



Republic of the Philippines
Department of Education
REGION III
SCHOOLS DIVISION OFFICE OF BATAAN

OCT 21 2025

DIVISION MEMORANDUM

No. 445, s. 2025

**PREVENTION, CONTROL, AND MANAGEMENT
OF INFLUENZA-LIKE ILLNESS (ILI)**

To: Assistant Schools Division Superintendent
Chief Education Supervisors
Education Program Supervisors
Public Schools District Supervisors
Public Elementary and Secondary School Heads
Division Unit Heads
All Others Concerned

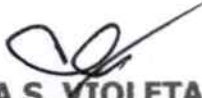
1. In light of the recent reports of increasing cases of **Influenza-like Illness (ILI)**, this Office reiterates the importance of observing health protocols and implementing preventive measures to ensure the safety and well-being of learners and personnel.
2. Points to Remember
 - a. Definition:
Influenza-like Illness (ILI) is characterized by symptoms such as fever, cough, sore throat, headache, and body aches.

Mode of Transmission:
Influenza-like Illness (ILI) spreads through respiratory droplets when an infected person coughs, sneezes, or talks.
 - b. Prevention: Maintaining proper hygiene and observing health protocols are essential to control the spread of ILI.
3. Precautionary Measures
 - a. Practice frequent handwashing with soap and water or use alcohol-based sanitizers.
 - b. Wear face masks when feeling unwell or exhibiting respiratory symptoms.



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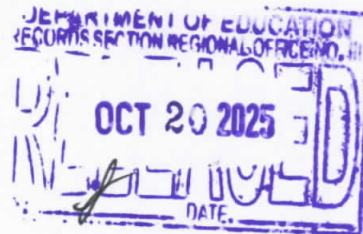
- c. Observe proper cough etiquette (cover mouth and nose with a tissue or elbow when coughing or sneezing).
 - d. Ensure adequate ventilation in classrooms and offices.
 - e. Disinfect frequently touched surfaces and maintain general cleanliness of all areas.
 - f. Encourage adequate rest, proper nutrition, and hydration to boost the immune system.
 - g. Avoid sharing personal items such as utensils, towels, or water bottles.
4. Further, teachers are instructed to monitor and report any learner exhibiting ILI symptoms to the School Health Personnel or School Head immediately.
 5. Confirmed or suspected ILI cases shall be recorded and reported to the School Health and Nutrition Section (SHNS) of the Schools Division Office on a regular basis.
 6. Learners and staff exhibiting symptoms should be advised to stay at home and seek medical attention. School must ensure confidentiality and proper documentation of reported cases, in accordance with DepEd and DOH health guidelines.
 7. Immediate dissemination of and strict compliance with this Memorandum is directed.


CAROLINA S. VIOLETA, EdD, CESO V
Schools Division Superintendent

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Republic of the Philippines
Department of Education
REGION III-CENTRAL LUZON



REGIONAL MEMORANDUM

No. 318, s. 2025

**DEPARTMENT OF EDUCATION REGION III GUIDELINES ON THE
IMPLEMENTATION OF INTERIM GUIDELINES ON THE PREVENTION,
CONTROL AND MANAGEMENT OF INFLUENZA AND INFLUENZA-LIKE ILLNESS
(ILI)**

To : Schools Division Superintendents
School Heads/Principals
School Health Personnel/Focals
All Others Concerned

1. In line with Department of Health (DOH) **Department Memorandum No.2023-0391** on **“Interim Guidelines on the Prevention, Control and Management of Influenza and Influenza-like Illness (ILI),”** and in view of observed seasonal increases in ILI, the Department of Education Regional Office III is issuing this Memorandum to standardize monitoring, reporting, and school-level management of influenza/ILI and Severe Acute Respiratory Infection (SARI) cases to protect learners and school personnel, and to ensure timely coordination with health authorities. The DOH interim guidelines contain the case definitions and recommended actions for ILI and SARI that schools and health partners must reference.
2. This Memorandum applies to all public schools and also recommended to all private schools to cover surveillance, reporting, on-site infection prevention and control (IPC), case management referrals, coordination procedures with Local Government Unit (LGU) health offices and DOH Central Luzon Centers for Health Development (CLCHD) and guidance in the suspension of classes and adoption of Alternative Delivery Mode (ADM) for learners.
3. In reference to **Republic Act No. 11332** also known as **“Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act,”** schools and Division Offices may use the following link for their Daily Case Log, Weekly Report of Cases (<https://tinyurl.com/2zbadm3z>) and Case Referral Form (bit.ly/ESUDirectory2025) for their monitoring and reporting.



Address: Matalino St. D.M. Government Center, Maimpis,
City of San Fernando (P)
Telephone Number: (045) 598-8580 to 89
Email Address: region3@deped.gov.ph
Website: <https://region3.deped.gov.ph>





Republic of the Philippines
Department of Education
REGION III-CENTRAL LUZON

4. All School Officials and Health Personnel are enjoined to observe and effectively implement strict infection control and prevention measures and give regular health information/education activities in their respective areas of concern.
5. For guidance and compliance of all concerned.

RONNIE S. MALLARI, PhD, CESO V
Regional Director

Encl: DOH Department Memorandum No. 2025-0096 and Department Memorandum No. 2023-0391

References: R.A. 11332

To be indicated in the Perpetual Index

Under the following subjects:

INFLUENZA	GUIDELINES
REPORTING	ADM

ESSD/Health1
October 17, 2025



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

October 20, 2023

DEPARTMENT MEMORANDUM
No. 2023 - 0391

TO: ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS AND CENTERS FOR HEALTH DEVELOPMENT (CHD); MINISTER OF HEALTH- BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (MOH- BARMM); CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA AND INSTITUTES; DOH ATTACHED AGENCIES AND INSTITUTIONS AND ALL OTHERS CONCERNED

SUBJECT: Interim Guidelines on the Prevention, Control, and Management of Influenza and Influenza-like Illness (ILI)

Viral acute respiratory infections such as Influenza remain a major health problem worldwide. While all age groups can get infected and are at risk of developing serious conditions, **the older age population, younger children, and those with chronic and certain health conditions suffer the highest risk of severe complications. Additionally, healthcare workers are at high risk of acquiring the viral infection due to increased exposure to patients (WHO, 2023).**

Influenza virus thrives in cold and dry, or humid and rainy seasons. Consequently, in the country, an observed rise in Flu cases coincides with the rainy season which occurs from June until November. There are two main types of Influenza viruses: types A and B. Although influenza can occur throughout the year, causing outbreaks in tropical countries, both types routinely spread among individuals, leading to seasonal flu epidemics annually.

Based on the latest Epidemic-prone Disease Case Surveillance (EDCS) Morbidity Week No. 39 (January 1 to September 30, 2023) there was a 44% increase in Influenza-like Illness (ILI) cases compared to the same period last year. Upon further perusing the report, clustering, and an increase in cases of Influenza/ Flu in some regions potentially signifies local outbreaks.

Subsequently, this memorandum is hereby being issued to provide guidance on the prevention and control, detection and reporting, and treatment and management of patients for Influenza, ILI, and Severe Acute Respiratory Infection (SARI).

I. OBJECTIVES

- A. To guide the DOH offices and bureaus, Centers for Health Development (CHDs), Local Government Units (LGUs), and health facilities on the prevention, control, treatment and management, outbreak and risk communication strategies for Influenza, ILI, and SARI;
- B. To ensure early and accurate diagnosis, administration of proper clinical management, and appropriate outbreak response;
- C. To promptly mitigate and contain the further increase in cases of influenza, ILI and SARI;
- D. To underscore the importance of vaccination, especially in the highly vulnerable age groups during the flu season.

II. GENERAL GUIDELINES

- A. All individuals, especially those at high risk for the influenza virus are advised to strictly adhere to standard precautions and additional transmission-based precautions to prevent and control the transmission of these viral acute respiratory diseases.
- B. Healthcare facilities from the different levels of care, healthcare provider networks, CHDs, and LGUs shall familiarize themselves with the strategies for the prevention and control, diagnosis, and management of influenza, ILI, and SARI and directly coordinate and promptly report identified cases and closed contacts to the DOH through the Epidemiology Bureau (EB).
- C. All partner agencies and stakeholders, both public and private organizations/institutions, schools, and business establishments, including all formal and informal sectors, shall adhere to these guidelines and provide adequate support as necessary in the prevention and control, and outbreak response efforts of the DOH.
- D. Healthcare workers shall identify cases and close contacts, immediately assess, and collect appropriate samples/specimens for laboratory confirmation, report to the epidemiology and surveillance network, and properly triage, coordinate, and refer patients to proper healthcare provider networks and facilities for further management as necessary. Care for all patients should be according to disease severity and acute care needs.

III. SPECIFIC GUIDELINES

A. Prevention and Control

Influenza/flu can spread easily, with rapid transmission in crowded areas such as schools, healthcare facilities, and long-term care homes. Transmission occurs from person to person through respiratory droplets (i.e. from coughing or sneezing and talking) dispersed into the air and spread up to (1) meter. Less often, the virus can be transmitted by indirect contact when individuals touch their faces after touching contaminated surfaces or objects (fomites). Airborne transmission via small particle aerosols can occur within confined air spaces.

Recommended preventive actions for influenza/ ILI and SARI include the following:

1. Observe the following respiratory etiquette mainly when sneezing and coughing:
 - a. Cover mouth and nose with tissues or wipes.
 - b. Properly dispose of used tissues or wipes immediately after.
 - c. If tissue is not available, use one's upper sleeve or arm.
 - d. Avoid coughing into hands which can easily spread viruses.
 - e. Wash hands with soap and water after coughing or sneezing, after contact with an infected person, and after touching potentially contaminated surfaces.
2. Refrain from touching one's eyes, nose, and mouth, especially with unwashed hands, and after touching potentially contaminated instruments and surfaces.
3. Avoid close contact with individuals who are sick. Individuals who exhibit signs and symptoms of influenza or SARI shall wear masks and limit contact with others as much as possible.
4. **Vaccination** is proven to be the most effective way to prevent influenza and its complications. Individuals who are unvaccinated or those who are at increased risk of severe illness are recommended to get their annual flu vaccines. Additionally, children 6 months and older should also be given their annual flu vaccine.

Individuals who are at increased risk for severe seasonal influenza and would highly benefit from vaccination include the following:

- a. Pregnant women at any stage of pregnancy and those at ≤ 2 weeks postpartum
 - b. Children younger than five (5) years
 - c. Adults older than sixty-five (65) years
 - d. People with chronic and certain medical conditions such as:
 - i. Immunocompromised due to certain medications and diseases such as HIV/AIDS
 - ii. Asthma, heart, and lung diseases
 - iii. Endocrine disorders such as diabetes
 - iv. Kidney and liver disorders
 - v. Metabolic disorders
 - vi. Neurological and neurodevelopmental conditions
 - vii. History of stroke
 - e. People with increased risk of exposure to influenza, which includes health care workers.
 - f. People living in nursing homes and other long-term care facilities
- Current DOH program only provides free flu vaccines to Senior Citizens. LGUs are strongly encouraged to procure for their constituents, while private citizens are encouraged to avail, if able.

5. In household settings: Individuals are recommended to practice standard precautionary measures even at home. These shall include the following:

- a. Frequent hand washing with soap and water, as well as hand hygiene using alcohol-based sanitizers, on all occasions, particularly when in contact with suspect and confirmed cases.
- b. Regularly clean and disinfect surfaces and objects that may be contaminated with the virus.
- c. Caregivers and those with children less than 6 months of age (<6 months) should get vaccinated against flu each year.
- d. As much as possible, minimize/limit contact with individuals who exhibit signs and symptoms of influenza. Those who are sick are also advised to wear masks and avoid contact with others at home, especially those who are vulnerable to infection such as children and elderly households.
- e. Monitor and observe sick individuals for signs and symptoms of respiratory infection. Seek proper consultation with a health care provider upon presentation of signs and symptoms, especially in caring for children and vulnerable individuals who exhibit any emergency warning signs of flu. These include, but are not limited to the following:
 - i. Difficulty breathing/ Shortness of breath/ Fast breathing
 - ii. Uncontrolled/ Worsening of fever and cough
 - iii. Chest pain/ pressure in the chest or abdomen
 - iv. Bluish lips or face
 - v. Seizures

6. In health facilities: Health care workers should strictly adhere to infection and prevention control measures by observing standard precautions complemented with droplet and contact precautions such as the following:

- a. Wear a well-fitted medical mask before entering the patient room and remove it upon exit. Additional Personal Protective Equipment (PPEs) may be worn upon risk assessment such as gloves.
- b. Perform hand hygiene before and after use of PPEs, and caring for patients.
- c. Use dedicated patient-care equipment (e.g. stethoscopes, blood pressure cuffs) and regularly clean and disinfect all equipment before and after use. Properly discard used disposable materials (e.g. tissues) immediately after use.
- d. Avoid contaminating environmental surfaces that are not directly related to patient care (e.g. door handles and light switches). Avoid medically unnecessary movement and transport of patients.
- e. Ensure availability of materials (e.g. tissues, alcohol-based sanitizers, no-touch receptacles) for adhering to respiratory hygiene/ cough etiquette, particularly in waiting areas for patients and personnel.

7. In schools and childcare institutions: Apart from recommending that children, parents and guardians, and school personnel get vaccinated each year, observing healthy behaviors at school and at home can help prevent the spread of the virus to others. These shall include the following:

- a. Encourage children, parents, and staff to wear medical masks and maintain a safe distance of at least 1 meter apart (≥ 3 feet). Moreso, to stay at home when sick and to avoid close contact with suspected or confirmed individuals.
- b. Clean and disinfect frequently touched surfaces in school, such as desks, doorknobs, handrails, and others, especially when there are sick students.
- c. Avoid touching the eyes, nose, and mouth, particularly with unwashed hands or without disinfecting the hands.
- d. Advocate for practicing proper respiratory etiquette in schools especially if with crowds.
- e. Maximize proper ventilation such as the use of well-ventilated and open spaces, ensuring good airflow, and avoiding crowding especially in indoor locations and enclosed spaces.

B. Diagnosis and Differential Testing

1. **Clinical Manifestations.** Acute respiratory infections may be due to COVID-19, influenza, and other non-influenza viruses (e.g., respiratory syncytial virus (RSV), rhinovirus, adenovirus, parainfluenza, and human metapneumovirus). The symptoms of COVID-19, influenza, and other influenza-like illnesses are often difficult to differentiate from each other (See Annex A).
2. **Differential Diagnoses.** The differential diagnoses of acute viral respiratory infections are shown in Annex A.
3. **Diagnostic Testing.** The decision to perform diagnostic testing should be based on local surveillance data and the availability of testing at local healthcare facilities.
 - a. Strict adherence to recommended infection prevention and control measures should be observed when collecting respiratory specimens for testing.
 - b. Co-testing of influenza and SARS-CoV-2 may be done depending on the clinical manifestations of the patient and the clinical suspicion of the healthcare provider.
 - c. The following tests may be performed to differentiate influenza from SARS-CoV-2 infection or detect co-infection:
 - i. COVID-19: SARS-CoV-2 nucleic acid detection (e.g., RT-PCR) OR antigen detection assay
 - ii. Influenza: Influenza nucleic acid detection assay (Note that rapid influenza antigen detection assays are not recommended for hospitalized patients due to low test sensitivity)
 - iii. Multiplex nucleic acid detection assays for SARS-CoV-2, influenza A and B viruses can also be done if available.
 - d. The possibility of co-infection should always be considered. A positive influenza test without concomitant SARS-CoV-2 testing does not exclude the latter and vice versa.

C. Isolation and Quarantine

1. All individuals who exhibit signs and symptoms of viral acute respiratory infections shall be appropriately assessed and triaged to ensure proper referral and timely management.
2. Individuals who are exposed but are asymptomatic are advised to monitor themselves for symptoms and practice minimum public health standards. Immediate medical consultation is recommended once symptoms are noted.
3. Patients suspected and confirmed with acute respiratory infections shall be placed in single rooms. Cohorting patients with the same etiological diagnosis in a room, maintaining at least (1)-meter distance between beds can also be done. If an etiological diagnosis is not possible, group patients with similar clinical diagnoses and based on epidemiological risk factors, with a spatial separation.
4. Limit patient movement within the institution to medically necessary purposes. Ensure that patients wear medical masks when being taken outside their rooms and outside facilities.
5. Suspect patients and close contacts shall be catered to in a separate area/ an isolation room with adequate ventilation if available. If it is not possible to separate the patient, keep at least (1)-meter distance between close contacts and suspected patients and the other patients in the waiting room.
6. Admission of suspected SARI patients, who otherwise may be discharged based on their clinical conditions, can be considered if there are no alternatives available to ensure safe infection control. These include travelers, homeless persons, and individuals who live in environments where infection control measures are not feasible or practical (e.g. crowded dormitories/shelters).

D. Treatment and Patient Management

1. Post-exposure Chemoprophylaxis

US Centers for Disease Prevention and Control (CDC) does not recommend widespread or routine use of antiviral medications for chemoprophylaxis except as part of the interventions to control institutional influenza outbreaks. Routine use of post-exposure chemoprophylaxis as well as seasonal or pre-exposure chemoprophylaxis is not recommended.

Decisions on whether to administer antivirals for chemoprophylaxis should take into account the exposed person's risk for influenza complications, the type and duration of contact, recommendations from local or public health authorities, and clinical judgment. Please see Annex B on the considerations in the provision of postexposure antiviral chemoprophylaxis in a noninstitutional setting for asymptomatic persons with influenza exposure.

Generally, post-exposure chemoprophylaxis for persons should be only used when antivirals can be started within 48 hours of the most recent exposure. Please see Annex C on the recommended chemoprophylaxis according to age.

Post-exposure chemoprophylaxis can be considered for pregnant women and women who are up to (2) weeks postpartum, including those with pregnancy loss, who have had close contact with individuals suspected of having influenza or viral acute respiratory infections, and those who cannot receive an influenza vaccine due to contraindications or unavailability of vaccines, or those who have severe immune deficiencies or suffer from other medical conditions that make them unlikely to respond to vaccination.

An alternative to chemoprophylaxis after a suspected exposure is close monitoring and early initiation of antiviral treatment if fever and/or respiratory symptoms develop.

2. Clinical Management

- a. In **non-high-risk/otherwise healthy patients** with illness <2 days, empiric antiviral treatment for influenza may be given based on the healthcare provider's clinical judgment. Giving antiviral treatment in these patients beyond 2 days of illness duration is unlikely to have clinical benefit.
- b. In patients suspected of having influenza based on clinical manifestations and **who are hospitalized, who have progressive disease of any duration, or who are at high risk for influenza complications**, (Annex D), even without influenza testing, empiric antiviral treatment should be initiated as soon as possible, ideally within 48 hours of symptom onset (Annex E).
- c. If there is suspicion of bacterial pneumonia or sepsis, antimicrobial testing should be done and antimicrobial therapy should be initiated according to existing evidence-based guidelines.
- d. Patients with SARS-CoV-2 infection should be treated according to the updated Philippine COVID-19 Living Guidelines.
- e. Supportive therapies should be administered in patients with acute viral respiratory infections, such as the following:
 - i. Adequate hydration
 - ii. Proper diet and nutrition
 - iii. Antipyretics for fever or pain relief
 - iv. Cold medications and mucolytics for symptomatic relief

IV. Surveillance

- A. Influenza-like illness and SARI are mandatorily notifiable diseases under Republic Act No. 11332 (*Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act*). As such, surveillance for ILI and SARI is conducted in an integrated manner with COVID-19 under a pan-respiratory illness surveillance system.

- B. The objectives of integrated ILI-SARI-COVID-19 surveillance are:
- To monitor trends, disease burden, and variant distribution of priority respiratory viruses such as influenza and SARS-CoV-2;
 - To detect and monitor co-circulation of respiratory viruses;
 - To provide targeted samples and information for genomic surveillance of respiratory viruses to describe the genetic composition and antigenic/mutation distribution of circulating viruses; and
 - To inform public health policies and interventions through timely provision of data on respiratory illnesses
- C. All health facilities, Rural Health Units, private clinics, and Epidemiology and Surveillance Units (ESUs) shall register all identified suspect, probable, and confirmed ILI, SARI, and COVID-19 cases using either the TanodKontraCOVID (TKC) platform or through the submission of a completely-filled out case investigation form (CIF) **within the prescribed timelines.**
- D. Identified case clusters and unusual health events, including outbreaks and those occurring in closed settings such as schools and workplaces, shall be reported to the Event-based Surveillance and Response (ESR) system within 24 hours of detection.
- E. The surveillance case definitions of ILI and SARI can be found in Annex F.
- F. Parallel confirmatory testing for ILI, SARI, and COVID-19 for surveillance purposes shall be performed by the Research Institute for Tropical Medicine and its identified and trained subnational laboratories (SNLs). However, suspect COVID-19 cases presenting with severe or critical disease may be tested for diagnostic purposes using validated rapid antigen kits and/or via PCR in licensed laboratories.
- G. Specific guidelines for reporting and testing can be found in Department Memorandum No. 2022-0526 (*Interim Guidelines on the Pilot Implementation of Integrated Sentinel Surveillance for SARS-CoV-2, Severe Acute Respiratory Illnesses, and Influenza-like Illnesses*), while specific guidelines on the use of TanodKontraCOVID can be found in Department Memorandum No. 2023-0117 (*Shift from COVIDKaya (CK) and Epidemic-prone Diseases Case Surveillance Information System (EDCS-IS) to TanodKontraCOVID (TKC) for Encoding of COVID-19, and Severe Acute Respiratory Infections (SARI) and Influenza-like Illness (ILI) Cases*).

V. Public Health Management Measures

A. School-setting

Younger children are among the vulnerable populations who have the highest risk of developing severe complications. In coordination with the Department of Education (DepEd), recommended school adjustments and shifts shall be undertaken to further manage the spread of ILIs among school-aged children and minimize its effect on their academic performance and health, such as but not limited to the following:

- Schools with a relatively high number of ILIs are recommended to shift modality to distance learning upon reaching particular thresholds, to prevent the spread of ILIs among learners, school personnel, and their families.

- i. **Threshold per classroom:** Classrooms with an absentee rate of 10 percent due to influenza or ILIs should institute a modality shift of two calendar days, triggered the day after class absentee rate reaches 10 percent.
 - ii. **Threshold per school:** Schools with an absentee rate of more than four percent due to influenza or ILIs, detected for two consecutive days, with the second day's absentee rate being higher or equal to the absentee rate on the first day should institute a school-wide modality shift for seven calendar days.
- b. Schools that have shifted modalities are also recommended to inform their Local Epidemiology and Surveillance Units (LESUs) of the shift due to influenza or ILIs, to ensure that LESUs can conduct the appropriate investigation and provide sound health advice to schools. A directory of LESUs may be accessed via bit.ly/DOHDirectoryLESU2023.
 - c. The DOH-proposed School Early Warning System (SEWS), where school heads are encouraged to report clusters and cases of unusual health events and health-related absences, is recommended to be followed as soon as possible. A list of unusual health events that schools shall report to the LESUs can be found in Annex F.

VI. Risk Communication and Community Engagement

- A. Implementing units shall utilize the communication products (bit.ly/RCCE-Influenza and bit.ly/RCCE-InfluenzaVax) to increase awareness on influenza and generate demand for the influenza vaccines. Online and offline platforms shall be leveraged as appropriate, especially to reach the vulnerable populations identified in Section III.A.4.
- B. CHDs shall localize the available communication products as relevant to their communities and their information needs, while ensuring that the following communication objectives are met:
 - a. Individuals should be aware of the risk of influenza, ILIs, and SARI, including their susceptibility and severity of these diseases
 - b. Individuals are aware of important measures that they can take for protection, including the following:
 - i. Protective measures such as individual behaviors and environmental controls that can be applied in the household, as well as school and childcare institutions.
 - ii. Home management for individuals exhibiting symptoms, and protective behaviors that caregivers can take as self-protection.
 - iii. Healthcare workers must be aware of protective behaviors while in health facilities.
 - c. Individuals must be aware of access sites for vaccination services, including the time in which facilities are available to administer vaccines.
 - d. Further, individuals must also be aware and encouraged to consult their nearest primary care provider should they feel the need to.
 - i. Ensure that individuals experiencing symptoms consult with the nearest primary care provider or call DOH National Patient Navigation

and Referral Center through 1555 and select option (2) for immediate and proper assessment as well as corresponding management and interventions.

- C. CHDs shall identify strategic partners for community engagement to expand the reach of communication products and identify strategies to address possible drivers and barriers of protective behaviors.
 - a. Strategic communities and stakeholders such as local chief executives, government agencies (e.g. the Department of Education, National Commission of Senior Citizens), medical and allied health societies (e.g. the Philippine Pediatric Society, Inc., Integrated Midwives Association of the Philippines, other specialty societies), faith-based organizations, patients groups, etc. that can support in reaching vulnerable populations.
 - b. Community engagement activities may include evidence generation for drivers and barriers to protective behaviors (a rapid assessment tool is available in the community toolkit), identification of local-level interventions such as town halls, use of public announcement systems and other mainstream broadcast media, and monitoring of planned interventions.
- D. CHD Communication Management Units shall manage crisis communications with clearance from the DOH Communication Office (COM).

For guidance and dissemination.

By Authority of the Secretary of Health:



Digitally signed by
Vergeire Maria Rosario
Singh

MARIA ROSARIO SINGH-VERGEIRE, MD, MPH, CESO II
Undersecretary of Health
Public Health Services Team

Annex A. Clinical Manifestations and Differential Diagnoses

	Influenza	Rhinovirus	Adenovirus	Respiratory Syncytial Virus (RSV)	Parainfluenza	Human metapneumovirus	COVID-19
Symptoms	Fever, cough with or without sputum, hoarseness, nasal discharge/ congestion, shortness of breath, wheezing, sneezing, sore throat, diarrhea	Symptoms of runny nose, sore throat, cough, wheeze, sometimes lethargy, body aches and fever, with or without gastrointestinal symptoms. Change in or loss of taste or smell is more frequent with COVID-19 than flu.					
Incubation Period	Median: 2 days (range 1-9 days)	12 hours to 5 days	12 hours to 5 days	Up to 8 days	2 to 6 days	12 hours to 5 days	Up to 14 days
Period of infectiousness	Starts with the onset of ILI symptoms and last for the entire duration of symptoms	Often begin 12-24 hours prior to symptom onset until 5 days afterwards					2 days prior to symptom onset until 10 days after symptom onset
Transmission	Primarily via droplet transmission when in close contact or direct interpersonal contact. Can also occur through aerosols and indirect contact with contaminated surfaces	Droplet transmission, direct contact, indirect contact with contaminated surfaces	Droplet transmission, direct contact, indirect contact with contaminated surfaces	Droplet transmission, direct contact, indirect contact with contaminated surfaces	Direct contact with infectious droplets or by airborne spread	Droplet transmission, direct contact, indirect contact with contaminated surfaces	Droplet transmission
Vaccine	Available	None	None for the general public	Available in the US (for pregnant women and older adults)	None	None	Available
Treatment	Empiric antiviral therapy ideally within 48 hours of symptom onset (e.g. oseltamivir) Supportive treatment	Supportive treatment	Supportive treatment	Supportive therapy Nirsevimab (for severe RSV disease)	Supportive treatment	Supportive treatment	Treatment according to the COVID-19 Living Guidelines

Annex B. Considerations in the Provision of Post-exposure Antiviral Chemoprophylaxis

Post-exposure chemoprophylaxis	Asymptomatic adults and children aged ≥ 3 months with the following conditions after household exposure to influenza: • With very high risk of developing complications from influenza (e.g., severely immunocompromised persons) • Contraindicated to influenza vaccine • Instances when influenza vaccine is unavailable • Expected to have low vaccine effectiveness
Post-exposure chemoprophylaxis in conjunction with influenza vaccination	Adults and children aged ≥ 3 months with the following conditions: • Unvaccinated • With influenza exposure
<i>Empiric initiation of antiviral treatment as an alternative to postexposure antiviral chemoprophylaxis</i>	

Annex C. Recommended Dosage and Duration of Influenza Antiviral Medications for Chemoprophylaxis

ADULTS	PREGNANT WOMEN	CHILDREN
Oseltamivir 75 mg once daily for 7 days	Oseltamivir** 75 mg orally once daily for 7-10 days	Oseltamivir (3-11 months) 3 mg/ kg/ dose once daily for 7 days
Zanamivir* 10 mg (two 5-mg inhalations) once daily for 7 days	Zanamivir* 10 mg (two 5-mg inhalations) once daily for 7-10 days	(> 1 year old) The dose varies by child's weight for 7 days: ● 15 kg or less: 30 mg once a day ● >15 to 23 kg: 45 mg once a day ● >23 to 40 kg: 60 mg once a day ● >40 kg: 75 mg once a day
		Zanamivir* (5 years or older) 10 mg (two 5-mg inhalations) once daily for 7 days

*Not recommended for persons with underlying airway disease (e.g., asthma or chronic obstructive pulmonary diseases)

**Considered drug of choice for chemoprophylaxis in pregnant women by the American Society of Obstetrics and Gynecology and the Infectious Diseases Society of America.

Note: For control of outbreaks in institutional settings (e.g., long-term care facilities for older adults and children) and hospitals, the US CDC recommends antiviral chemoprophylaxis with oral oseltamivir or inhaled zanamivir for a minimum of 2 weeks and continuing up to 1 week after the last known case was identified.

Annex D. Patients at High-Risk for Influenza Complications

HIGH-RISK GROUPS (RECOMMENDED TO RECEIVE EMPIRIC ANTIVIRAL TREATMENT FOR INFLUENZA)
• Adults 65 years and older • Children younger than 2 years old¹ • Asthma • Neurologic and neurodevelopment conditions • Blood disorders (such as sickle cell disease) • Chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis) • Endocrine disorders (such as diabetes mellitus) • Heart disease (such as congenital heart disease, congestive heart failure and coronary artery disease) • Kidney diseases • Liver disorders • Metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders) • People who are obese with a body mass index [BMI] of 40 or higher • People younger than 19 years old on long-term aspirin- or salicylate-containing medications. • People with a weakened immune system due to disease (such as people with HIV or AIDS, or some cancers such as leukemia) or medications (such as those receiving chemotherapy or radiation treatment for cancer, or persons with chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system) • People who have had a stroke • Pregnant people and people up to 2 weeks after the end of pregnancy • People who live in nursing homes and other long-term care facilities • ¹Although all children younger than 5 years old are considered at higher risk for complications from influenza, the highest risk is for those younger than 2 years old, with the highest hospitalization and death rates among infants younger than 6 months old. Because many children with mild febrile respiratory illness might have other viral infections (e.g., respiratory syncytial virus, rhinovirus, parainfluenza virus, or human metapneumovirus), knowledge of other respiratory viruses as well as influenza virus strains circulating in the community is important for treatment decisions. • People from certain racial and ethnic minority groups are at increased risk for hospitalization with influenza, including non-Hispanic Black persons, Hispanic or Latino persons, and American Indian or Alaska Native persons
Adapted from: US Centers for Disease Control and Prevention. September 27, 2023. Influenza Antiviral Medications: Summary for Clinicians. https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Annex E. Antiviral Therapies for Influenza

ANTIVIRAL	ADULT DOSE	PEDIATRIC DOSE
Oseltamivir PNF Status: Listed FDA: with CPR	Adults: 75 mg orally twice daily for 5 days (extended duration up to 10 days may be considered in patients with severe disease, particularly if immunosuppressed)	Children: ≤ 8 months: 3 mg/kg/ dose orally twice daily ≥9 months: 3-3.5 mg/kg/dose orally twice daily ≤15 kg: Oral: 30 mg orally twice daily. >15 to 23 kg: Oral: 45 mg orally twice daily. >23 to 40 kg: Oral: 60 mg orally twice daily. >40 kg: Oral: 75 mg orally twice daily.
Zanamivir PNF Status: Not Listed FDA: with CPR	Adults: 10 mg (two 5 mg inhalations) twice daily for 5 days	Children ≥7 years and Adolescents: Oral inhalation: Two 5-mg inhalations (10 mg) twice daily for 5 days; doses on the first day should be separated by at least 2 hours; on subsequent days, doses should be spaced by ~12 hours.
Peramivir PNF Status: Not listed FDA: No CPR	Adults: 600 mg intravenously as a single dose	Children 6 months to 12 yrs of age: One 12 mg/kg dose, up to 600 mg maximum, via intravenous infusion for a minimum of 15 minutes (US FDA approved and recommended for use in children 6 months or older)
Baloxavir PNF Status: Not Listed FDA: Expired CPR	Adults: 40 kg to <80 kg: 40 mg orally as a single dose ≥80 kg: 80 mg orally as a single dose	Children 5 yrs and older weighing <20 kg: single dose of 2 mg/kg by suspension; Children 5 years and older weighing 20 kg to <80 kg: single dose of 40 mg by tablet or suspension Children 5 years and older weighing ≥80 kg: single dose of 80 mg by tablet or suspension) (US FDA approved and recommended for use in otherwise healthy children 5 yrs and older.)
Note: <i>Oseltamivir and peramivir should be dose-adjusted in patients with renal impairment</i> Adapted from: US Centers for Disease Control and Prevention. September 27, 2023. Influenza Antiviral Medications: Summary for Clinicians. https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm		

Annex F. Surveillance Case Definitions

Influenza-like Illness (ILI) Suspect Case: Any person with an acute respiratory infection with ALL of the following: - Measured fever of $\geq 38^{\circ}\text{C}$; - Cough or sore throat; AND - With symptom onset within the last 10 days.
Severe Acute Respiratory Infection (SARI) Suspect Case: Any of the following: - Any person older than five years old with ALL of the following: - Acute respiratory infection with history of fever or measured fever of $>38^{\circ}\text{C}$ and cough; - With onset within the last 10 days; AND - Requires hospitalization. - Any child 2 months to 5 years of age with cough or difficulty of breathing AND: - Breathing faster than 60 breaths/min (for infants aged < 2 months) - Breathing faster than 50 breaths/min (for infants aged 2-12 months) - Breathing faster than 40 breaths/min (for children aged 1-5 years old) - Requires hospitalization - Any child 2 months to 5 years of age with cough or difficulty of breathing and ANY of the following danger signs: - Unable to drink or breastfeed; - Vomits everything; - Convulsions; - Lethargic or unconscious; - Chest in-drawing or stridor in a calm child; - Requires hospitalization. Probable Case: A person fitting the definition above of a "Suspect Case" fulfilling ALL of the criteria: - With clinical, radiological, or histopathological evidence of pulmonary parenchyma disease (e.g., pneumonia or ARDS) but no possibility of laboratory confirmation either because the patient or samples are not available or there is no testing available for other respiratory infections; - Close contact with a laboratory-confirmed case; AND, - Condition not already explained by any other infection or etiology, including alternative clinically-indicated tests for community-acquired pneumonia according to local management guidelines. Confirmed Case: A suspected case that is laboratory-confirmed. Cluster: Three (3) or more cases with onset of signs or symptoms within the same 14-day period and who are associated with a specific setting, such as a community, classroom, workplace, household, extended family, hospital, other residential institution, military barracks or recreational camp.

Source: *Philippine Integrated Disease Surveillance and Response (PIDSR) Manual of Procedures (MOP)*, 3rd Edition, 2014

Note: Case definitions may change without prior notice as the latest scientific consensus on these diseases evolves. Please consult with the Regional Epidemiology and Surveillance Units or the Epidemiology Bureau for any questions regarding these case definitions.

Annex G. List of Signals in a School for Reporting to ESUs

Signals are raw data or unverified information that tells people that something is happening or **suggesting a possible problem which may represent a potential acute public health risk**. These signals will trigger the LESU to either monitor or investigate once they are detected, by filtering and verifying the report.

The list of signals in a school setting may include, but are not limited to, the following:

1. Two (2) or more students in a class/section or school employees within seven (7) days with any of the following:
 - a. Influenza-like illness (Fever and cough/cold/sore throat);
 - b. Respiratory illness (cough, colds, sore throat, difficulty of breathing);
 - c. Fever and rash;
 - d. Blisters on hand, foot, and/or mouth;
 - e. Fever or headache with changes in mental status/sensorium, seizures, neck stiffness, and/or other neurological signs or symptoms.
2. Three (3) or more students in a class/section or school employees who have sudden onset of gastrointestinal signs and symptoms, which may include watery or bloody diarrhea*, abdominal pain, and vomiting;
3. Two (2) or more students who developed any signs and symptoms following immunization and/or deworming in school (Example: Fever, rash, vomiting, abdominal pain, dizziness);
4. One (1) or more student reported to have sudden onset of weakness in the arms and/or legs;
5. Two (2) or more students or school employees who became ill due to heat stroke;
6. Two (2) or more students or school employees who were absent from school due to the same illness within seven (7) days

*Criteria for diarrhea: must be three (3) or more episodes in a day

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Republic of the Philippines
DEPARTMENT OF HEALTH
Office of the Secretary



February 19, 2025

DEPARTMENT CIRCULAR

No. 2025- 0096

TO : ALL CENTERS FOR HEALTH DEVELOPMENT DIRECTORS; MINISTER OF HEALTH - BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO; EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA AND INSTITUTES; AND ALL OTHERS CONCERNED

SUBJECT : Reiteration of the Department Memorandum No. 2023-0391: Interim Guidelines on Prevention, Control and Management of Influenza and Influenza-Like Illness (ILI)

Increasing cases and trends of acute respiratory diseases, particularly influenza-like illness (ILI), have been reported in several countries in the Northern Hemisphere this year. Notably, a surge in cases of acute respiratory infections was reported in China in January 2025, with increased detections of seasonal influenza, rhinovirus, respiratory syncytial virus (RSV), and human metapneumovirus (hMPV), particularly in its northern provinces. This increase in cases is within the expected range for the time of the year during the northern hemisphere winter. This was followed by reports of increased influenza cases in Japan in February 2025. From September 2024 to January 26, 2025, Japan recorded approximately 9.5 million influenza cases, mainly caused by influenza A. Densely populated areas with numerous tourist attractions and crowded spaces which include Tokyo, Hokkaido, Osaka, and Fukuoka are among regions in Japan with the highest recorded cases.

In the Philippines, as of Morbidity Week (MW) 6 or February 8, 2025, 14,362 of ILI cases have been reported nationwide. This is 43% lower compared to the 25,138 cases reported during the same time last year. Seven deaths were reported with 0.05% case fatality rate (CFR), which is 85% lower than the deaths reported during the same time last year. Among the ILI cases that were tested and were positive for a pathogen, 27% were due to Influenza A, 26% were Influenza B, and 16% were Rhinovirus. Only twelve out of 508 positive ILI cases (2%) are caused by Human Metapneumovirus (hMPV).

Cases of COVID-19 are also decreasing with 1,207 total cases including the 16 deaths reported nationwide as of MW 6. Moreover, ICU admissions continue to decline with 81% of these admissions being incidental¹.

There were 1,568 cases of Severe Acute Respiratory Infection (SARI) reported nationwide as of MW 6, with a 14% increase from the 1,372 cases reported during the same time last year. Similar

¹ Per DM 2022-0501, *Incidental COVID* refers to confirmed cases admitted to any health facility who do not fulfill epidemiological criteria and who were tested for SARS-CoV-2 testing due to a hospital testing policy.

to ILI cases, Influenza A was the most commonly detected pathogen, followed by RSV among SARI cases.

Despite the overall decreasing trends of ILIs in the Philippines, the potential risk posed by increased travel to and from affected countries necessitates continued vigilance. In line with this, all Centers for Health Development (CHDs) including the Ministry of Health - Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) are directed to maintain heightened surveillance and implement proactive measures to prevent and control ILIs in alignment with the Department Memorandum No. 2023-0391 entitled "*Interim Guidelines on the Prevention, Control, and Management of Influenza and Influenza-like Illness (ILI)*".

- I. Continuously promote the following preventive actions:
 - A. Encourage individuals who exhibit signs and symptoms of influenza, ILI or SARI to practice the following :
 1. Proper respiratory etiquette mainly when sneezing and coughing.
 2. Refrain from touching one's eyes, nose, and mouth, especially with unwashed hands, and after touching potentially contaminated instruments and surfaces.
 3. Wear face masks and limit contact with others as much as possible, especially to those who are vulnerable to infection such as children and elderly households.
 - B. Encourage individuals who have a household member who are sick to practice the following:
 1. Avoid close contact with sick individuals.
 2. Frequent hand washing with soap and water, as well as hand hygiene using alcohol-based sanitizers, on all occasions, particularly when in contact with suspect and confirmed cases.
 3. Regularly clean and disinfect surfaces and objects that may be contaminated with the virus.
 4. Monitor and observe sick individuals for signs and symptoms of respiratory infection. Seek proper consultation with a health care provider upon presentation of signs and symptoms, especially in caring for children and vulnerable individuals who exhibit any emergency warning signs of flu.
 - C. Recommend annual influenza vaccination, especially to individuals who are unvaccinated or those who are at increased risk of severe illness, in line with recommendations in the Omnibus Health Guidelines. Additionally, parents and those who care for children (including personnel in schools and childcare institutions) and children should also be given their annual flu vaccine on the recommended schedule.
 1. DOH provides free flu vaccines to indigent senior citizens. An advisory shall be released once the vaccines are available.
 2. LGUs are encouraged to procure for their constituents beyond the priority population of the DOH, while other individuals are encouraged to avail of flu vaccines in pharmacies, if able.

- D. Ensure strict adherence to the infection and prevention control measures in all health care facilities by observing standard precautions complemented with droplet and contact precautions.
- E. Schools shall encourage observance of the following preventive behaviors:
 - 1. Ask students and school personnel to stay at home when sick and to avoid close contact with suspected or confirmed individuals.
 - 2. Clean and disinfect frequently touched surfaces in school, such as desks, doorknobs, handrails, and others, especially when there are sick students.
 - 3. Avoid touching the eyes, nose, and mouth, particularly with unwashed hands or without disinfecting the hands.
 - 4. Advocate for practicing proper respiratory etiquette in schools especially if with crowds.
 - 5. Maximize proper ventilation such as the use of well-ventilated and open spaces, ensuring good airflow, and avoiding crowding especially in indoor locations and enclosed spaces.
 - 6. Recommend school adjustments and shifts outlined in DM 2023-039 in coordination with the Department of Education to further manage spread of cases of ILI among school-aged children.
- II. Inform the public to watch out for any symptom of influenza and ILI. Diagnostic testing ensuring the following protocols shall be performed based on local surveillance data and availability of testing at local health care facilities:
 - A. Strict adherence to recommended infection prevention and control measures should be observed when collecting respiratory specimens for testing.
 - B. Co-testing of influenza and SARS-CoV-2 shall be done depending on the clinical manifestations of the patient and the clinical suspicion of the healthcare provider. Multiplex nucleic acid detection assays for SARS-CoV-2, influenza A and B viruses can also be done if available.
 - C. The possibility of co-infection should always be considered. A positive influenza test without concomitant SARS-CoV-2 testing does not exclude the latter and vice versa.
- III. ILI and SARI are mandatorily notifiable diseases under Republic Act No. 11332 (Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act). As such, surveillance for ILI and SARI is conducted in an integrated manner with COVID-19 under a pan-respiratory illness surveillance system.
 - A. All health facilities, Rural Health Units, private clinics, and Epidemiology and Surveillance Units (ESUs) shall register all identified suspect, probable, and confirmed ILI, SARI, and COVID-19 cases using either the TanodKontraCOVID (TKC) or Philippine Integrated Disease Surveillance and Response - Information System (PIDSR-IS) within the prescribed timelines.
 - B. Identified case clusters and unusual health events, including outbreaks, clusters occurring in closed settings such as schools and workplaces, and cases with exposure to poultry, swine, game birds, or other animals, shall be

reported to the Event-based Surveillance and Response (ESR) system within 24 hours of detection.

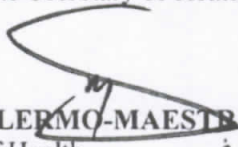
- C. Parallel confirmatory testing for ILI, SARI, and COVID-19 for surveillance purposes shall be performed by the Research Institute for Tropical Medicine and its identified and trained subnational laboratories (SNLs). However, suspect COVID-19 cases presenting with severe or critical disease may be tested for diagnostic purposes using validated rapid antigen kits and/or via PCR in licensed laboratories.
- IV. Ensure appropriate assessment/ referral and timely management of all individuals who exhibit signs and symptoms of acute viral respiratory infections.
 - A. Place suspect and confirmed patients in single rooms. Cohorting patients with the same etiological diagnosis in a room, maintaining at least (1)-meter distance between beds can also be done. If an etiological diagnosis is not possible, group patients with similar clinical diagnoses and based on epidemiological risk factors, with a spatial separation.
 - B. Limit patient movement within the institution to medically necessary purposes. Ensure that patients wear medical masks when being taken outside their rooms and outside facilities.
 - C. Suspect patients and close contacts shall be catered to in a separate area/ an isolation room with adequate ventilation if available. If it is not possible to separate the patient, keep at least (1)-meter distance between close contacts and suspected patients and the other patients in the waiting room.
 - D. Consider admission of suspected SARI patients, who otherwise may be discharged based on their clinical conditions, if there are no alternatives available to ensure safe infection control. These include travelers, homeless persons, and individuals who live in environments where infection control measures are not feasible or practical (e.g. crowded dormitories/shelters).
- V. Routine use of post-exposure chemoprophylaxis as well as seasonal or pre-exposure chemoprophylaxis is not recommended. Decisions on whether to administer antivirals for chemoprophylaxis should take into account the exposed person's risk for influenza complications, the type and duration of contact, recommendations from local or public health authorities, and clinical judgment. An alternative to chemoprophylaxis after a suspected exposure is close monitoring and early initiation of antiviral treatment if fever and/or respiratory symptoms develop.
- VI. Empiric antiviral treatment may be given based on the risk of the patient and assessment of the health care provider.
 - A. It may be given to non-high-risk/otherwise healthy patients with illness <2 days, based on the healthcare provider's clinical judgment. Giving antiviral treatment in these patients beyond 2 days of illness duration is unlikely to have clinical benefit.
 - B. It should be initiated as soon as possible, ideally within 48 hours of symptom onset to patients suspected of having influenza based on clinical manifestations and who are hospitalized, who have progressive disease of any

duration, or who are at high risk for influenza complications, even without influenza testing.

- C. Antimicrobial testing should be done and antimicrobial therapy should be initiated in accordance with existing evidence-based guidelines if there is suspicion of bacterial pneumonia or sepsis.
 - D. Treat patients with SARS-COV-2 infection according to the latest DOH guidelines on COVID-19 treatment and updated Philippine COVID-19 Living Guidelines.
 - E. Supportive therapies should be administered in patients with acute viral respiratory infections.
- VII. Health care providers may refer to the Omnibus Health Guidelines through <https://doh.gov.ph/dpcb/omnibus-health-guidelines/> and DOH-approved Clinical Practice Guidelines at <https://doh.gov.ph/dpcb/doh-approved-cpg> for additional clinical guidance.
- VIII. Utilize the communication products (bit.ly/RCCE-Influenza and bit.ly/RCCE-InfluenzaVax) to increase awareness on influenza and generate demand for the influenza vaccines. Online and offline platforms shall be leveraged as appropriate, especially to reach the vulnerable populations.
- A. CHDs shall localize the available communication products as relevant to their communities and their information needs, while ensuring that the communication objectives outlined in DM 2023-0391 are met.
 - B. CHDs shall identify strategic partners for community engagement to expand the reach of communication products and identify strategies to address possible drivers and barriers of protective behaviors.
- IX. CHD Communication Management Units shall manage crisis communications with clearance from the DOH Communication Office (COM).

For compliance.

By Authority of the Secretary of Health:


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