



Republic of the Philippines  
**DEPARTMENT OF HEALTH**  
*Office of the Secretary*



MAR 23 2026

**ADMINISTRATIVE ORDER**

No. 2026 - 0005

**SUBJECT: Guidelines on Differentiated Service Delivery (DSD) for Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) in the Prevention of HIV in the Philippines**

**I. RATIONALE**

The Philippines remains to have a less than one percent HIV prevalence. Despite the low prevalence, there is a concentrated epidemic within key populations. The country has been reported to have the fastest-growing epidemic in Asia and the Pacific Region with a 550% increase in annual new infections between 2010 and 2024.

As of November 2025, an average of 55 new HIV cases are reported daily, bringing the total to 162,056 cumulative cases nationwide (HASP, 2025). Key populations include males having sex with males (MSM), transgender women (TGW), sex workers, people who inject drugs (PWID), and young key populations (YKP) aged 15-24 years. Additionally, vulnerable populations, including migrant workers, pregnant women, and persons deprived of liberty (PDL), are significantly impacted by HIV. This highlights the strong need for HIV prevention strategies such as Pre-Exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP), which are proven to halt HIV seroconversion by almost 99%. With PrEP and PEP implementation, an estimated 43,000 new HIV cases will be averted in the Philippines by 2030 (AEM, 2024).

In 2021, the Department of Health (DOH) released Department Memorandum (DM) No. 2021-0017 entitled, "*Interim Guidelines on Pre-Exposure Prophylaxis (PrEP) for the Prevention of HIV Infection in the Philippines,*" providing details on the delivery of PrEP services for people at higher risk of HIV infection. In January 2022, oral PrEP (Tenofovir Disoproxil Fumarate + Emtricitabine) was also included in the Philippine National Formulary, supporting the integration of PrEP into national HIV prevention services.

Building on this, the DOH has implemented simplified and differentiated service delivery (DSD) models for both PrEP and PEP, guided by Republic Act (RA) No. 11166 (the Philippine HIV and AIDS Policy Act), World Health Organization recommendations, and the country's national priority health outcomes plans.

This Administrative Order (AO) updates the interim policy to reflect advances in implementation, service delivery innovations, and the availability of additional PrEP and

PEP formulations. It formalizes and strengthens the integration of PrEP and PEP into HIV prevention programming, expands service delivery modalities, and provides clear, unified national guidance to scale up equitable and timely access across all settings.

## II. OBJECTIVES

This Order shall provide programmatic guidance on differentiated and integrated PrEP and PEP service delivery for HIV prevention among all key populations and vulnerable groups with substantial risk for HIV infection. Specifically, it shall:

- A. Establish guiding principles in the differentiated delivery of PrEP and PEP;
- B. Facilitate integration of PrEP and PEP into the Combination HIV Prevention approach;
- C. Identify eligible service delivery points for PrEP and PEP provision;
- D. Prescribe facility requirements for PrEP and PEP provision, including but not limited to licensing, resource allocation, capacity building, demand generation, community mobilization, and integration with STI and other health programs; and
- E. Define monitoring and evaluation mechanisms covering key indicators, system requirements, and adherence tracking.

## III. SCOPE OF APPLICATION

This Order shall apply to the DOH Central Office bureaus, services, and units, Centers for Health Development (CHDs), and other DOH facilities. Local government units (LGUs), the Ministry of Health – Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM), national government agencies (NGAs), civil society organizations (CSOs), non-governmental organizations (NGOs), development partners, academic institutions, and other supporting institutions are likewise encouraged to align their HIV prevention-related programs, service delivery models, and policies with this Order and support its effective implementation.

This Order covers all modes of PrEP and PEP service delivery across clinical, community-based, outreach, and virtual platforms, and applies to all public and private HIV service providers, including healthcare providers, facility heads or managers overseeing HIV programs, and community-led organizations (CLOs) directly involved in the delivery of HIV prevention services.

## IV. DEFINITION OF TERMS

A. **Acute retroviral syndrome (ARS)** refers to a condition that may develop as early as 2 to 4 weeks after exposure to HIV. The possibility of ARS is considered if there are flu-like signs and symptoms such as sore throat, swollen lymph glands, and body aches, and the person reports condomless sex in the past 14 days.

B. **Combination HIV Prevention approach** refers to a mix of biomedical, behavioral, and structural interventions to reduce the number of new HIV infections, i.e., the strategic use of PEP, PrEP, condoms and lubricants, substance-related harm

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reduction, safe needle and syringe practices, and/or treatment of HIV-positive partners.

- C. **Community-led organization (CLO)** refers to an entity where the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to them.
- D. **Daily Oral PrEP** involves taking a single antiretroviral pill at approximately the same time every day to prevent HIV infection, and is appropriate for all people at risk.
- E. **Differentiated service delivery (DSD)** refers to a responsive, people-centered approach that simplifies and adapts HIV services to better serve the needs of people living with HIV while optimizing the available resources in the health system.
- F. **Estimated Glomerular Filtration Rate (eGFR)** refers to an estimate of kidney function or how well the kidneys are filtering waste.
- G. **Event-Driven Oral PrEP (ED-PrEP)** refers to an alternative to Daily Oral PrEP for those who have frequent sexual contact and can plan ahead of schedule. It involves taking a double dose of two pills 2-24 hours before exposure, then one pill 24 hours after the first dose, and a final pill 48 hours after the first dose.
- H. **Gender-diverse** refers to an evolving umbrella term to describe a gender identity not consistent with what is perceived as the societal gender norm.
- I. **HIV self-testing (HIVST)** refers to self-administration of an HIV test; in a setting where the individual performing the test feels most comfortable and, more importantly, private.
- J. **HIV vulnerable population** refers to groups that, due to various socio-economic factors, may be more susceptible to the negative impacts of HIV. They may not be members of HIV key populations, including the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, and those with other chronic health conditions, including severe mental illness.
- K. **Key population (KP)** refers to people at increased risk of acquiring the HIV infection due to behavior and facilitating situations that are associated with higher risk of HIV transmission, i.e., people in sex work, men who have sex with men, transgender women, people who inject drugs, and people in prisons and other enclosed settings.
- L. **Mucosal exposure** occurs when mucous membrane found in the rectum, vagina, mouth, or tip of the penis comes into contact with another individual's bodily fluid.

- M. **Occupational exposure** occurs when exposure to blood and/or body fluids that may contain HIV happens in the workplace, e.g., needle-stick injury from used hypodermic needles.
- N. **Parenteral exposure** occurs when exposure happens outside of the alimentary tract, such as in subcutaneous, intravenous, and intramuscular injections.
- O. **Sexual exposure** occurs when an individual engages in sexual activity that involves contact between mucous membranes and body fluids (e.g., semen, vaginal or rectal secretions) that may contain HIV.
- P. **Peer-led service delivery** refers to services provided by persons with the same lived experiences as that of the person being served.
- Q. **Post-exposure prophylaxis (PEP)** refers to a 28-day, 3-drug antiretroviral regimen taken within 72 hours of a possible HIV exposure to prevent infection.
- R. **Pre-exposure prophylaxis (PrEP)** refers to the use of antiretroviral drugs by people to prevent infection of HIV before exposure.
- S. **People-centered care** refers to an approach that is informed by the health needs and expectations of persons and communities rather than on diseases.
- T. **Proxy consent** refers to the process by which people with the legal right to consent to medical treatment (ex. HIV prevention, diagnosis, treatment, and care) for themselves or for a minor or a ward delegate that right to another person.
- U. **Recent HIV exposure** refers to HIV exposure (sexual, mucosal, parenteral, occupational) occurring within the 72 hours.
- V. **Renal impairment** refers to an estimated glomerular filtration rate [eGFR] of <60 mL/min per 1.73 m<sup>2</sup>; a contraindication for Tenofovir Disoproxil Fumarate (TDF)-based oral PrEP.
- W. **Seroconversion** refers to the transition from the point of infection to the development of antibodies in the blood serum.
- X. **Substantial risk** refers to the characteristics and behaviors of persons that could lead to HIV exposure.
- Y. **Task sharing** refers to the systematic and rational redistribution of certain tasks among the health workforce team, including nurses, pharmacists, community health workers and lay providers who may have shorter training and fewer qualifications, in order to maximize the efficient use of resources.

- Z. **Telehealth/telemedicine** refers to the provision of remote healthcare services and information through electronic and telecommunication technologies between a patient and the healthcare provider.

## V. GENERAL GUIDELINES

- A. Prescription and dispensing of PrEP and PEP must be in accordance with the requirements and standards set forth by Food and Drug Administration (FDA) and the Professional Regulation Commission (PRC).
- B. All HIV healthcare providers shall institutionalize and promote PrEP and PEP as an integral, beneficial, and empowering choice for combination HIV prevention. It shall be delivered as a fundamental part of the HIV combination prevention approach (condom, lubricant, and PrEP) as an additional option to other effective, well-established prevention interventions.
- C. PrEP and PEP shall be offered through Differentiated Service Delivery (DSD), readily available at public and private clinics, community-based centers, individual pick-ups, and virtual spaces to ensure person- and community-centered care.
- D. PrEP and PEP shall be offered and delivered free from discrimination, stigma, and bias.
- E. Effective pharmacovigilance mechanisms shall be established to monitor adverse events and ensure safety of PrEP and PEP use.
- F. PrEP and PEP shall be integrated with other health services such as reproductive health, maternal-child care, adolescent care, trans health, harm reduction, TB control program, and health services for PDLs and those in other enclosed settings.
- G. The implementation of PrEP and PEP shall continue in emergency health situations and resource-limited settings as stated in Department Circular 2021-0507 or the *Implementation and Dissemination of the Human Immunodeficiency Virus (HIV) Adaptive Plan*. This shall ensure that PrEP and PEP implementation will be continuous and will not have any interruptions in cases of emergency and resource-limited situations.
- H. Task-sharing and peer-led service delivery shall be supported through DOH-accredited training programs, with CHDs and partner organizations leading community-level rollout.
- I. Monitoring and evaluation of PrEP and PEP implementation shall be done regularly.

## VI. SPECIFIC GUIDELINES

### A. Pre-Exposure Prophylaxis (PrEP)

#### 1. PrEP Eligibility

- a. PrEP shall be recommended for persons with a substantial risk of acquiring HIV. PrEP shall be offered to the following:
- i. Sexual partner of a person living with HIV who is not virally suppressed despite on HIV treatment;
  - ii. Persons with recent or probable future inconsistent use of condoms for vaginal or anal sex;
  - iii. Persons with recent sexually transmitted infection (STI);

- iv. Persons with recent PEP use for sexual exposure to HIV, especially for persons who have used PEP more than once;
  - v. People who inject drugs (PWID) and people who use drugs (PWUD);
  - vi. Persons who request PrEP shall be given priority as it may indicate the likelihood of HIV exposure; and
  - vii. Persons who screen non-reactive and test negative for HIV shall be routinely offered PrEP.
- b. PrEP is NOT appropriate and shall not be given to:
- i. People living with HIV;
  - ii. People with a known or suspected HIV exposure within the past 72 hours (e.g., due to sexual assault, occupational exposure, or other one-time incidents);
  - iii. People with suspected Acute HIV infection manifesting with signs of ARS and with a potential HIV exposure in the previous 14 days;
  - iv. People with a contraindication, allergy or hypersensitivity to components of the PrEP product;
  - v. People with renal impairment (eGFR < 60 ml/min per 1.73 m<sup>2</sup>); and
  - vi. People unwilling or unable to commit to effectively using PrEP.

## 2. PrEP Service Delivery

- a. PrEP service providers shall offer screening, initiation, counseling, dispensing, and monitoring services either in-person or through telemedicine. For clients with complex medical needs or requiring proxy consent, access to trained health professionals or clinicians for medical consultation and prescription shall be ensured, whether in-person or via telehealth.
- b. HIV testing and tests for monitoring shall be implemented without allowing pending test results to cause a delay in PrEP initiation.
- c. In re-initiation counseling and laboratory screening:
  - i. Pre-initiation counseling shall be people-centered, facilitated in-person, or provided virtually through telemedicine by service providers.
  - ii. HIV screening shall be done within seven days before PrEP initiation. This can be done in a facility, through community-based screening, or self-testing. If no documentation is available, the provider may repeat the test.
  - iii. Viral Hepatitis (Hepatitis B and C) and Syphilis rapid testing and STI screening shall be done based on the recommended screening period.
  - iv. Other considerations for laboratory screening tests are outlined in Annex A. (All annexes cited in this AO [Annexes A–M] may also be accessed at: <https://tinyurl.com/AnnexesPrEPandPEPAO>).
  - v. Regarding the need for a kidney function test:
    - 1. The kidney function can be estimated using serum creatinine and computing for the eGFR. The Chronic Kidney Disease Epidemiology Collaboration equation (CKD EPI 2021) or an online calculator may be utilized as highlighted in Annex B.

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2. Serum creatinine testing is not required before starting PrEP and should not delay its initiation. It can be completed within the first three months after starting PrEP.
3. Other considerations for serum creatinine testing are highlighted in Annex B.

d. PrEP initiation:

- i. Oral tenofovir-based (TDF) PrEP is available locally in two forms and may be used interchangeably:
  1. **Tenofovir 300 mg + emtricitabine 200 mg**
  2. **Tenofovir 300 mg + lamivudine 300 mg**
- ii. Other forms of PrEP, if available locally, can also be used including but not limited to:
  1. Dapivirine Vaginal Ring (DVR) for high-risk women
  2. Injectable long-acting PrEP (Lenacapavir, Cabotegravir)
- iii. PrEP dosing regimens are expounded in detail in Annex C.
- iv. For sexual exposure of women and gender-diverse people assigned female at birth, and gender-diverse people assigned male at birth taking exogenous estradiol-based hormones; and people using oral PrEP to prevent HIV acquisition from injecting practices (Annex C, Figure 1):
  1. Start PrEP with one dose of TDF-based oral PrEP on day one;
  2. Continue PrEP at one dose for each day during the period of exposure or risk. Additional HIV prevention methods, such as condoms and lubricants, should be used, especially during the first seven days while PrEP achieves protective concentrations.
- v. If PrEP is to be discontinued, stop seven days after the last day of sexual activity.
- vi. For sexual exposure of people assigned male at birth and not taking estradiol-based hormones (Annex C, Figure 2):
  1. Start PrEP with two doses of TDF-based oral PrEP taken 2-24 hours before sexual exposure (ideally closer to 24 hours before potential exposure).
  2. Continue PrEP at one dose for each day during the period of exposure or risk.
  3. If PrEP is to be discontinued, stop two days after the day of last sexual activity.
- vii. Guidelines for starting, using, and stopping oral PrEP are enumerated in Annex D.

e. PrEP dispensing:

- i. All clients shall be provided one bottle of PrEP within the same day of initial counseling, regardless of dosing modality.
- ii. On the second encounter, the client will be given two bottles of PrEP.
- iii. On the third encounter and subsequently, the client will be given three bottles of PrEP.



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- f. In PrEP re-initiation:
  - i. Clients who have stopped PrEP in the past and wish to start PrEP again shall follow similar procedures with initiation.
  - ii. During counseling, the health worker shall:
    - 1. Explore reasons why PrEP was stopped;
    - 2. Emphasize adherence and effective oral PrEP use; and,
    - 3. Provide ease of access through DSD.
  - iii. Clients enrolled on PrEP shall be retested on the following:
    - 1. Follow-up HIV
    - 2. Kidney function test
    - 3. Hepatitis B and C
  - iv. Specific considerations are further explained in Annex E.
- g. Counseling and follow-up:
  - i. PrEP providers should customize counseling sessions to address individual sexual health concerns and goals. Facilitate informed and shared decision-making of prevention options.
  - ii. The person's choice of PrEP and its availability may change over time. Information about all available options should be part of an ongoing conversation.
  - iii. Key counseling messages are detailed on Annex F.
- h. Referrals:
  - i. PrEP providers shall create a coordinated network of public, private, community-based, and telehealth PrEP providers to ensure sustained service delivery.
  - ii. Clients with complex needs shall be referred to specialized care to ensure holistic and comprehensive support. This includes individuals such as young people, victims of intimate partner violence, or others facing psychosocial challenges who may benefit from enhanced counseling, mental health services, and social support.

## **B. Post-Exposure Prophylaxis (PEP)**

### **1. PEP Eligibility**

Individuals with a known or suspected exposure to HIV within the past 72 hours can benefit from PEP and shall be offered PEP accordingly. The criteria for use of PEP and PEP initiation are outlined in Annex G.

### **2. PEP Service Delivery**

- a. PEP service providers shall deliver screening, risk assessment, initiation, counseling, dispensing, and follow-up services through in-person consultations or via telemedicine, if feasible. PEP shall be readily available in HIV treatment hubs, social hygiene clinics, and other DOH-accredited facilities designated for HIV prevention services.
- b. Timely access to PEP is the most crucial factor in PEP effectiveness. Broader access to PEP, including community-based delivery and task-sharing, shall be promoted to mitigate barriers such as stigma and to ensure timely access to post-exposure prophylaxis.

- c. Where exposure is suspected, provision of PEP should not be delayed by trying to identify or find out the HIV status or viral load of the source of exposure.
- d. Risk assessment:
  - i. Assess whether exposure that occurred renders a person eligible for PEP and assess when exposure occurred.
  - ii. The complete protocol for risk assessment for PEP is outlined in Annex H.
- e. PEP regimens:
  - i. PEP Regimen for adults
    - 1. **TDF + lamivudine (3TC) or emtricitabine (FTC)** is the recommended 2-drug backbone.
    - 2. **Dolutegravir (DTG)** is the recommended third drug for adults. The fixed-dose combination of TDF+3TC+DTG may be preferable to reduce the pill burden.
    - 3. When available, **atazanavir/ritonavir (ATV/r), darunavir/ritonavir (DRV/r), lopinavir/ritonavir (LPV/r), and raltegravir (RAL)** may be considered as alternative third-drug options for PEP.
  - ii. PEP Regimen for children who weigh <30 kg:
    - 1. **Abacavir (ABC) + 3TC** is the recommended 2-drug backbone. **Zidovudine (ZDV) + 3TC or TDF + 3TC (or FTC)** are alternatives.
    - 2. **Dolutegravir (DTG)** is recommended as the preferred third drug, dosed accordingly
    - 3. When available, **atazanavir/ritonavir (ATV/r), darunavir/ritonavir (DRV/r), lopinavir/ritonavir (LPV/r) and raltegravir (RAL)** may be considered as alternative third-drug options for PEP.
  - iii. PEP should be taken within 72 hours and be continued daily for 28 days.
  - iv. Important considerations for PEP use are provided in Annex I.
- f. PEP monitoring and follow-up:
  - i. HIV retesting should be done at four (4) and 12 weeks.
  - ii. The client may be provided with two (2) HIV self-test kits for convenience.
  - iii. The client may have the test done at the facility should they prefer it.
  - iv. Some people with continuing risk of exposure may benefit from and be interested in transitioning to PrEP after completing the PEP course.
  - v. People with active hepatitis B virus (HBV) infection should be monitored for a flare of hepatitis (which is rare) after discontinuation of PEP if these drugs are not continued for the treatment of HBV. This may require a referral to a hepatologist.

**C. Transitioning from PEP to PrEP and from PrEP to PEP**

- a. Immediate transition to PrEP is preferable for persons with ongoing exposure to HIV.
- b. People *who* complete the 28-day PEP regimen and wish to use PrEP can start PrEP without a gap if they have a negative HIV test result upon completion of PEP and do not have any contraindications to the chosen PrEP product.
- c. Full *transition* protocol from PrEP to PEP is elaborated in Annex J.

**D. Differentiated Service Delivery for PrEP and PEP**

- a. Sites of delivery shall be diversified to include health facilities, fixed and mobile community settings, pharmacies, and homes via telemedicine and other virtual models. This approach expands individual choice and enhances convenience by allowing people to select their preferred location and type of service
- b. Community settings can include a wide range of options, including but not limited to pharmacies, CLOs, drop-in centers, mobile clinics and online delivery.
- c. Community delivery shall complement delivery in other settings with strong linkages and referral pathways. For community delivery sites, adequate community sensitization and involvement shall be ensured in service design, planning, mobilization, recruitment, service delivery and evaluation.
- d. Full implementation details for implementing PrEP and PEP is outlined in Annex K.

**E. Funding for PrEP and PEP**

- a. The National HIV, AIDS, and STI Prevention and Control Program of the DPCB and CHDs shall allocate a budget to support the implementation of these policies and guidelines, including but not limited to capacity building, monitoring, and evaluation of PrEP and PEP drug supply.
- b. PrEP and PEP drugs shall be preferably sourced from DOH funds and can also be sourced from development partners and other financing means.
- c. The LGUs may procure FDA-registered PrEP and PEP drugs based on their respective annual operational plans as an augmentation to centrally-procured PrEP and PEP drugs.

**F. Monitoring and Evaluation for PrEP and PEP**

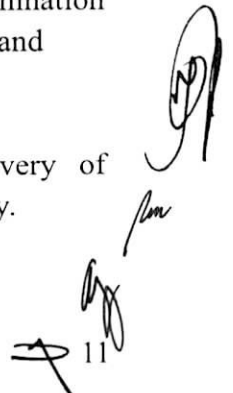
- a. Health facilities, including HIV treatment hubs, Social Hygiene Clinics, and other DOH-accredited facilities designated for HIV prevention services, involved in PrEP and PEP service delivery shall ensure timely and consistent encoding in the One HIV, AIDS, and STI Information System (OHASIS). Standardized indicators across all partners and reporting units shall be utilized. Core programmatic indicators shall include, but are not limited to commodity distribution, uptake, new and current users, continuation of PrEP, recent use among newly HIV-diagnosed, and prevalence of drug-associated toxicity (see Annex L).

- b. Health facilities involved in PrEP and PEP service delivery shall include community-led monitoring inputs and contributions, where members of the key population and civil society organizations identify issues or challenges of the HIV program that are not part of routine reporting (e.g. policies, finance, service quality, stigma and discrimination).
- c. Health facilities involved in PrEP and PEP service delivery shall comply with FDA regulations on reporting adverse side effects using existing pharmacovigilance mechanisms.

## VII. VIII. <sup>ny</sup>

### ROLES AND RESPONSIBILITIES

- A. The **Disease Prevention and Control Bureau (DPCB)** shall:
  1. Develop, update, and disseminate national guidelines and operational policies for PrEP and PEP implementation;
  2. Ensure adequate PrEP and PEP procurement and distribution;
  3. Coordinate with regional and local health offices to ensure consistent implementation of PrEP and PEP services;
  4. Provide support for capacity-building initiatives and training programs, such as but not limited to training module development and training of trainers, for healthcare providers involved in PrEP and PEP service delivery;
  5. Coordinate with partners to advocate support for PrEP and PEP implementation;
  6. Coordinate with the Philippine Health Insurance Corporation (PHIC) to develop benefit packages for PrEP and PEP implementation; and
  7. Lead the development of Monitoring and Evaluation frameworks on the implementation of DSD models for PrEP and PEP to ensure greater access and uptake.
- B. The **Epidemiology Bureau (EB)** shall:
  1. Lead in the collection, analysis, and reporting of epidemiological data related to PrEP and PEP implementation;
  2. Support the development of monitoring and evaluation frameworks for PrEP and PEP programs; and
  3. Collaborate with other government and non-government agencies to ensure data-driven decision-making in PrEP and PEP service delivery.
- C. The **Health Promotion Bureau (HPB)** shall:
  1. Develop demand generation strategies such as health fairs and exhibitions and peer education programs to raise awareness and knowledge on HIV;
  2. Develop relevant, engaging, and context-specific information dissemination materials on HIV, PEP, PrEP, and the combination prevention package; and
- D. The **Supply Chain Management Service (SCMS)** shall:
  1. Ensure timely and efficient supply chain management and delivery of commodities to HIV facilities involved in PrEP and PEP service delivery.



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- E. The **Centers for Health Development - Infectious Disease Unit (CHD-IDU)** shall:
1. Help disseminate and implement DSD models for PrEP and PEP at the local level, including task-sharing and community-based service delivery;
  2. Support the DPCB in distribution and supply chain management to ensure prompt distribution of commodities in collaboration with their regional SCMS counterpart;
  3. Conduct quality improvement of PrEP and PEP services and monitoring of PrEP and PEP implementation; and
  4. Ensure timely submission of reports.
  5. Utilize reports for analysis and programmatic improvement.
- F. The **Local Government Units (LGUs)** are enjoined to:
1. Implement DSD models for PrEP and PEP at the local level, including task-sharing and community-based service delivery;
  2. Mobilize resources and support implementation for PrEP and PEP and augmentation of commodities within their jurisdictions;
  3. Coordinate with local agencies and partners to ensure alignment with national guidelines and policies;
  4. Conduct quality improvement of PrEP and PEP services and monitoring of PrEP and PEP implementation;
  5. Provide psychosocial support and protection for clients in need; and
  6. Ensure timely submission of reports.
  7. Utilize reports for analysis and programmatic improvement.
- G. The **Philippine National AIDS Council (PNAC)** shall:
1. Collaborate with the DPCB and DOH to integrate PrEP and PEP services into existing local government health programs;
  2. Create support groups and co-learning spaces for PrEP and PEP service providers across facilities to facilitate the exchange of knowledge and best practices; and
  3. Ensure cross-sectoral collaboration to address social determinants of health that impact PrEP and PEP access and uptake.
- H. The **public and private sector HIV care facilities** are enjoined to:
1. Implement DSD models for PrEP and PEP delivery in health facilities and community settings based on these guidelines;
  2. Provide clinical and non-clinical support services for PrEP and PEP users, including counseling, adherence support, and linkage to care; and
  3. Engage in community outreach and education to raise awareness about PrEP and PEP and promote uptake among key populations.

- I. The **community-led organizations (CLOs)** are encouraged to:
  1. Mobilize communities to raise awareness on HIV, the combination prevention package, and encourage testing and treatment;
  2. Work with health facilities and undergo training as PrEP and PEP providers;
  3. Help provide HIV education through personal and virtual networks;
  4. Offer adherence counseling and support services to persons accessing PrEP and PEP; and
  5. Establish linkages to care for treatment and support.
  
- J. The **development partners** are encouraged to:
  1. Provide technical and financial support for the scale-up of PrEP and PEP programs and DSD models;
  2. Collaborate with government agencies and local partners to strengthen health systems and improve access to PrEP and PEP services; and
  3. Assist in monitoring and evaluation efforts to assess the impact of DSD in PrEP and PEP implementation and identify areas for improvement.

~~VIII.~~  
~~XH.~~ **REPEALING CLAUSE**


All other issuances inconsistent for this particular circumstance wherein the same is applicable, are hereby amended, modified, or repealed accordingly.

~~IX.~~  
~~XII.~~ **SEPARABILITY CLAUSE**

If any of the provisions of this Order shall be declared unconstitutional by a competent court of jurisdiction, the other provisions not affected shall remain valid, in force, and in effect.

~~X.~~  
~~XIV.~~ **EFFECTIVITY**

This Order shall take effect fifteen (15) days following the publication in the Official Gazette or in a newspaper of general circulation and filing with the Office of the National Administrative Register of the UP Law Center.

  
**TEODORO J. HERBOSA, MD**  
Secretary of Health

**Annex A. Recommended Laboratory Tests for PrEP AND PEP Service Delivery**

Test	When to test	Result - Action	Monitoring
HIV screening or testing	Within seven days before PrEP initiation and before PEP initiation	<ul style="list-style-type: none"> <li>● Reactive: link to care for ART</li> <li>● Nonreactive and with exposure in last 72 hours: link to care for PEP</li> <li>● Nonreactive and with signs of ARS: link to care</li> <li>● Nonreactive without any of the above: initiate PrEP                             <ul style="list-style-type: none"> <li>➤ If coming from PEP, transition to PrEP without any gap</li> </ul> </li> </ul>	One month after PrEP initiation, then every three months thereafter
HBV Surface Antigen (HBsAg) Test	At PrEP initiation or within one to three months of starting PrEP	<ul style="list-style-type: none"> <li>● HBsAg positive: TDF-based PrEP can be safely prescribed</li> <li>● HBsAg negative: evaluate for HBV vaccination</li> </ul>	For HBsAg negative - do anti-HBs test one month after last vaccine dose to confirm response
HCV Antibody (anti-HCV) Test	At PrEP initiation or within one to three months of starting PrEP	For anti-HCV positive and negative: TDF-based PrEP can be safely prescribed	HCV testing every 12 months

  
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Test	When to test	Result - Action	Monitoring
<b>Kidney Function Test (serum creatinine)</b>			
a. <30 years old with no kidney-related comorbidities	a. Optional	<ul style="list-style-type: none"> <li>eGFR &lt;90 mL/min per 1.73 m<sup>2</sup> - may start TDF-based PrEP but with follow-up measurements every 6–12 months</li> <li>eGFR &lt;60 mL/min per 1.73 m<sup>2</sup> - TDF-based oral PrEP contraindicated</li> </ul>	For <50 years old with no kidney-related comorbidities: <ul style="list-style-type: none"> <li>Normal initiation test or if they did not require initiation testing - optional</li> <li>eGFR &lt;90 mL/min per 1.73 m<sup>2</sup> - every 6–12 months</li> </ul>
b. 30-49 years old with no kidney-related comorbidities	b. Optional given the low risk of impairment in this age group, but may be conducted once at or within 1-3 months of initiation		
c. 50 years or older, those of any age with kidney-related comorbidities, and those with a previous GFR <90 mL/min per 1.73 m <sup>2</sup>	c. Once at or within 1-3 months of initiation		For 50 and above years regardless of comorbidities, individuals of any age with kidney-related comorbidities, and those with a previous eGFR <90 mL/min per 1.73 m <sup>2</sup> - every 6–12 months
<b>STI Screening Test</b>			
a. Syphilis b. Gonorrhea c. Chlamydia	<ul style="list-style-type: none"> <li>At initiation</li> <li>If testing is not available, screen for STI symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Reactive for any STI: treat STI based on WHO guidance</li> <li>Continue TDF-based oral PrEP.</li> </ul>	Testing every 3 to 6 months thereafter, when available.

  
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## Guide Notes:

### A. PrEP pre-initiation counseling

1. PrEP benefits as an additional method of the HIV combination prevention strategy;
2. PrEP limitation in that it prevents only HIV and not other STIs or unwanted pregnancies;
3. What type of PrEP is most suitable for the person;
4. PrEP adherence and efficacy;
5. Side effects and how to address them;
6. Use of other components of the HIV combination prevention package should PrEP be discontinued and the person remains at substantial risk of HIV.

### B. HIV Testing

1. Persons who are reactive to HIV screening should be immediately linked to care for antiretroviral therapy (ART) including persons presenting with signs of ARS.
2. If there is a history of recent HIV exposure in the past 72 hours, the person should be given PEP. After 28 days of PEP and the person remains HIV-negative, the person should transition to PrEP smoothly, without a gap.

### C. Hepatitis Screening

1. Persons at substantial risk for HIV may also be at risk for Hepatitis B and/or C.
2. Screening can be done at PrEP initiation, or within one to three months of initiation. PrEP can be initiated before results are available. It is not a requirement for PrEP use.
3. Screening for Hepatitis can be done using a rapid test or a lab-based test.
4. Hepatitis B screening is done by testing for HBsAg.
5. For HBsAg positive - TDF-based PrEP can be safely prescribed. Persons should be linked to care for monitoring of Hepatitis B.
6. For HBsAg negative - evaluate for HBV vaccination.
7. Hepatitis C screening is done by testing for Anti-HCV.
8. For anti-HCV positive - TDF-based PrEP can be safely prescribed. Persons should be linked to care for treatment.

### D. STI Screening

1. People who could benefit from PrEP are at increased risk for other STIs. High prevalence of STIs such as gonorrhea, chlamydia, and syphilis have been observed among PrEP users.
2. Testing for STIs, with or without symptoms, is suggested at initiation and every three to six months thereafter.
3. The use of dual HIV/syphilis rapid diagnostic tests is recommended, when available.
4. If testing is not available, screen for STI symptoms and refer accordingly.

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**Annex B: CKD EPI 2021 Formula to compute for Estimated Glomerular Filtration Rate (eGFR)**

For people assigned female at birth with serum creatinine $\leq 0.7$ mg/dL	$eGFR = 142 \times \left(\frac{Scr}{0.7}\right)^{-0.241} \times 0.9938^{age} \times 1$
For people assigned female at birth with serum creatinine $> 0.7$ mg/dL	$eGFR = 142 \times \left(\frac{Scr}{0.7}\right)^{-1.2} \times 0.9938^{age} \times 1.0$
For people assigned male at birth with serum creatinine $\leq 0.7$ mg/dL	$eGFR = 142 \times \left(\frac{Scr}{0.9}\right)^{-0.302} \times 0.9938^{age}$
For people assigned male at birth with serum creatinine $> 0.7$ mg/dL	$eGFR = 142 \times \left(\frac{Scr}{0.9}\right)^{-1.2} \times 0.9938^{age}$

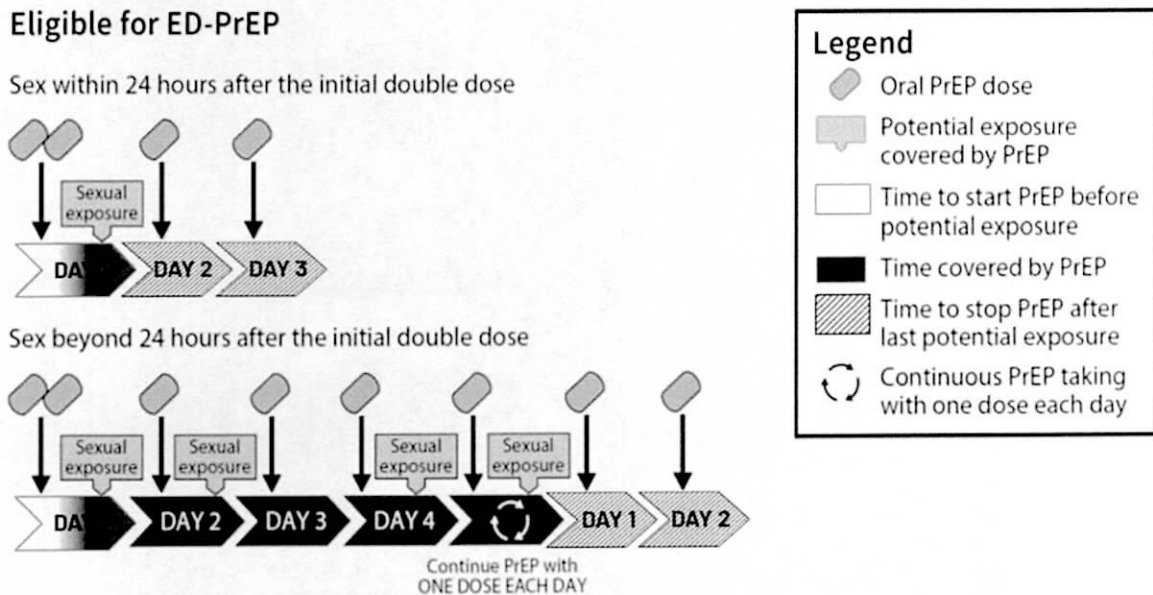
**Guide Notes:**

- a. An online calculator may also be utilized:  
[https://www.kidney.org/professionals/kdoqi/gfr\\_calculator](https://www.kidney.org/professionals/kdoqi/gfr_calculator).
- b. For individuals  $< 30$  years old with no kidney-related comorbidities, serum creatinine is optional.
- c. For individuals 30-49 years old with no kidney-related comorbidities, serum creatinine is optional given the low risk of impairment in this age group, but may be conducted once at or within 1-3 months of initiation if with risk factors.
- d. For 50 years or older, those of any age with kidney-related comorbidities, and those with a previous GFR  $< 90$  mL/min per  $1.73 \text{ m}^2$ , conduct once at or within 1-3 months of initiation

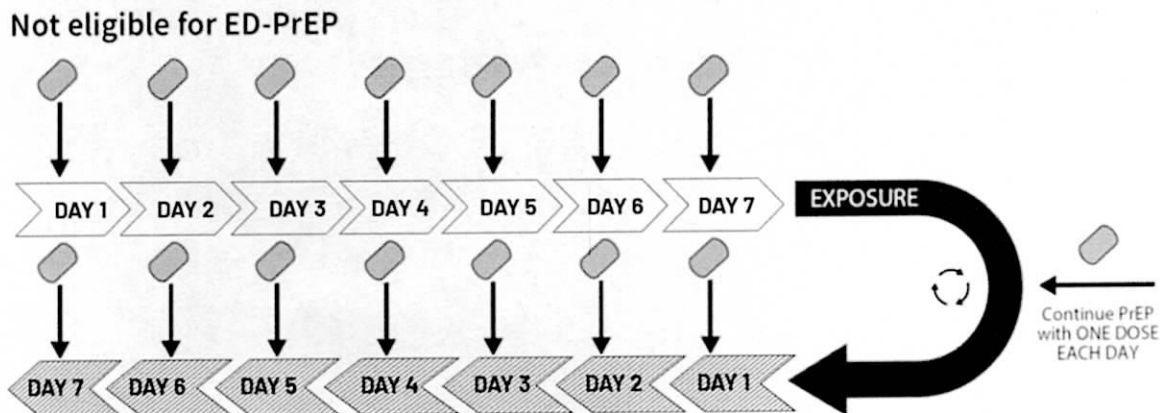
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## Annex C: Dosing for Pre-Exposure Prophylaxis (PrEP)

**Figure 1.** Dosing for those who are eligible who can benefit from ED-PrEP (*Adapted from WHO PrEP 2022 Guidelines*)



**Figure 2.** How to start and stop oral PrEP for those who are not eligible for ED-PrEP who will benefit from daily PrEP.



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**Annex D. Guidelines for Starting, Using, and Stopping Oral Pre-Exposure Prophylaxis (PrEP)**

Population (s)	Often includes[1]	Starting Oral PrEP	Using Oral PrEP	Stopping PrEP
People assigned male at birth who are not using estradiol-based exogenous hormones and are using oral PrEP to prevent HIV acquisition during sex	<ul style="list-style-type: none"> <li>● cisgender men</li> <li>● transgender women who are not using estradiol-based exogenous hormones</li> <li>● nonbinary people assigned male at birth who are not using estradiol-based exogenous hormones</li> </ul>	<u>Daily &amp; ED:</u> Take a double dose two to 24 hours before potential sexual exposure. Ideally, this loading dose should be taken closer to 24 hours before potential exposure.	Take one dose per day.	<u>Daily and ED:</u> PrEP can be stopped after taking a single dose daily for two days after the last potential exposure.
People assigned female at birth who are using oral PrEP to prevent HIV acquisition during sex	<ul style="list-style-type: none"> <li>● cisgender women</li> <li>● transgender men</li> <li>● nonbinary people assigned female at birth</li> </ul>	<u>Daily:</u> Take a single dose daily for seven days before potential exposure. Especially for the first seven days while PrEP achieves	Take one dose per day.	<u>Daily:</u> PrEP can be stopped after taking a single dose daily for seven days after the last potential exposure.
People assigned male at birth who are using estradiol-based exogenous hormones who are using oral PrEP to prevent HIV acquisition during sex	<ul style="list-style-type: none"> <li>● transgender women who are using estradiol-based exogenous hormones</li> <li>● nonbinary people assigned male at birth who are using estradiol-based exogenous hormones</li> </ul>	protective concentrations, additional HIV prevention methods such as condoms & lubes should be used.		
People using oral PrEP to prevent HIV acquisition from nonsexual exposures	<ul style="list-style-type: none"> <li>● anyone who shares injection-related materials[2]</li> </ul>			

[1] This list is provided to support interpretation of this guidance and is not inclusive of all gender identities or terms that may be used by people with diverse gender identities to describe themselves and/or their communities. Starting and stopping oral PrEP should be based on the factors in the first column.

[2] Injection drug use is mentioned in this guidance; however, first-line prevention strategies for people who inject drugs are needle exchange and/or drug use harm reduction and treatment. Daily oral PrEP has some preventative effects for this population and should be offered as part of a larger prevention package.



## Annex E: Clinical Monitoring of Clients Enrolled in Pre-Exposure Prophylaxis (PrEP)

### A. HIV testing

1. Should be done after one month of initiation and then every three months thereafter;
2. Can be done using different modalities: assisted or unassisted HIV self-testing, community-based screening, or facility-based HIV testing.
3. Clients with a reactive or indeterminate HIV test result should be immediately linked to care. Continue PrEP while waiting for medical care, but consultation should not be delayed.

### B. Kidney Function Test

1. For <50 years old with no kidney-related comorbidities nor risk factors:
  - a. Follow-up creatinine is optional if the initiation test is normal, or if they did not require initiation testing;
  - b. If the initiation test result suggests at least mild loss of kidney function (eGFR <90 mL/min per 1.73 m<sup>2</sup>), follow-up measurements every 6–12 months is preferred.
  - c. For 50 and above years regardless of comorbidities, persons of any age with kidney-related comorbidities, and those with a previous GFR that suggests at least mild loss of kidney function (<90 mL/min per 1.73 m<sup>2</sup>):
  - d. Follow-up measurements every 6-12 months are advised
  - e. If renal impairment (eGFR <60 mL/min per 1.73 m<sup>2</sup>) is noted during follow-up:
    - i. Conduct testing again on a different day;
    - ii. If renal impairment is confirmed, PrEP should be discontinued;
    - iii. Refer to the primary care physician for proper management;
    - iv. Counsel on alternative forms of HIV prevention while not on PrEP.

### C. Hepatitis B and C

1. For HBsAg positive - must be evaluated for long-term HBV therapy. Should a person be a candidate for HBV treatment, daily PrEP can be beneficial for both HIV protection and HBV treatment. Should the person decide to discontinue PrEP, shifting TDF-based oral PrEP to tenofovir alone for the HBV treatment can be done.
2. For HBsAg negative - evaluate for HBV vaccination. Confirm immune response to vaccination 1 month after last vaccine dose. Hepatitis C
3. For anti-HCV positive - should be referred for HCV treatment.
4. For anti-HCV negative and self-identify as a key population with substantial risk for HCV infection (i.e., people who inject drugs), continue HCV testing every 12 months.



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**Annex F: Key Counselling Messages for Pre-Exposure Prophylaxis (PrEP)**

- A. All PrEP choices are effective HIV prevention options.
- B. Effective use is important to prevent HIV acquisition (this means using PrEP according to the dosing schedule during periods of HIV risk).
- C. PrEP does not offer prevention against other STIs or pregnancy.
- D. PrEP products are generally safe and well tolerated. Side-effects are typically mild and resolve on their own and can be treated symptomatically. Severe side-effects should be reported to the PrEP provider without delay.
- E. Regular follow-up is important to support effective PrEP use and to provide other services including HIV testing. The follow-up visit schedule will depend on the PrEP product chosen.
- F. Provide tools and resources to support adherence, such as pill organizers or reminder apps. Document adherence and address any barriers or challenges that may impact it.
- G. Discuss strategies for safer sex practices and partner communication, and navigating challenges in PrEP use (ex. changes in relationship status, alcohol and drug use, leaving school, leaving home, trauma, migration, etc.). Facilitate client education in empowerment and communication skills.
- H. Consider DSD options for PrEP that might support the person to stay engaged with the service, mindful of individual needs, adherence, and risk factors. Options for telemedicine, PrEP delivery, and other innovative methods to conduct follow up should be offered to clients.

  
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## **Annex G: Post Exposure Prophylaxis (PEP) Eligibility Criteria and Initiation**

### **A. Use PEP for:**

1. Parenteral exposure through occupational exposure, other needle-stick injuries, or use of contaminated needle or syringes during illicit or licit injecting drug use;
2. Mucosal exposure through sex, including that involving sexual assault and rape where the source has an unknown status or if viral load is detectable;
3. Mucosal exposure from body fluids with risk of HIV infection (blood, blood-stained saliva, breast milk, genital secretions, and cerebrospinal, amniotic, rectal, peritoneal, synovial, pericardial or pleural fluids);
4. Direct contact of blood or body fluid with risk of HIV infection on skin with compromised integrity such as dermatitis, chapped skin, abrasion, or open wound.

### **B. PEP is not suitable for:**

1. Exposure beyond 72 hours;
2. Exposed persons who are already HIV positive;
3. When the source is established to be HIV-negative;
4. Exposure to bodily fluids that does not pose a significant risk: tears, non-blood-stained saliva, urine and sweat;
5. Sexual exposure from a source known to be HIV-positive on ART with good adherence within the last 6 months, with an undetectable viral load in the same period.

### **C. PEP Initiation**

1. Pre-initiation counseling should be people-centered, discussing the following concepts, in addition to specifications of PEP use:
2. Enhanced adherence counseling include baseline individual needs assessment, counseling and education and follow-up telephone calls;
3. Side effects and how to address them;
4. Age-specific considerations for offering adherence counseling to children and adolescents who have been sexually abused;
5. Use of other components of the HIV combination prevention package while on PEP;
6. Transitioning to PrEP seamlessly should the person remain at substantial risk of HIV.

  
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**Annex H: Risk Assessment for Post Exposure Prophylaxis (PEP) Provision**

- A. HIV Screening will be conducted before PEP initiation.
- B. Use of the rapid HIV test or HIV self-test is recommended.
- C. No other test is required before PEP initiation.
- D. PEP should not be delayed for medicolegal reporting or procedures.
- E. Clients with risk exposures within 72 hours will be provided with PEP.
- F. If a person's risk exposures are more than 72 hours, encourage screening and initiation to PrEP.
- G. If a person does not want to disclose details about exposure, this should not create a barrier to receiving PEP.
- H. If the test is reactive for HIV, the person should be started on ART or linked to the nearest HIV Treatment Facility.
- I. If HIV tests are unavailable but the person is suspected to have been exposed to HIV, PEP should be started regardless.
- J. If the HIV test is non-reactive, PEP should be continued.
- K. Should the HIV test later turn out to be reactive, the person should be linked to care while continuing PEP.

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## **Annex I. Important Considerations on Post Exposure Prophylaxis (PEP) Use**

### **A. Hepatitis B**

1. If the test is available, determine hepatitis B infection for a seamless transition to treatment after PEP.
2. Hepatitis B is not a contraindication to starting PEP that contains TDF, FTC or 3TC.
3. Assessment of hepatitis B infection is not a precondition for starting PEP.

### **B. Status of exposure source**

1. Do not wait for confirmation of the source's HIV status before starting PEP.
2. If the status of the source is confirmed negative, discontinue PEP.
3. If the exposure was sexual and the source has an undetectable viral load, discontinue PEP.

### **C. Provision of other service**

1. The provision of other interventions should not create barriers to PEP or be prerequisites for PEP.
2. Other possibly relevant interventions include pregnancy testing, emergency contraception, STI and viral hepatitis testing, condoms, harm reduction and PrEP.
3. If needed, refer people subjected to sexual violence (gender-based violence [GBV]) to additional support services.
4. Full blood count, liver and renal function tests are not needed for PEP provision.
5. Condoms and lubricants should be provided while on PEP, and continued after, as part of the combination prevention package.

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**Annex J: Guidelines in Transitioning from Pre-Exposure Prophylaxis (PrEP) TO Post-Exposure Prophylaxis (PEP)**

**A. Transitioning from PrEP to PEP**

1. If oral TDF-based PrEP is not used as directed or is stopped, there may be a risk of acquiring HIV if exposure occurs; The need for PEP, for people previously on PrEP depends on adherence the week before an HIV exposure, individual characteristics, and type of exposure
2. For persons assigned male at birth, not on estradiol-based hormones, with sexual exposure:
  - b. If 4-5 PrEP doses were taken in the 7 days prior to exposure, no need for PEP. Instead, continue daily PrEP.
  - c. If 0-3 PrEP doses were taken in the 7 days prior to exposure, consider PEP.

**B. For all other groups and any type of exposure to HIV:**

1. If 6-7 out of 7 PrEP doses were taken in the 7 days prior to exposure, no need for PEP, instead continue daily PrEP.
2. If 0-5 out of 5 PrEP doses were taken in the 7 days prior to exposure, consider PEP.



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## **Annex K: Implementation of Differentiated Service Delivery for Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)**

### **A. Service location**

1. Convenient in-person or telemedicine-based access for PrEP and PEP screening, initiation, prescription, counseling, monitoring and providing proxy consent shall be provided if available.
2. Task sharing among the different providers and with various health workforce teams, including pharmacists, nurses, doctors and trained lay and peer health workers shall be employed to dispense, distribute, provide and monitor PrEP and PEP. Clear protocols for expanded roles and referral lines for clients must be established.
3. Training, support and supervision for all providers is essential, including sensitization on stigma and discrimination and key populations.
4. Providers should offer first-line support, and offer post-rape care for survivors of sexual assault at the first point of contact in line with guidelines and refer to additional support services as needed.

### **B. Service Roles**

1. Trained physicians, nurses, and midwives
  - a. Screen for, initiate, and dispense PrEP and PEP;
  - b. Clinical care and monitoring, counseling, and support;
  - c. Provide proxy consent;
  - d. Supervision of other providers and trained community health workers, lay and peer providers;
  - e. Sensitization on stigma & discrimination of providers and healthcare workers.
2. Trained community health workers, lay and peer providers
  - a. Screen for, initiate, and dispense PrEP and PEP;
  - b. Identify need for clinical care and appropriate referrals;
  - c. Counseling and support;
  - d. Sensitization on stigma & discrimination;
  - e. Generate awareness, demand, and support for PrEP uptake and retention of clients who will benefit from PrEP;
  - f. Program coordination.

### **C. Service package**

1. HIV self test kits - HIVST can complement existing HIV testing strategies to support DSD approaches for PrEP and PEP. It may be preferred for convenience, privacy and self-managed care, while also reducing clinic visits. Assisted HIVST is recommended for PrEP and PEP initiation, and subsequent tests may be unassisted if preferred.
2. STI services - PrEP and PEP services open up opportunities to provide comprehensive sexual and reproductive health care. Integrating PrEP, PEP and STI services means providing information and key messages related to both, counseling, provision of commodities (ex. condoms, lubricants), vaccinations for

hepatitis A, hepatitis B, and HPV, STI testing & treatment, partner services, and referrals & linkages.

3. Other services to integrate with include antenatal, postnatal, family planning, gender-based violence, harm reduction, mental health, peer support, comprehensive sexual and reproductive, and gender-affirming services.

#### D. Access for Young People

Young people and young key populations may benefit from PrEP and PEP, and should be given age-appropriate counseling, access to necessary health care, sufficient support services, and provided proxy consent as needed, based on the following principles:

1. Evolving Capacities of the Child - recognizing the developmental changes and the corresponding progress in cognitive abilities and capacity for self-determination undergone by children as they grow up, thus requiring parents and others charged with the responsibility for the child to provide varying degrees of protection, and to allow their participation in opportunities for autonomous decision-making.
2. Mature Minor Doctrine - recognizing the capacity of some minors to consent independently to medical procedures, if they have been assessed by qualified health professionals to understand the nature of procedures and their consequences to make a decision on their own. Interventions for children in need of special protection must be conducted in a safe, confidential, and child-friendly environment.
3. The Best Interest of the Child Doctrine - children have a right to have their best interests taken into account as the primary consideration in all decisions affecting them. In all cases, the right of any child below that minimum age and able to demonstrate sufficient understanding to be entitled to give or refuse consent should be recognized.
4. Proxy Consent - Used for minors aged below 15 years old who are unable to provide informed consent to initiate PrEP or PEP themselves. Consent from the parent or guardian shall be secured. The person providing proxy consent should be fully informed about the implications of PrEP and PEP. Counseling should also be provided to both the minor and the consenting adult. Providers must secure the assent of the minor in addition to securing parental or guardian consent according to RA 11166, Sec. 26. For minors aged 15-18, consent for PrEP/PEP is independent, confidential, and does not require guardian involvement. Proxy consent does not apply to this age group.

#### E. Stigma and Discrimination

1. Judgment about risk compensation may influence the willingness of providers to provide PrEP and PEP. Persons may encounter stereotyping, and anticipated stigma related to past experiences in the healthcare system may limit disclosure and health-seeking behavior. Providers need to call out stigma and discrimination

and be open to learning and changing behaviors, structures, and systems. Three evidence-based, effective priority principles to ensure quality care that is free from stigma:

- a. Ensure that people are at the center of processes, and approaches are framed around enabling quality of life.
- b. Increase awareness of stigma, people-centered care, and models that support quality care.
- c. Build trusting relationships with local communities.
- d. Build capacity for a multidisciplinary primary health care workforce.
- e. Use digital technologies.
- f. Build stigma reduction into facility-based quality improvement approaches to improve quality of health care services.
- g. Invest and allocate funds at facility level to reduce stigma.
- h. Create systems that catalyze quality improvement processes.
- i. Institutionalize routine learning, reflection and quality improvement.
- j. Foster inclusive and non-discriminatory workplace cultures in health care.
- k. Engage structures and systems that create enabling environments for quality health care.
- l. Strengthen collaborations among health care leaders.
- m. Engage and broker partnerships between all stakeholders.
- n. Explore and scale up models of care that use community-based and community-led service delivery.
- o. Develop and strengthen networks.
- p. Advocate investment in interventions that reduce stigma across social determinants of health.

## Annex L. Core Indicators for Pre-Exposure Prophylaxis (PrEP)

Data should be collected continuously at the facility level, aggregated periodically and aligned with the reporting frequency of other routinely collected indicators (often monthly or quarterly). These data should then be combined for annual reporting.

Indicator	Definition	Numerator	Denominator
PrEP Uptake	Percentage of eligible people who initiated oral antiretroviral PrEP in the last 12 months. Includes new and re-initiation	The number of people who initiated oral PrEP in the last 12 months.	Number of people who were newly offered PrEP in the last 12 months.
New PrEP Users	This indicator aims to monitor how many people used PrEP for the first time in their lives during the reporting period.	The number of unique individuals who received PrEP for HIV prevention for the first time during the reporting period	N/A (optional for reporting : per 100 000 population)
Current PrEP Users	This indicator aims to keep track of how many people used PrEP during the reporting period.	The number of unique individuals who received PrEP for HIV prevention at least once during the reporting period.	N/A (optional for reporting : per 100 000 population)
Continuation of PrEP	Percentage of PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP in the last 12 months	Number of people who continued on PrEP for three consecutive months after having initiated PrEP in the last 12 months.	Number of people who initiated oral PrEP in the last 12 months
Recent PrEP use among those newly diagnosed with HIV	This indicator aims to measure how many people who experienced an HIV seroconversion, recently accessed PrEP.	The number of people who received PrEP at least once in the 12 months prior to being diagnosed with HIV, and who had at least one follow-up HIV test, among the denominators.	The number of people newly diagnosed with HIV during the reporting period.
PrEP associated toxicity prevalence	Percentage of people who received oral PrEP who have discontinued or interrupted PrEP due to a serious ARV-associated toxicity in the last 12 months	Number of people who received oral PrEP and have discontinued or interrupted PrEP due to a serious antiretroviral-related	Number of people who received oral PrEP at least once in the last 12 months.

Indicator	Definition	Numerator	Denominator
		toxicity in the last 12 months.	

*Adapted from the WHO Implementation Tool for PrEP of HIV Infection (2018) & ECDC PrEP Indicators*

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**Annex M.      References**

Chronic Kidney Disease Epidemiology Collaboration equation (CKD EPI 2021).

DOH Department Memorandum 2021-0017: *“Interim Guidelines on Pre-Exposure Prophylaxis (PrEP) for the Prevention of HIV Infection in the Philippines.*

DOH Department Circular 2021-0507: *Implementation and Dissemination of the Human Immunodeficiency Virus (HIV) Adaptive Plan.*

WHO: *WHO Guidelines for HIV post-exposure prophylaxis (2024)*

WHO: *WHO Implementation Tool for PrEP of HIV Infection (2018) & ECDC PrEP Indicators*

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