
	Pudtol RHU, Pudtol, Apayao		
Abra	Abra Provincial Hospital, Bangued, Abra		
	La Paz District Hospital. La Paz, Abra		
Ifugao	Ifugao Provincial Hospital, Lagawe, Ifugao		
	Potia District Hospital, Alfonso Lista, Ifugao		
Mountain Province	Bontoc General Hospital, Bontoc, Mt. Prov.		
	Luis Hora Memorial Regional Hospital, Bauko, Mountain Province		
Kalinga	Kalinga Provincial Hospital, Bulanao, Tabuk City		
	Western Kalinga District Hospital, Balbalan, Kalinga		
Baguio	Baguio City Health Service Office, T. Alonzo St., Baguio City		
	Baguio General Hospital and Medical Center, BGHMC Compound, Baguio City		
CARAGA			
Agusan Del Norte	Agusan del Norte Provincial Hospital		
	Cabadbaran district Hospital		
	Nasipit District Hospital		

Agusan Del Sur	D. O Plaza Memorial Hospital		
	Bunawan District Hospital		
	Bayugan Community Hospital		
Surigao Del Norte	Caraga Regional Hospital		
	Siargao District Hospital		
Surigao Del Sur	Adela Sera TY Memorial Medical Center		
	Bislig District Hospital		
	Marihatag District Hospital		
	Liang District Hospital		
	Madrid District Hospital		
Dinagat Islands	Dinagat District Hospital		
	Albor District Hospital		
	Loreto District Hospital		
Butuan City	Butuan City Medical Center, Langihan, Butuan City		
Surigao City	City Health Office, Surigao City		
NATIONAL CAPITAL REGION			
Referral Hospitals	Research Institute for Tropical Medicine (RITM), Alabang, Muntinlupa City		
	San Lazaro Hospital, Sta Cruz, Manila		
	Philippine General Hospital, Taft Avenue, Manila		
District I	Pagamutang Bayan ng Malabon, Maya-Maya St. cor. Dagat-Dagatan Avenue, Malabon City		(02) 285-2898/ 285-2804
	Navotas Emergency & Lying-in Clinic, M. Naval St., San Jose, Navotas		(02) 281-8728
	Malinta Health Center, Brgy. Hall, Malinta, Valenzuela City		(02) 445-1406

	Bagong Silang Health Center, Phase I, Brgy. Bagong Silang, Caloocan City		(02) 962-8206
District II	Marikina Health Office, Prissa Bldg., Shoe Avenue, Sto. Niño, Marikina City		(02) 998-5045
	Pasig Health Office, Market Avenue., Pasig City		(02) 642-7754/ 640-2058
	Delfin Salonga Health Center, Emerald Court Subd., Sto. Rosario, Pateros		(02) 641-3246
	Ibayo Health Center, Natividad St., Bry. Ibayo, Tipas, Taguig City		(02) 642-2462
	Quezon City Employees Clinic, Quezon City Health Department, Kalayaan Avenue, Quezon City		(02) 926-4237/ 926-4201
District III	Makati Health Department, Makati City Hall, J.P. Rizal Avenue, Makati City		(02) 895-4001 local 604/606/607
	Mandaluyong Health Office, Boni Ave., Maysilo St., Mandaluyong City		(02) 534-0163
	San Juan Health Office Unit I, Municipal High School, Narciso St., San Juan City		(02) 744-0736
	Main Health Office, San Juan Unit II, P. Narciso St., Pinaglabanan, San Juan City		(02) 724-0271
	Manila Health Department, Division of Preventable Diseases, Manila City Hall		(02) 527-4941
District IV	Las Pinas Health Center, Pamplona III, Las Pinas City		(02) 871-3909/ 873-9145/ 872-3169
	Silverio Health Center, Parañaque City		(02) 826-9712
	Alabang Health Center, National Road, Putatan, Muntinlupa City		(02) 842-2560
	San Isidro Health Center, Domingo St., Pasay City		(02) 831-5275

ARMM			
Maguindanao	Maguindanao Provincial Hospital		
	Datu Blah District Hospital		
Lanao del Sur	Wao District Hospital		
Sulu	Sulu, Provincial Health Office		
	Sulu Sanitarium, Jolo Sulu Dr. Majid - 09277704771		

Appendix 3: List of Rabies Diagnostic Laboratories

Name of Laboratory	Address	Contact Person	Contact No.
Region I	Tebag, Sta. Barbara, Pangasinan	Dr. Florentino Adame	(075) 523 3928
Region II	Tuguegarao, Cagayan	Dr. Susie Clemente	(078) 844 3101 (078) 846 4834
Region III	Capitol Compound, San Fernando, Pampanga	Dr. Eduardo Lapuz, Jr.	(045) 961 2934 (045) 961 3336
Region IV-A	Marauoy, Lipa City, Batangas	Dr. Gloria Salazar	((043) 312 0411
Region V	Cabangan, Camalig, Albay	Dr. Marissa Guillermo	CP# 0927 835 2489 (052) 484 1600
Region VI	Fort San Pedro, Iloilo City	Dr. Vicente Nim	(033) 336 9737
Region VII	M. Velez St., Cebu City	Dr. Teodoro A. Dabocol Dr. Rachel Cadelina	(032) 254 4005
Region VIII	Brgy. Diit, Tacloban City	Dr. Archie T. Lluz	(053) 321 3043
Region IX	RADDL, Tumaga, Zamboanga City	Dr. Marie France Que-Jalao	(062) 991 6350/ 992 4165
Region X	Luna St., Cagayan de Oro City	Dr. Ma. Teresa B. Roa	(088) 856 2753
Region XI	San Gabriel, Mintal, Davao City	Dr. Erlinda P. Lim	
Region XII	Sinsuat Ave., Cotabato City	Dr. Jennefer Bulawan	(064) 421 5857/ 421 3789
Region XIII	Capitol Site, Butuan City	Dr. Esther Cardeño	(085) 342 0457/342 7445
CAR	BDF Compound, St. Tomas Road, Baguio City	Dr. Arlene Sagayo	(074) 445 4973/4449872
ARMM	DAF-ARMM, ORG Complex, Cotabato City	Dr. Norodin A. Kuit	(064) 421 1234

Others

Name of Laboratory	Address	Contact Person	Contact No.
Philippine Animal Health Center (PAHC)	Visayas Ave., Diliman, Quezon City	Dr. Magdalena S. Cruz	(02) 928 2177 Fax # 9200429
RITM	Muntinlupa City	Dr. Fidel Malvas	(02) 807 2628 loc. 233
Aklan State University			

Case Investigation Form

Rabies

Name of DRU:		Type: <input type="checkbox"/> RHU <input type="checkbox"/> CHO <input type="checkbox"/> Gov't Hospital <input type="checkbox"/> Private Hospital <input type="checkbox"/> Clinic					
Address:		<input type="checkbox"/> Gov't Laboratory <input type="checkbox"/> Private Laboratory <input type="checkbox"/> Airport/Seaport					
I. PATIENT INFORMATION:	Patient Number:	Patient's First Name		Middle Name		Last Name	
Complete Address:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: MM DD YY		Age: <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years		
District: _____ LHZ: _____		Patient Admitted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date Admitted/Seen/Consult: MM DD YY		Date Onset of Illness: MM DD YY	
II. EXPOSURE HISTORY:							
Type of exposure: <input type="checkbox"/> bite <input type="checkbox"/> saliva <input type="checkbox"/> scratch <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____ Date of Bite: _____							
Place where bitten: _____ Site of Body bitten: _____							
Category of Exposure:							
<input type="checkbox"/> Feeding/touching an animal							
<input type="checkbox"/> Licking of intact skin (with reliable history and thorough physical examination)							
<input type="checkbox"/> Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensils							
<input type="checkbox"/> Casual contact (talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms of rabies							
<input type="checkbox"/> Nibbling of uncovered skin with or without bruising/hematoma							
<input type="checkbox"/> Minor scratches/abrasions without bleeding							
<input type="checkbox"/> Minor scratches/abrasions which are induced to bleed							
<input type="checkbox"/> All Category II exposures on the head and neck area are considered Category III and should be managed as such							
<input type="checkbox"/> Transdermal bites (puncture wounds, lacerations, avulsions) or scratches/abrasions with spontaneous bleeding							
<input type="checkbox"/> Licks on broken skin							
<input type="checkbox"/> Exposure to a rabies patient through bites, contamination of mucous membranes (eyes, oral/nasal mucosa, genital/anal mucous membranes) or Open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation.							
<input type="checkbox"/> Handling of infected carcass or ingestion of raw infected meat							
<input type="checkbox"/> All Category II exposures on head and neck area							
Type of animal: <input type="checkbox"/> dog <input type="checkbox"/> cat <input type="checkbox"/> bat <input type="checkbox"/> Other, specify _____							
Lab. diagnosis done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, result: _____							
Animal status: <input type="checkbox"/> domestic <input type="checkbox"/> stray <input type="checkbox"/> wild <input type="checkbox"/> Other, specify _____							
Outcome of biting animal: <input type="checkbox"/> alive <input type="checkbox"/> died <input type="checkbox"/> Killed intentionally Place of Incidence: _____							
III. VACCINATION HISTORY:							
Animal vaccination history:		Patient History:			Date vaccine started: _____		
<input type="checkbox"/> Vaccinated		Wound cleaned?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Brand Name of Vaccine: _____		
<input type="checkbox"/> Unvaccinated		Patient given RIG?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Route of Administration:		
<input type="checkbox"/> Unknown		(RIG is Rabies Immunoglobulin)			<input type="checkbox"/> IM <input type="checkbox"/> Intradermal		
		Patient given rabies vaccine?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Post exposure completed		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
IV. CLASSIFICATION AND OUTCOME:							
FINAL CLASSIFICATION				OUTCOME			
<input type="checkbox"/> Suspected Case				<input type="checkbox"/> Alive			
<input type="checkbox"/> Probable Case				<input type="checkbox"/> Died Date died: ____/____/____			
<input type="checkbox"/> Confirmed Case				<input type="checkbox"/> Unknown			
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Philippine Integrated Disease
Surveillance and Response

Case Investigation Form



Rabies

CASE DEFINITION/CLASSIFICATION:

- **Suspected Case:** A person presenting with an acute neurological syndrome (encephalitis) dominated by forms of hyperactivity (furious rabies) or paralytic syndromes (dumb rabies) that progresses towards coma and death, usually by respiratory failure, within 7 to 10 days after the first symptom if no intensive care is instituted.

- **Probable case:** A suspected case plus history of contact with suspected rabid animal.

Note: Bites or scratches from a suspected animal can usually be traced back in the patient medical history. The incubation period may vary from days to years but usually falls between 30 and 90 days.

- **Confirmed case:** A suspected case that is laboratory confirmed.

LABORATORY CONFIRMATION:

One or more of the following:

- Detection of rabies viral antigens by direct fluorescent antibody (FA) in clinical specimens, preferably brain tissue (collected post mortem);
- Detection by FA on skin or corneal smear (collected ante mortem);
- FA positive after inoculation of brain tissue, saliva or CSF in cell culture, in mice or in suckling mice;
- Detectable rabies-neutralizing antibody titer in the CSF of an unvaccinated person;
- Identification of viral antigens by PCR on fixed tissue collected post mortem or in a clinical specimen (brain tissue or skin, cornea or saliva);
- Isolation of rabies virus from clinical specimens and confirmation of rabies viral antigens by direct fluorescent antibody testing.

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DEPARTMENT OF HEALTH
National Rabies Prevention and Control Program

Form 2

Post - Exposure Prophylaxis Cohort Report Form
Period Covered(Q/SM/A): _____

Category of Exposure	No. of Registered Exposures	Number of patients who Received RIG	Outcome of Post- Exposure Prophylaxis			
			Complete	Incomplete	None	Died
Category II						
Category III						

- Complete- Patient received at least days 0, 3 and 7 doses
- Incomplete- Patient did not receive received any of the day 0,3 and 7 doses
- None- Category II and III patients who did not receive any TCV/vaccines
- Died- Patient died of any cause while on PEP

Form 3

Human Rabies Reporting Form

Reporting Unit: _____

[illegible]

Name of Animal Elite Treatment Center:

[illegible]

Registration Number-(current year) - DD1 (Chronologic number)
Registration date: date patient was first seen, regardless whether patient was given PEP or not
Type of Animal- (PD)- Pet dog, (SD)- Stray dog- Owned or ownerless dogs freely roaming the community, (C)- Cat, (O)- Others
Type of Bite - (B)- Bite and (NB)- Non-bite- to include all non-biting rabies exposures (feeding of raw meat, splattering, kissing and others)

Department of Health

[illegible]

Outcome: (C) Complete—Patients received at least days 0, 3 and 7 doses, (NC)—Patients who did not receive at least days 0, 3 and 7 doses, Died(D)—Patient who died of whatever cause while on PEP, None (N)—Category ■ and ■ exposures who did not receive any of the TCV doses.

Status of Biting Animal: (A) Alive, (D)—Dead and (L)—Lost—Animal not available for observation for 14 days

**Rabies Prevention and Control Program
Inventory of Vaccines and Other Logistics**

For the Quarter ____ 2nd ____

Year ____ 2011

Item	Beginning Balance (Vials)	Received During the Period (Vials)	Lot or Batch No.	Expiry Dates (Vials)	Total Available (Vials)	Issuances (Vials)	Stock on Hand as of June 23, 2011 (Vials)
1. Purified Check Embryo Cell Vaccine (Rabipur)							
2. Equine Rabies Immune Globulin (Favirab) 3. Purified Verocell Rabies Vaccine (Verorab)							

Note: *received

Prepared by:

With fund support from:



**World Health
Organization**