PART 2

of

Policies Adopting Administrative Order and Memorandums

1. PATIENT RIGHTS AND ORGANIZATION

We encourage you to speak openly with your health care provider, take part in your treatment choices, and protect your own safety by being well informed and involved in your care. As a patient at Pototan Rural Health Unit Birthing Clinic and Primary Health Care Facility, you have the following rights:

1. You have the right to receive considerate, respectful and compassionate health care in a safe setting regardless of your age, sex, gender, religion, ethnicity, political affiliation, disability or capacity to pay free from all forms of abuse, neglect, or ill treatment.

2. You have the right to be assigned to a competent doctor/resident physician and be told of the names of all health care team members who are qualified to provide diagnosis, treatment and medical advice. Likewise, you have the right to know your hospital and physician fees, and receive information about the possibility of financial assistance.

3. You have the right to notify a family member or person of your choice and your chosen doctor of your admission to the hospital.

4. You have the right to have someone remain with you during your hospital stay unless it compromises your or others' rights, safety or health.

5. You have the right to exercise your spiritual and cultural beliefs within the capacity and rules of the hospital/medical center.

6. You have the right to be informed and give consent before any non-emergency procedure or research/experiment or to refuse such.

7. You have the right to privacy and confidentiality of your medical records according to laws, as well as in care discussions, examinations, and treatments and the right to see or get a copy of your medical records except those records restricted by law.

8. You may request for an escort during physical examinations.

9. You have the right to be represented by someone (assignee) to decide on your behalf when the 10. circumstances warrant.

10. You have the right to ask about and be informed of the complaint process and express grievances without fear of recrimination or reprisal. You are encouraged to speak directly to the health care provider involved in your care.

2. PATIENT CARE

Strengthening the capacity of LGU of Measles Outbreak in identifying potentials Measles Outbreak

That the LGU shall implement the following mechanism as mandated in the DOH AO 2014-0039 the following mechanism as stated.

V. IMPLEMENTING MECHANISM

OBJECTIVE 1. PROVIDE HEALTH WORKERS GUIDANCE ON RESPONDING TO HIGH TRANSMISSION OF MEASLES IN THE COMMUNITY

Health workers at all levels are encouraged to follow these basic steps in outbreak response:

- Investigate and isolate suspected measles case(s) in the household
- Obtain appropriate blood specimens for laboratory confirmation
- Inform health authorities
- Assess immunization coverage in affected and surrounding barangays by conducting a rapid convenience survey
- Ensure appropriate case management, including Vitamin A administration in an age-appropriate dose
- Provide measles vaccine to unvaccinated household and community contacts
- Implement active case search in the community and nearby health facilities
- Alert surveillance focal points
- Monitor, analyze and prepare outbreak summary report

1.A. ISOLATION INSTRUCTIONS

- At home, isolate the suspected measles case and limit contact with other household members whenever possible until five days after the rash appears.
- Suspected measles cases should not be hospitalized unless necessary (e.g. when complications develop such as pneumonia or severe diarrhea).
- In schools, suspected measles cases should be sent home and parents should be advised to keep the child at home for five days.
- At the hospital, isolate suspected measles cases in isolation ward/room from rash onset up to 5 days to prevent nosocomial spread.

1.B. INVESTIGATION INSTRUCTIONS

- All Disease Surveillance Officers and Coordinators should report cases based on the standard measles case definition (rash, fever and either cough, coryza or conjunctivitis).
- All disease reporting units, including private clinics and facilities and the community are encouraged to report suspected measles cases to the concerned regional, provincial or city epidemiology and surveillance unit.
- Each suspected measles case should be completely investigated using the standard measles-rubella CIF (Annex A).
- Collect serum/ dried blood spot (DBS) sample from ALL cases in a barangay with only 1-5 suspected measles cases. If the number of cases exceeds 5, collect at least 5 serum/DBS samples per barangay.
- When the number of cases exceeds the level where completing the CIF is operationally feasible due to limited resources, case investigators should collect at least the 10 core variables (information items) required to allow for meaningful epidemiological analysis to guide health workers in implementing appropriate measles outbreak response measures.

- Core variables/information to be collected from suspected measles cases in all barangays where measles transmission is observed, especially in barangays where high measles transmission is occurring:
  - case identification
  - date of birth/age
  - sex
  - place of residence
  - vaccination status or date of last vaccination
  - date of rash onset
  - date of notification
  - date of investigation
  - date of blood specimen collection
  - place of infection and travel history
- Collect information about the measles immunization status from all suspected measles cases, especially if the case is an under-five child. If the investigator failed to collect this data or the case is found to be unimmunized, the investigator(s) must immediately inform the local EPI coordinator and encourage to validate the information and to immunize the case as needed.

1.C. CROSS NOTIFICATION

- Health workers at all levels should immediately be oriented and involved in all aspects of the outbreak response.
- Health workers of neighboring barangays should be notified so that they will begin implementing preventive actions as necessary.
- The public should be informed through the media about the outbreak and any protective measures that they can take.
- If a suspected case has traveled or has close contact with individuals from other barangays of the country 7-21 days before the onset of the illness, the DSO in those barangays should be notified immediately.

1.D. MEASLES CASE MANAGEMENT

- All suspect cases with clinical manifestation of measles, e.g. maculopapular rash, high fever (≥38 C) accompanied by either cough, runny nose or red eyes, should receive recommended age-specific Vitamin A dosage.
- Administration of Vitamin A is the standard of care in measles case management.
- Vitamin A supplementation has been shown to reduce all-cause mortality by 23%-30%.
- Health workers are encouraged to include Vitamin A administration in the immunization response activity whenever possible if adequate supply is available.

1.F. INTENSIFY MEASLES SURVEILLANCE

- Measles surveillance should be intensified to search for additional suspected cases.
- For every chain (date of rash onset of cases fall within an interval of 7-21 days from each other) of confirmed measles cases, at least 5 representative nasopharyngeal or oropharyngeal swab samples should be collected for laboratory measles viral isolation and allowing identification of the circulating measles virus strain.
- Ideally the nasopharyngeal or oropharyngeal swabs should be collected from cases within seven days of rash onset. Whereas, serum IgM or DBS for measles-specific IgM is more likely to be positive if collected between 4-28 days after rash onset. Specimens for IgM testing and for virus isolation should be collected during the first contact. Specimens for virus isolation and for IgM testing do not need to be collected from the same cases during an outbreak investigation.
- All reporting units should be notified once a measles outbreak is suspected and be alerted to be vigilant for additional cases.
- Health workers and public should be encouraged to report cases.
- The public should be informed where to report cases and where to get information for measles prevention and control.

1.G. OUTBREAK MONITORING AND SUMMARY REPORTING

- All epidemiology and surveillance units should aim to update their measles database regularly. At least one staff in each unit should be assigned for this purpose.
- Surveillance data should be analyzed using the most updated information.
- Data should be analyzed for both suspected, clinically-compatible, and confirmed measles cases.
- Basic weekly analysis should include the following:
    - Distribution of cases by case classification. Epidemiologically-linked cases should be determined as soon as a laboratory confirmed measles case is identified.
    - Distribution of cases by morbidity week and place
    - Age distribution of cases and immunization status
    - Patterns of transmission, including travel and exposure history
    - Measles incidence and case fatality ratio
    - Immunization response activities

2.A. ESTABLISHING EPIDEMIOLOGICAL LINKAGE

A measles case confirmed by epidemiological linkage to a laboratory-confirmed case or epidemiologically-linked case is a suspected measles case with a credible mode of transmission from a laboratory-confirmed case or (in the event of a chain of transmission) to another epidemiologically-confirmed case seven to 21 days prior to rash onset.

How should a "credible mode of transmission" be understood?

Cases must be linked geographically and temporally, although the contact details may not always be proven and sometimes must be assumed. Measles virus spreads very rapidly and people may be completely unaware that they have been in contact with infected persons who have not yet developed a rash. The following situations are all credible and should be considered:

- A case in the same village or urban community;
- A case in a neighbouring community with contact occurring through schools, markets and social events;
- A case who has travelled to a country known to have measles circulating during the past seven to 21 days; and
- A case having visited a health facility where a confirmed case is known to have occurred.

Who should perform epidemiological linking of measles cases?

- A barangay with *no* laboratory-confirmed measles case:
  - Depending on which unit is responsible for the barangay where the cases were reported, the provincial, municipal or city epidemiology and surveillance unit (MHO/PHO/CHO) shall be responsible for determining if the cases are epidemiologically-linked to confirmed measles or other epidemiologically-linked measles cases from neighboring barangays or municipalities where laboratory-confirmed cases are identified.
  - As the MHO/PHO/CHO has access to the measles database of the whole municipality, province or city, it has the ability to determine which of the newly reported cases are epidemiologically-linked to the laboratory-confirmed measles cases from other areas by reviewing individual case's core information (e.g. date of onset, exposure and travel history).

2.D. STRATEGIC APPROACH TO SERUM/DBS COLLECTION DURING HIGH MEASLES TRANSMISSION

In line with the above mentioned strategy, it is recommended that specimen collection be done strategically to facilitate the process of epidemiological linkage of measles cases, particularly in provinces and cities with high measles transmission (e.g. multiple barangays with more than one laboratory-confirmed measles case in several municipalities, provinces and/or cities) without overwhelming the NMRL's capacity to test specimens and provide timely test results. Please refer to the table below for the supplemental guidelines that apply ONLY during a period of high and widespread measles transmission.

SCENARIO	MINIMUM SURVEILLANCE RESPONSE AND SPECIMEN COLLECTION
A barangay with 1-5 new suspected case and no previous confirmed case/outbreak in the last 6 or more months	• Complete the case investigation form (CIF) per suspected measles case; ensure data for for the 10 core variables are collected • Collect serum/DBS sample from each suspected measles case. • Search for other cases
A barangay with more than five new suspected cases and no previous confirmed case/outbreak in the last 6 or more months	• Complete the CIF per suspected measles case if cases are less than 30 or collect data only for the 10 core variables if with 30 or more cases • Collect serum/DBS sample from first 5 cases, preferably geographically representative of the barangay. • Monitor appearance of new cases. • Once laboratory result is available, reclassify clinically-measles compatible cases that can be epidemiologically-linked to the laboratory-confirmed measles case.
A barangay with one or more new suspected measles case(s) after ≥2 months of zero case report from the last laboratory and/or epidemiologically-linked case	
A barangay with known laboratory-confirmed case(s) and with continuous detection of new cases that are epidemiologically-linked to the last confirmed case.	• Complete the CIF per suspected measles case if cases are less than 30 or collect data only for the 10 core variables if with 30 or more cases • NO NEED to collect serum/ DBS sample from new cases • Establish epidemiological linkage of new cases to either laboratory-confirmed or another epidemiologically-linked case(s).

Adoption of Guidelines on Philippine Integrated Disease Surveillance and Response (PIDSR)

That the LGU shall implement the DOH AO 2021-0057 to efficiently implement EDCS, ESR, established ESU with dedicated team as seen in the specific guidelines as well as informed the LGU headed by the LCE of the status of reported events as well as DM 2012-0163 on Guidance on Taking, Using and Disseminating Visual Recordings of Cases Included in PIDSR Disease under Surveillance

VI. SPECIFIC GUIDELINES

A. Epidemic-Prone Disease Case Surveillance Core Processes

1. **Case Detection**

   Diseases notifiable to EDCS shall be based on standard case definition and list of diseases detected and reported to the Epidemic-Prone Disease Case Surveillance System (EDCS) (*see Annex B).*

2. **Case Registration**

   Case registration shall require complete core information in Case Investigation Forms (CIFs)/Case Report Forms (CRFs) in the EDCS system.

3. **Case Reporting**

   Reporting of all epidemic prone diseases shall be through the online or offline EDCS system at all levels. If there are no available information systems, ESU shall submit CIF/CRF to the next higher ESU level. Zero case reporting of notifiable diseases and syndromes shall be implemented at all levels. This means reporting of "zero case" when no case is detected by the reporting unit.

4. **Laboratory Testing and Confirmation**

   A standard protocol, capacity building, and laboratory networking for specimen collection, preparation, storage, transport and interpretation of results shall be developed and available at all levels. The specimen collection kits for priority diseases (e.g. acute flaccid paralysis and measles) shall be made available at the regional and local levels.

5. **Data Management**

   Computerized data management shall be strengthened at all ESUs and health facilities. This includes data management training on data processing and quality assurance: checking for data completeness and inconsistencies, duplication process and data reconciliation. A mechanism of archiving databases (raw, cleaned and final) to Network-attached storage (NAS) or other protected hardware or software applications for filing and storage shall be developed.

6. **Analysis, Interpretation and Report Generation**

   ESUs shall analyze weekly surveillance data for detecting clustering, outbreaks and unexpected increase or decrease in disease occurrence, monitoring disease trends, and evaluating the effectiveness of disease control programs and policies. In the event of outbreaks or unusual increase in the number of cases, frequency analysis of surveillance data may be modified.

7. **Feedback**

   ESUs shall conduct regular (e.g. daily/weekly/monthly/quarterly/ annual) and timely feedback of surveillance data, data request, monitoring and evaluation reports and management review/meetings to the data sources. Networks across all levels of ESUs shall be strengthened in alert notification about epidemics and other health events of public concern.

B. Event-based Surveillance and Response Core Processes

1. Capture

Detection of any event that may pose a health risk in the community shall emanate from three broad categories, namely, the media, facility-based reports and general public. Events originated from a rumor that may present possible health risks shall not be ignored and would need further investigation from health authorities.

2. Verify

A health event reported to ESR shall be substantiated within a 24-hour time period from date and time of capture. It shall involve asking another informant about the event, including basic information about time, place and person if possible from trained health personnel.

3. Assessment

Analysis of health events whether it is a public health risk shall be done within a 48 hours time period from date and time of verification. Classification of health events as to level of concern shall be based on the criteria provided in the latest ESR MOP.

Assessment and notification of health events shall follow the use of Annex 2: Decision instrument for assessment and notification of events that may constitute a public health emergency of international concern of the International Health Regulations (*see Annex C and D*).

4. Feedback and Information Dissemination

Feedback and dissemination of written reports may be done on a daily, weekly or monthly basis and sent to relevant stakeholders or during a regular Program Implementation Review (PIR).

C. Epidemic Response

The flow of investigation, reporting and response to a suspected epidemic or epidemic shall be based on the PIDSR Manual of Procedures. The Secretary of Health has the authority to declare if an epidemic or outbreak has ended (Rule III, Section 1 of the 2020 Revised IRR of RA 11332).

1. Detection

Epidemics can be detected through EDCS, ESR, and Laboratory-based surveillance. The initial response activities shall be conducted by local levels in coordination with the concerned CHD, LGU, and other agencies involved.

2. **Verification**

   Municipal and/or city health offices shall promptly verify reports of epidemics received from health facilities or through community rumors and notify the next higher level within 24 hours.

3. **Declaration of an Epidemic**

   Declaration of an epidemic (local, national and/or international) shall be based on RA 7160 or the "Local Government Code of 1991" (Section 105) and on the 2020 Revised IRR of RA 11332 (Rule III, Section 1); and shall be supported by sufficient scientific evidence as follows: disease surveillance data, epidemiologic (descriptive or analytic), environmental, and laboratory investigations.

4. **Containment**

   After verification of an epidemic, concerned Municipal Health Officers/City Health Officers shall activate the epidemic response team thus the appropriate control measures shall be conducted immediately. Risk assessment and submission of epidemiological investigations and other response activities shall be provided to the next higher level ESUs.

D. Monitoring and Evaluation

Mechanism for monitoring the system shall be established at all ESUs and health facilities (sentinel and non-sentinel) to track the implementation of planned surveillance activities and of the overall performance of surveillance systems. PIDSR implementation shall be evaluated every 3 - 5 years or as needed.

Surveillance officers are therefore reminded to obtain the patient's/guardian's consent prior to taking photos, videos and other recordings that will be used to aid in investigation. Measures to ensure protection of patient's identity should be done, such as concealing the patient's eyes or the entire face; manually during the act of recording (e.g. use of cardboard to cover the patient's eyes/face) or through the use of a digital enhancement software (e.g. adobe photoshop). Moreover, the patient's genital part should remain covered during the recording process, unless the lesions are in the genital part and must be documented.

GUIDELINES ON THE SURVEILLANCE AND MANAGEMENT OF AEFI

That the LGU shall implement the following as mandated in the DOH 2023-0007 the following implementing guidelines as stated to conduct a standardized, efficient and responsible actions on aefi following NIP.

I. IMPLEMENTING GUIDELINES

A. AEFI Surveillance

1. Detection and Reporting

a) The detection and reporting of AEFIs shall be a shared responsibility among DRUs, including all health facilities, healthcare providers, and vaccine recipients.

b) For newly introduced (novel) vaccines such as those for COVID-19, **all AEFIs, regardless of severity**, that are *suspected* by the health care provider to be associated to the vaccine, are immediately notifiable and shall be reported by the DRU using the appropriate reporting platform upon collection of the minimum required case details.

c) For vaccines under the NIP with established safety profiles, the list of immediately notifiable AEFIs are included under ***Annex B***. But in general, it is advised to report all AEFIs as long as no other clear cause has been identified and the causal link to vaccine has not been established.

d) Accomplished AEFI case reports shall use the latest version of the AEFI Case Investigation Form (CIF) (https://bit.ly/aefic19ph) submitted to the appropriate reporting platform along with supporting documents such as, but not limited to, vaccination card, and pertinent medical records.

e) The LESUs shall return incompletely filled or incoherently narrated forms to the reporter or the submitting DRUs. Reporting serious AEFIs shall require validation and approval from Regional ESUs (RESUs), with guidance from the EB, and as coordinated with the corresponding DRU and the Municipal ESU (MESU) and/or Provincial ESU (PESU), prior to submission to the appropriate reporting platform.

2. Investigation

a) **Only suspected serious AEFI** cases that were endorsed to EB and/or the respective RESUs following the criteria and prioritization framework for serious AEFI cases in ***Annex C***, shall be eligible for case investigation.

b) The RESU of the region where the AEFI case was **last admitted** shall take the lead in investigating and compiling the minimum required case files to proceed with the causality assessment, as necessary. RESU shall investigate, in close coordination with the respective Hospital ESUs (HESU), LESU, and Local Health Officers (LHOs) in gathering details and verifying information. Actions may be performed asynchronously and/or virtually, as long as the veracity of information is upheld.

c) The LESUs, with assistance from RESUs, shall **immediately** conduct community case investigations for cases with complete clinical investigations and with concluded AEFI case investigation, observing the AEFI case investigation guidelines.

d) Other coordination mechanisms may be established as approved by respective CHD Directors or the Minister of Health without prior approval by EB. Mutually agreed process deviations among the regions shall be relayed to EB for notation.

e) Closing of investigations shall be at the discretion of the lead investigator upon collection of all necessary medical information to conclude an assessment. Investigations may be re-opened or continued depending on the discretion of the RESU, N/RAEFIC, and EB.

f) The protocols for the investigation of deaths following immunization including the conduct of medical autopsy shall abide by the Department Memorandum (DM) No. 2021-0425 (*Interim Guidelines for the Conduct of Medical Autopsies for Deaths Following Immunization with COVID-19 Vaccines)*, or any latest applicable issuances.

3. **Causality Assessment**

a) Only serious suspected AEFI cases **with complete (clinical and community) investigation** details that fit the prioritization criteria set in ***Annex C*** shall proceed to a causality assessment conducted by the N/RAEFIC following the latest algorithms established by the WHO.

b) Causality assessment shall commence upon completion of case investigation and retrieval of pertinent medical records and documents.

c) The N/RAEFIC shall consist of specialists in each field including but not limited to cardiology, neurology, allergology, hematology, and pathology. The N/RAEFICs may call on other resource persons or experts recognized by the DOH or by the respective N/RAEFIC.

d) Causality assessments conducted by a RAEFIC following a complete AEFI case investigation shall be deemed final and valid, unless the RAEFIC performed reclassification of the vaccine-event causality for the AEFI case following new information received, or if the AEFI case has been specifically endorsed to NAEFIC for reassessment.

e) The Secretariats of each RAEFIC shall prepare the minimum required documents for submission and internal documentation to the EB not more than fifteen (15) working days following the conduct of the RAEFIC causality assessment.

4. **Analysis**

a) All concerned staff involved in the vaccination program shall endeavor to perform routine pharmacovigilance analysis using vaccine safety data, within their scope of service, and submit it to the corresponding lead of the vaccination program at an agreed frequency or as needed. Corresponding programmatic changes in the vaccination program that were identified should be done based on recent guidelines set by the WHO, international and local clinical practice guidelines and/or expert's opinion, including but not limited to that of the NAEFIC and National Immunization Technical Advisory Group (NITAG), as applicable.

b) RESUs shall endeavor to issue and maintain a comprehensive AEFI bulletin to be shared with the EB according to the agreed timelines.

5. **Feedback**

   a) Results of all causality assessments conducted by N/RAEFICs shall be documented and transmitted to the appropriate stakeholders. Feedback of NAEFIC causality assessment results are endorsed by EB to the RESUs through an official memorandum and a linelist of cases, every six (6) months or according to the agreed frequency. Likewise, a separate regional linelist shall be prepared by the RESUs for cases assessed solely by their respective RAEFICs for endorsement to EB for internal documentation.

   b) The LESUs and LHOs shall verbally communicate the results of the causality assessments to the person of interest. Each CHD Director or Minister of Health shall designate personnel or team with adept crisis communication competency to ensure comprehensive feedback.

B. Management and Response

1. All vaccination sites shall have at least one (1) complete AEFI kit per composite team containing first-line treatment drugs such as epinephrine for allergic reactions and other items for managing the clinical presentation of AEFIs. These kits shall be replenished prior to each vaccination run.

2. Individuals presenting an anaphylactic reaction after receiving a vaccine dose shall consult and seek clearance from an allergologist on the decision to proceed with their next scheduled vaccinations. However, in cases wherein no allergologists are situated in the hospital/clinic, the attending physician, irrespective of their specialty, shall provide clearance for the individual's next vaccination.

3. All health care providers in vaccination sites and health facilities shall be able to screen, detect, monitor, and manage presentations of medical emergencies and other conditions after immunization. Immediate clinical management and response for specific adverse events of vaccines shall be referenced from available guidelines published by different medical societies as cleared and endorsed by the DOH.

4. Integrated health service approach for AEFI response through the healthcare provider network shall include clinical management, navigation, referral, and communication, according to the updated DOH-endorsed AEFI management pathways and clinical practice guidelines as stipulated in DM No. 2021-0218 and its amendments. LGUs shall design patient-centered referral pathways that are locally defined and have mutually agreed on service-level allocations, in accordance with DOH AO No. 2020-0019 (*Guidelines on the Service Delivery Design of Health Care Provider Networks*) and its related guidelines and amendments.

5. LGUs shall assist and provide social and mental welfare services and other non-financial and nonmedical needs for vaccine recipients, within their locality.

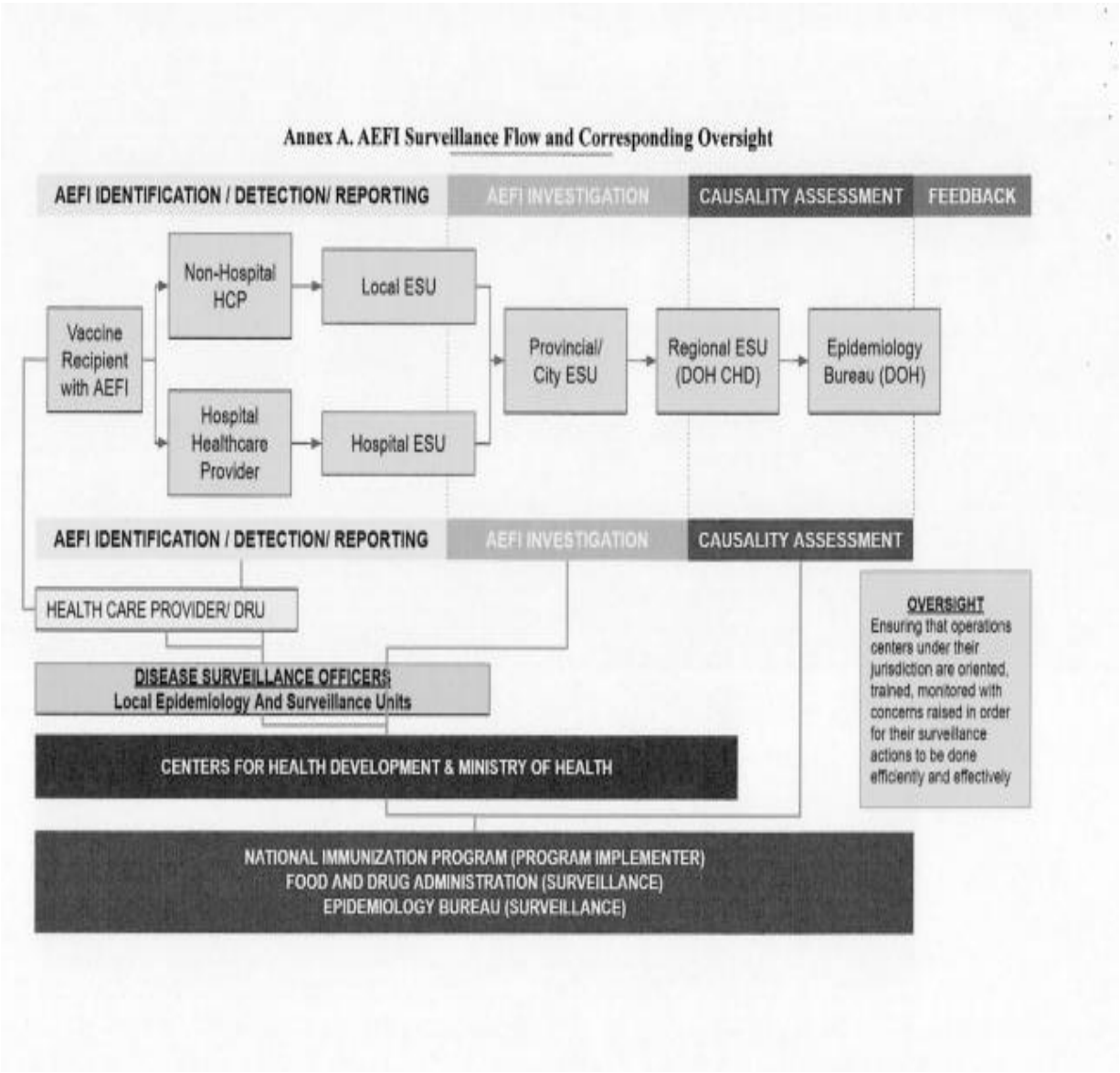
6. Expenses incurred for the transportation and management of AEFI cases, until the patient is stabilized and/or the AEFIs are resolved, shall be financed by their respective LGU or CHD and PhilHealth, following their respective rules and regulations. Other mechanisms for financial and medical assistance shall be communicated by their LGU or CHD.

7. Recipients of COVID-19 vaccines who experienced serious AEFIs may be entitled to the COVAX No-Fault Compensation Program, or the PhilHealth Vaccine Injury Compensation Package (VICP). Eligibility for PhilHealth claims of COVID-19 vaccine AEFI cases are subject to the provisions stated under PhilHealth Circular No. 2021-0007 and other guidelines that will be issued by PhilHealth thereafter. Other existing benefit packages provided by PhilHealth for hospitalized cases shall remain in effect.

8. The process and guidelines set forth by the Health Promotion Bureau (HPB) for risk communications of AEFIs and by the Communications Office (COM) of the Public Health Services Team for crisis communication and community management as stated in DM No. 2021-0224 and other succeeding guidelines shall be observed, following reports of AEFI cases.

9. The Health Emergency and Management Bureau (HEMB) and its respective regional and local counterparts shall be alerted to respond in terms of

Annex A. AEFI Surveillance Flow and Corresponding Oversight



Annex B. List of Immediately Notifiable AEFIs

Adverse event	Case definition	Vaccine
Acute flaccid paralysis (Vaccine associated paralytic poliomyelitis)	Acute onset of flaccid paralysis within 4 to 30 days of receipt of oral poliovirus vaccine (OPV), or within 4 to 75 days after contact with a vaccine recipient **and** neurological deficits remaining 60 days after onset, or death. Notifiable if the onset is within 3 months after immunization	OPV
Anaphylactoid reaction (acute hypersensitivity reaction)	Exaggerated acute allergic reaction, occurring within 2 hours after immunization, characterized by one or more of the following: • Wheezing and shortness of breath due to bronchospasm • One or more skin manifestations, e.g. hives, facial oedema, or generalized oedema. Less severe allergic reactions do not need to be reported. • Laryngospasm/laryngeal oedema Notifiable if the onset is within 24 to 48 hours after immunization	All
Anaphylaxis	Severe immediate (within 1 hour) allergic reaction leading to circulatory failure with or without bronchospasm and/or laryngospasm/laryngeal oedema. Notifiable if the onset is within 24 to 48 hours after immunization	All
Arthralgia	Joint pain usually including the small peripheral joints. **Persistent** if lasting longer than 10 days, **transient**: if lasting up to 10 days Notifiable if the onset is within 1 month after immunization	Rubella, MMR
Brachial neuritis	Dysfunction of nerves supplying the arm/shoulder without other involvement of the nervous system. A deep steady, often severe aching pain in the shoulder and upper arm followed in days or weakness by weakness and wasting in arm/shoulder muscles. Sensory loss may be present, but is less prominent. May present on the same or the opposite side to the injection and sometimes affects both arms. Notifiable if the onset is within 3 months after immunization	Tetanus
Disseminated BCG infections	Widespread infection occurring within 1 to 12 months after BCG vaccination and confirmed by isolation of *Mycobacterium bovis* BCG strain. Usually in immunocompromised individuals.	BCG
Encephalopathy	Acute onset of major illness characterized by any two of the following three conditions: seizures, severe alteration in level of consciousness lasting for one day or more distinct change in behavior lasting one day or more. Needs to occur within 48 hours of DTP vaccine or from 7 to 12 days after measles or MMR vaccine, to be related to immunization.	Measles, Pertussis
Hypotonic, hyporesponsive episode (HHE or shock-collapse)	Event of sudden onset occurring within 48 [usually less than 12] hours of vaccination and lasting from one minute to several hours, in children younger than 10 years of age. **All** of the following must be present: • Limpness (hypotonic) • Reduced responsiveness (hyporesponsive) • Pallor or cyanosis – or failure to observe/ recall	Mainly DTP, rarely others

Injection site abscess	Fluctuant or draining fluid filled lesion at the site of injection. **Bacterial** if evidence of infection (e.g. purulent, inflammatory signs, fever, culture), **sterile** abscess if not. Notifiable if the onset is within 7 days after immunization	All
Lymphadenitis (includes simple and suppurative lymphadenitis)	**Either** at least one lymph node enlarged to >1.0 cm in size (one adult finger width) **or** a draining sinus over a lymph node. Almost exclusively caused by BCG and then occurring within 2 to 6 months after receipt of BCG vaccine, on the same side as inoculation (mostly axillary). May develop as early as two weeks after vaccination, most cases appear within six months, and almost all cases occur within 24 months.	BCG
Osteitis/ Osteomyelitis	Inflammation of the bone with isolation of *Mycobacterium bovis* BCG strain. Notifiable if the onset is between 1 and 12 months after immunization	BCG
Persistent inconsolable screaming	Inconsolable continuous crying lasting 3 hours or longer accompanied by high-pitched screaming. Notifiable if the onset is within 24 to 48 hours after immunization	DTP, Pertussis
Seizures	Occurrence of generalized convulsions that are not accompanied by focal neurological signs or symptoms. **Febrile seizures**: if temperature elevated >38°C (rectal) **Afebrile seizures**: if temperature normal Notifiable if the onset is within 14 days after immunization	All, especially DTP, Measles
Sepsis	Acute onset of severe generalized illness due to bacterial infection and confirmed (if possible) by positive blood culture. Needs to be reported as a possible indicator of program error. Notifiable if the onset is within 7 days after immunization	All
Severe local reaction	Redness and/or swelling centered at the site of injection and one or more of the following: • Swelling beyond the nearest joint • Pain, redness, and swelling of more than 3 days duration • Requires hospitalization. Notifiable if the onset is within 7 days after immunization. **Local reactions of lesser intensity occur commonly and are trivial and do not need to be reported.**	All
Thrombocytopenia	Serum platelet count of less than 150,000/ml leading to bruising and/or bleeding Notifiable if the onset is within 3 months after immunization	MMR
Toxic shock syndrome (TSS)	Abrupt onset of fever, vomiting and watery diarrhea within a few hours of immunization. Often leading to death within 24 to 48 hours. Needs to be reported as a possible indicator of program error. Notifiable if the onset is within 24 to 48 hours after immunization	All

*Brighton collaboration has developed case definitions for many vaccines reactions and is available at: www.brighton collaboration.org. Reference: *Manual of Procedures for Surveillance and Response to AEFI*, 2014

GUIDELINES ON THE IMPLEMENTATION OF HAND, FOOT AND MOUTH DISEASE SURVEILLANCE, CLINICAL MANAGEMENT AND PREVENTIVE MEASURES

That LGU shall implement the following as mandated in the DM 2020 2023-0097 on HFMD disease surveillance, clinical management and preventive measures as such:

V. SPECIFIC GUIDELINES

A. CLINICAL ASSESSMENT

In most cases, HFMD is a self-limiting illness, with the majority of children recovering spontaneously with symptomatic treatment. Only a small proportion of children with HFMD develop neurological involvement, which may further progress to potentially fatal cardiopulmonary failure (Refer to Annex 1 and 2).

Severe cases of Enterovirus 71 infection can be classified into 4 stages:

Stage 1 – Hand foot and mouth disease (HFMD), oral ulcers and vesicular rash appearing on the hands, feet, knees and / or buttocks; or herpangina including oral ulceration over anterior tonsillar pillars, the soft palate, buccal mucosa or uvula.

Stage 2 – CNS involvement - aseptic meningitis with headache, irritability or myoclonic jerk and CSF pleocytosis (> 5 x 106 leucocytes / litre) but without altered level of consciousness and focal signs, or encephalitis with altered level of consciousness plus CSF pleocytosis or poliomyelitis like syndrome with acute limb weakness and decreased reflex and muscle strength, or encephalomyelitis with the occurrence of both encephalitis and poliomyelitis like syndrome.

Stage 3 – Cardiopulmonary failure, pulmonary edema or hemorrhage with decreased ejection fraction of left ventricle as assessed by echocardiography necessitating inotropic agent support.

Stage 4 – Convalescence - is defined as recovery from cardiopulmonary failure. (Malaysia Ministry of Health HFMD Guidelines, 2018)

B. DIAGNOSTICS

Routine diagnostics plus ancillary tests

Samples for virological investigation:

1. Throat swab
2. Vesicle swab
3. Rectal swab/stool
4. Cerebrospinal fluid (CSF)

Ancillary Tests:

1. Complete blood count
2. Chest X-ray
3. Blood glucose
4. Arterial Blood gas
5. 2D Echocardiography
6. Blood culture and sensitivity if septic shock cannot be excluded – CP
7. MRI – if with nervous system involvement – CNS, ANS
8. CSF examination – if with nervous system involvement – CNS, ANS

C. CLINICAL MANAGEMENT OF HFMD

HFMD is usually mild and self-limiting. In general, most cases of HFMD do not require admission but can be managed as an outpatient basis. Most fatal HFMD cases are due to enterovirus infection.

1. **Mild HFMD cases** only need symptomatic management such as management of fever and relief of symptoms, adequate hydration and rest.
2. **Severe HFMD** was defined as mild HFMD with the addition of neurological, respiratory, or circulatory complications, or death.

   2.1 Criteria for admission

   • Signs of dehydration and cannot feed
   • Clinically very ill or toxic-looking
   • Persistent hyperpyrexia (e.g >38°C) for >48 hours;
   • Suspicion of neurological complications, e.g increased lethargy, myoclonus, increased drowsiness, change in sensorium and/or seizures; and
   • Suspicion of cardiac complications (myocarditis), e.g., low blood pressure, weak pulse volume, heart rhythm abnormalities.

2.2. IF WITH COMPLICATIONS, REFER TO SPECIALIST

D. PREVENTION AND CONTROL MEASURES

People infected with hand, foot, and mouth disease can spread the disease to others through coughing, sneezing or contact with an infected person's blister fluid or feces.

1. IN A COMMUNITY SETTING

Parents and care takers should be educated on hygiene and preventive measures to prevent transmission.

a. Do strict handwashing before and after toilet use. Regularly wash hands with soap and water for at least 40-60 seconds;
b. Disinfect dirty surfaces and soiled items;
c. Avoid close contact (kissing, hugging, or sharing eating utensils or cups) with infected people (CDC, 2019); and
d. Do proper waste disposal.

2. IN A HOSPITAL SETTING

All patients, caretakers and health practitioners are encouraged to:

- Do proper hygiene including mandatory hand washing after contact with patient, and appropriate cleanliness during diaper change;
- Do not allow sharing of personal items such as spoons, cups and utensils. These items should be properly washed with detergent after use;
- Use gowns if you are taking care of an HFMD patient; and
- Isolate patient with HFMD following standard contact and droplet infection control procedures.

E. SURVEILLANCE AND MONITORING

E.1. MANAGEMENT OF SPORADIC CASES

A sporadic HFMD case is defined as a single case of HFMD in the absence of a previously known close contact with another case.

a previously known close contact with another case.

E.2. PUBLIC HEALTH MEASURES

a. Case investigation is required for every notified HFMD case that fulfilled any one of the criteria below:

a.1. case was admitted to the hospital
a.2. case died
a.3. case aged 6 years and below and goes to any pre-schools or nurseries

The first two criteria indicate severity of illness and it served as a proxy of possible EV71 infection. Meanwhile, the third criterion is important in preventing spread of illness among the pre-school children (high risk group) and reducing public anxiety.

b. Every case with positive EV71 laboratory result.

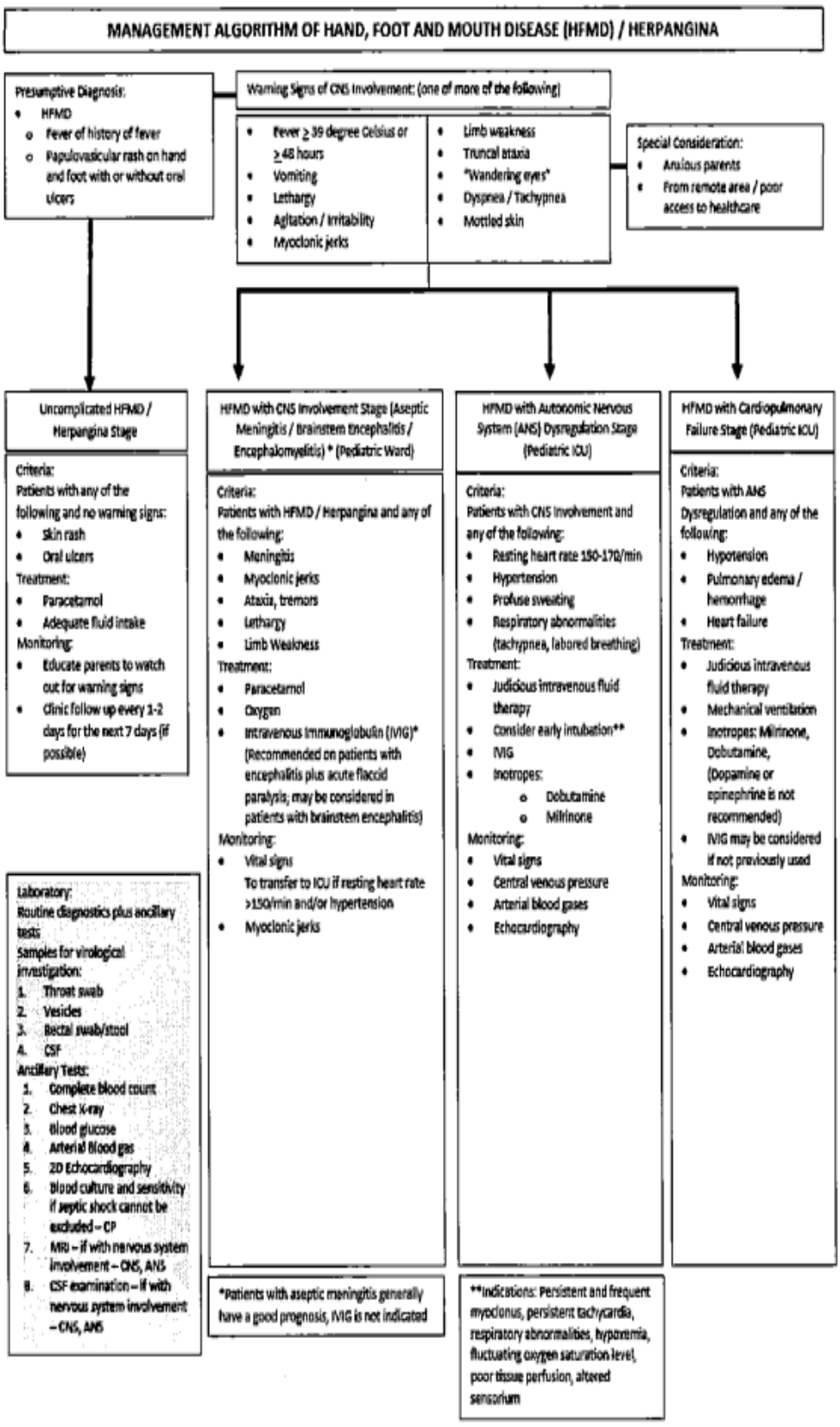
Investigation should be carried out to determine the course, source and severity of infection. Enquiries shall be made into:

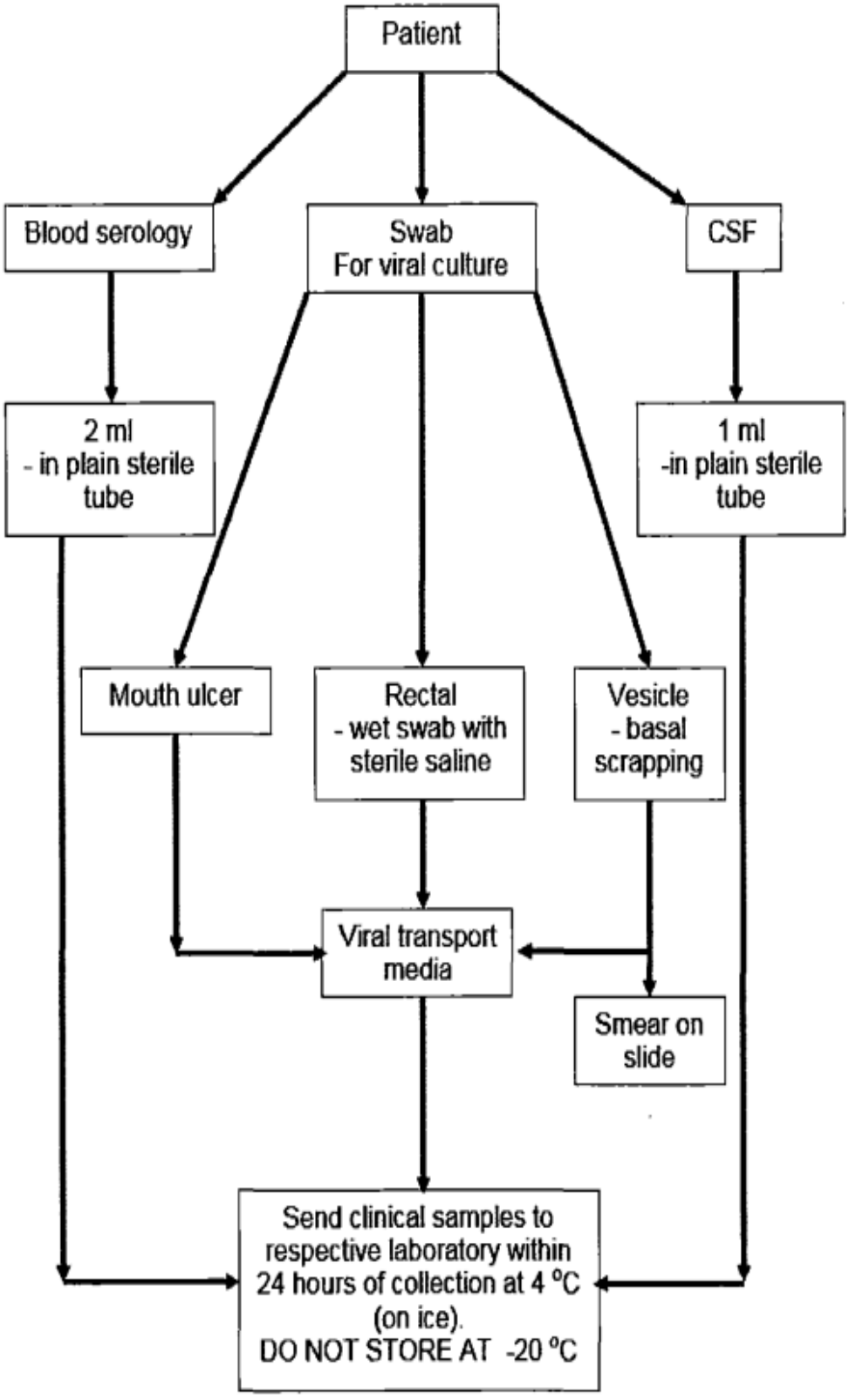
1. Particulars of the person affected
2. Clinical signs and symptoms with date of onset. Enterovirus infections that are not associated with complications may not have cutaneous manifestations
3. Duration of illness
4. Type of treatment sought, including details of hospitalization and reason for admission
5. History of travel especially to and from outbreak area in the past two weeks
6. Contacts with similar illness in a particular institution (child care center or kindergarten),
   family or neighborhood.
7. If patient is a newborn, include antenatal history, maternal history of febrile illness, and mode of delivery

1. Clinical surveillance

It is mandatory to notify for HFMD under the National Notification of Infectious Diseases (list of notifiable diseases). Notification must be done within 24 hours of diagnosis via telephone, submission of the notification form shall be done after. All HFMD cases detected must be submitted to Epidemiology Bureau (EB) Regional Epidemiology and Surveillance Units (RESU). Laboratory confirmation is NOT required for notification.

ANNEX 2.
MANAGEMENT ALGORITHM OF HAND, FOOT AND MOUTH DISEASE (HFMD)





(Refer to RITM HFMD Guidelines)

GUIDELINES ON THE IMPLEMENTATION OF MONKEY POX SURVEILLANCE, SCREENING, MANAGEMENT AND INFECTION CONTROL

The LGU will adopt and implement the following guidelines as reflected in the DM 2022-0220 in order to pro-actively disseminate, prevent and cut off transmission through prompt referral to Health Units

II. GENERAL GUIDELINES

A. The Department of Health (DOH), through its Communication Office, shall keep the general public up to date with the latest news on Monkeypox in and outside the country from reputable sources.

B. Health care facilities from the different levels of care, health care provider networks, Local Government Units (LGUs), and private organizations/institutions including business establishments, schools, other public facilities, and formal and informal sectors shall familiarize themselves with the DOH Interim Guidelines on Monkeypox and report/coordinate information on suspect and confirmed cases to the DOH through the Epidemiology Bureau (EB) and respective Centers for Health Development (CHDs).

C. Healthcare workers shall refer exposed and at-risk individuals who are experiencing signs and symptoms of monkeypox, which include skin rashes accompanied by fever, intense headache, lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle aches) and intense asthenia (lack of energy), and /or skin eruption, to the nearest higher level of healthcare facility for thorough assessment.

D. Exposed and at-risk individuals shall be profiled, and health status shall be monitored for immediate detection, laboratory confirmation, and reporting to the epidemiology and surveillance network.

E. Individuals or travelers from countries with reported or ongoing cases of monkeypox, who are manifesting the above-mentioned signs and symptoms shall coordinate with the Philippine Embassy or the Department of Foregin Affairs (DFA), the DOH Bureau of Quarantine (BOQ), Department of Labor and Employment (DOLE), Overseas Workers and Welfare Administration (OWWA), and Philippine Overseas Employment Administration (POEA) for proper coordination and management.

F. Individuals traveling to monkeypox-endemic countries shall avoid contact with mammals such as rodents, marsupials, and non-human primates (dead or alive) that could harbor monkeypox virus and shall refrain from eating or handling wild game meat (bushmeat).

G. All individuals are advised to strictly adhere to the minimum public health standards (MPHS) set by the DOH to prevent different infectious diseases including monkeypox.

H. A Monkeypox Operation Center (MPXOpCen) shall be established by the DOH and the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF-EID) shall be activated once there is an observed increasing risk of importation of monkeypox in the country based on criteria of risk classification and assessment to be set by the DOH.

III. SPECIFIC GUIDELINES

A. Prevention and Control

1. Individual

a. Steps for self-protection include:
   i. Avoiding direct skin to skin or face-to-face contact, including any sexual activity, with anyone who experiences symptoms or had a direct contact with contaminated materials of probable or confirmed case of monkeypox;
   ii. Keeping hands clean by hand washing with water and soap or using an alcohol-based hand rub; and
   iii. Maintaining respiratory etiquette to include use of personal protective equipment such as face masks.

b. Any individual who develops skin lesions such as a macule, papule, pustule, vesicle, and accompanied by fever, intense headache, unilateral or bilateral lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle aches) and intense asthenia (lack of energy) shall contact their health care provider for risk assessment and diagnostic evaluation.

c. Any individual who develops skin lesions during international travel or upon return to the country shall immediately report to a health professional, and provide information about all recent travel history, sexual history, and smallpox immunization history.

d. Any individual who is a Suspected or Probable Case of monkeypox shall undergo home isolation for at least 21 days or until the resolution of all symptoms, including any rash, crusting, or scabs, and observe appropriate infection control protocols .

e. A person with confirmed infection (Confirmed Case) who does not require hospitalization for medical indications shall undergo home isolation for at least 21 days or until the resolution of all symptoms including any rash, crusting, and scabs and observe appropriate infection control measures such as the following:
   i. Persons with extensive lesions that cannot be easily covered (excluding facial lesions), draining/weeping lesions, or respiratory symptoms (e.g. cough, sore throat, runny nose) shall be isolated in a room or area separate from other family members when possible;
   ii. Persons with monkeypox shall wear a surgical mask, especially those
   iii. Persons with monkeypox shall not leave home for any purpose, including work, except as required for follow-up medical care. They shall also avoid contact with wild or domestic mammals if possible;
   iv. Persons with monkeypox shall be advised to avoid skin manipulation or scratching and keep the lesions dry, clean and covered to avoid further transmission and superinfection;
   v. Disposable gloves shall be worn for direct contact with lesions and disposed after use;
   vi. Skin lesions shall be covered to the best extent possible (e.g., long sleeves, long pants, and wound dressing with sterile gauze for weeping lesions) to minimize risk of contact with others;
   vii. Disinfection shall be done prior to the disposal of contaminated/potential infectious waste (such as dressings and bandages) in a separate receptacle or use a yellow bag. Household members or caregivers of infected patients shall inform the waste collector about the presence of contaminated/potential infectious waste in waste receptacles. The latter shall avoid disposing directly in landfills or dumps;
   viii. Unexposed persons who do not have an essential need to be in the home of others are advised not to visit homes with persons under isolation;

ix. Household members who are not ill shall limit contact with the person with monkeypox; and
x. Pets shall be excluded from the infected person's environment.

f. Vaccination
   i. Currently, there is no Philippine Food and Drug Administration (FDA) approved and authorized vaccine for use against monkeypox;
   ii. Existing processes and requirements of the Philippine FDA and Health Technology Assessment Council (HTAC) shall be followed prior to the procurement of these vaccines to ensure local availability.

2. Household

a. Household members caring for a person who is a suspected case, a probable case, or a confirmed case of monkeypox shall use the appropriate personal protective equipment and measures including wearing of a mask and disinfecting surfaces using FDA-registered and approved standard household cleaning materials.
b. Household members are encouraged to practice proper hand hygiene and cleaning practices such as the following:
   i. Hand hygiene (i.e. hand washing with soap and water or use of an alcohol-based hand rub) shall be performed by infected persons and household contacts after touching lesion material, clothing, linens, or environmental surfaces that may have had contact with lesion material;
   ii. Laundry (e.g., bedding, towels, clothing) may be washed in a standard washing machine with warm water and detergent; bleach may be added but is not necessary;
      1. Gloves and mask shall be worn when handling soiled laundry to avoid direct contact with contaminated material;
      2. Soiled laundry shall not be shaken or otherwise handled in a manner that may disperse infectious particles;
   iii. Dishes and other eating utensils shall not be shared. Soiled dishes and eating utensils shall be washed in a dishwasher or by hand with warm water and soap;
   iv. Contaminated surfaces shall be cleaned and disinfected. Standard household cleaning/disinfectants may be used in accordance with the manufacturer's instructions.

3. Community

a. Members of the community including schools, workplaces, and other public places shall be informed of the following preventive measures:
   i. Avoid contact with animals that could harbor the virus (including animals that are sick or that have been found dead in areas where monkeypox occurs);
   ii. Avoid contact with any materials, such as bedding, that have been in contact with a sick animal;
   iii. Observe proper isolation of infected individuals;
   iv. Practice good hand hygiene, including handwashing with soap and water or using an alcohol-based sanitizer, at all hand hygiene moments;
   v. Use of proper personal protective equipment (PPE) when caring for patients.

4. **Primary Care Facilities**
   a. Primary care providers who identify patients with skin lesions like macule, papule, pustule or vesicular rash that could be consistent with monkeypox, especially those with a recent travel history to a country where monkeypox cases have been reported, shall consider monkeypox as a differential diagnosis.
   b. Primary care providers shall elicit the following signs and symptoms associated with monkeypox during history-taking and physical examination such as but not limited to:
      i. Fever, chills, myalgia, back pain, asthenia, or lymphadenopathy;
      ii. Skin lesions such as vesicles or pustules that are deep-seated, firm or hard, well-circumscribed, and usually located on the head, palms and soles. The rash associated with monkeypox can be confused with other diseases that are more commonly encountered in clinical practice (e.g., secondary syphilis, herpes, chancroid, and varicella zoster);
      iii. Lesions that umbilicate or become confluent and progress over time to scabs.
   c. Primary care providers shall observe a high index of suspicion for monkeypox when evaluating people with the characteristic skin lesions, particularly for the following groups:
      i. People reporting contact with people who have a similar rash or have received a diagnosis of suspected or confirmed monkeypox;
      ii. People reporting sexual contact with the same sex or with multiple partners, and who present with lesions in the genital/perianal area; and
      iii. People reporting a significant travel history in the month before illness onset.
   d. Primary care providers shall observe standard environmental sanitation protocols, including adequate decontamination and disinfection, after each patient encounter.

5. **Environmental Sanitation (Home, Establishment, Health Facility)**
   a. Ensure that procedures are in place for cleaning and disinfecting environmental surfaces at home, establishments, and especially health facilities:
      i. At home, contaminated surfaces shall be cleaned and disinfected. Any FDA registered standard household cleaning/disinfectants may be used following the manufacturer's instructions;
      ii. At the establishments, in case of possible contamination of monkeypox virus, any FDA registered industrial grade cleaner/disinfectant whether alcohol or chlorine-based may be used particularly following the manufacturer's recommendations for concentration, contact time, and care in handling (information may be found in the Safety Data Sheet);
      iii. At the health facilities, any FDA registered industrial or hospital-grade alcohol-based or chlorine-based disinfectant may be used and particularly following the manufacturer's recommendations for concentration, contact time, and care in handling (information may be found in the Safety Data Sheet).

B. Detection

1. The main objective of detection is to rapidly identify cases, contacts, and clusters to provide rapid containment, appropriate clinical care, and prevent further transmission.
2. Monkeypox shall be considered a notifiable disease as defined under Republic Act No. 11332 (Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act) and its Implementing Rules and Regulations.
3. Samples shall be collected from all individuals fitting case definitions for suspect or probable case.
4. Samples of suspect or probable cases of monkeypox shall be coordinated with the Epidemiology Bureau for referral to the appropriate laboratory facility for confirmatory testing.
5. At the points of entry, the BOQ shall conduct symptom-based screening for monkeypox for all incoming international travelers, especially those individuals who came from countries with reported monkeypox cases. Symptom-based screening shall aim to capture the symptoms described in the case definitions for patients under investigation or suspect cases of monkeypox **(refer to *Annex A1*)**.
6. The BOQ shall immediately coordinate suspected cases to the EB and designated referral hospitals for further assessment, testing, and management.
7. Guidelines for public health surveillance are as follows:
    a. For humans
        i. All primary care providers, clinicians, public health authorities, points of entry, and institutions/offices shall notify the DOH of any suspect, probable, or confirmed case within 24 hours of detection;
        ii. Surveillance case definitions for monkeypox are found in ***Annex A1***;
        iii. Reporting of cases or contacts shall utilize the Case Investigation Form (CIF) attached as ***Annex B*;**
        iv. Case investigation shall focus on:
            1. Exposure investigation (back tracing) within 21 days prior to symptom onset;
            2. Characterization of clinical presentation; and
            3. Tracing and profiling of identified contacts.
        v. Contacts shall be quarantined and closely monitored at least a period of 21 days from the last contact with a patient or their contaminated materials during the infectious period.
    b. For animals
        i. Shipments of rats and primates shall be strictly monitored by the Department of Agriculture (DA), Department of Environment and Natural Resources (DENR), and Bureau of Customs (BOC) for animals with monkeypox symptoms.
8. Laboratory confirmation of monkeypox shall be done through the Reverse Transcription Polymerase Chain Reaction (RT-PCR) and/or whole-genome sequencing of skin lesion samples and other samples, as may be included in future policies.
    a. Two samples shall be collected and shall need to have sufficient volume to be able to accommodate parallel testing for differential diagnosis and whole-genome sequencing (WGS);
    b. Sample collection guidelines can be found in *Annex C*;

d. The second sample shall be sent to RITM for confirmatory testing through RT-PCR;
e. The RITM may opt to send out samples for PCR confirmation by its partner facility in Australia.

9. Reporting and Recording
   a. Cases reported to the RESU and EB using the CIF ***(Annex B)*** shall be recorded into a line list. The RESU and EB shall generate analysis and case bulletins on a regular basis.

Isolation/Quarantine

1. **Isolation Facilities (depending on the risk of the patient)**
   a. During the activation of Doors 1 and 2 of DOH's 4-Door Alert System, the RITM is hereby designated as the main isolation facility for suspect, probable, and confirmed monkeypox cases. Regional isolation facilities/hospitals catering to other international points of entry shall be designated by the DOH Field Implementation and Coordination Team (FICT) and One Hospital Command Center (OHCC);
   b. All government hospitals shall prepare an area for isolation and treatment facilities in the event that Doors 3 and 4 are activated;
   c. Cases shall be immediately isolated in a private room, preferably with negative air pressure, until signs and symptoms have been resolved.

2. **Quarantine**
   a. The DOH will designate dedicated isolation and quarantine facilities. Travelers coming in from countries with confirmed community transmission who meet the criteria for suspect, probable, or confirmed case shall be isolated. Close contacts of the cases shall be quarantined. The quarantine facility will be nearby the point of entry or within the region where the point of entry is located, if possible;
   b. Infection prevention and control must be strictly observed during transfer of patients from point of entry to quarantine facility;
   c. The DOH will instruct the BOQ, DOH-CHD, RESU and other concerned bureau to operate and maintain these quarantine facilities;
   d. All patients under quarantine who manifest signs and symptoms of monkeypox shall be immediately transferred to the dedicated referral hospital for treatment;
   e. All patients under quarantine who manifest signs and symptoms not related to monkeypox shall be treated onsite by a licensed physician and may refer to an infectious disease specialist, if necessary.

Treatment

1. Treatment for Monkeypox is mainly supportive and is directed at relieving symptoms such as fever, body malaise, and exhaustion.
2. Use of antipyretics, anti-inflammatory, and non-steroidal anti-inflammatory drugs (NSAIDS) may be warranted.

E. Reintegration

1. Discharge guidelines

a. Recovering adults shall continue to observe infection control;
b. Parents/Guardians of recovering children younger than 12 years shall likewise ensure compliance to infection control measures;
c. Individuals within the households, communities, schools and workplaces including key populations shall continuously observe infection control measures.

2. Precautions for the home

a. All household members shall practice hand hygiene especially:
    i. Before, during, and after preparing food;
    ii. Before and after meals;
    iii. Before and after use of the bathroom;
    iv. Before and after handling animals or animal waste;
    v. More frequently when someone in the home is sick;
b. All household members shall avoid touching the eyes, nose or mouth with unclean hands;
c. Members of the household shall clean and disinfect household surfaces likely to be contaminated by infectious secretions;
d. Individuals who have come into close contact with sick animals, or with other people with signs or symptoms of monkeypox such as skin rashes accompanied by fever, intense headache, lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle aches) and intense asthenia (lack of energy), and /or skin eruption, shall immediately isolate and contact the DOH Health Emergency Management Bureau Operations Center at +63 (2) 8711-1001, +63 (2) 8711-1002. The general public is reminded to be aware and get the right information from the DOH or their respective local health offices.

3. Reintegration to the Workplace (in the case of a worker who has recovered from an infection):

a. Clearance to return to work shall be provided by the attending physician and subsequently verified by the Human Resource Officer or the Occupational Health Physician;
b. A reintegration plan shall be implemented to bring back the worker's confidence in performing tasks, avoid possible stigma, and maintain confidentiality in terms of his medical condition;
c. Ensure constant implementation of the minimum public health standards as appropriate;
d. Employers shall ensure/arrange for the provision of workplace entitlements. (e.g. use of leave credits, medical benefits, alternative work arrangement)

IV. Disposal of Dead Bodies

Guidelines on the handling and disposal of dead bodies due to a confirmed, probable, or suspected case of Monkeypox shall follow the provisions of Chapter XXI Disposal of Dead Persons of the Code on Sanitation of the Philippines PD 856 and its Revised Implementing Rules and Regulations. Reference citations were based on Annex 7 "Prescribed Sanitation Requirements on the Handling and Disposal of Dead Persons When the Cause of Death is Dangerous Communicable Disease," as appropriate.

A. Handling of Remains

1. Removal of the Body of Suspect, Probable, and Confirmed Monkeypox Cases from Isolation Room or Area in a Healthcare Facility
    a. All healthcare personnel, support staff, and funeral parlor workers, among others, shall wear appropriate PPE before handling the human remains.
    b. All tubes, drains, and catheters shall be removed with extreme caution and disposed of properly.
    c. Implants (e.g. pacemaker, orthopedic implants) in the cadaver shall not be removed to minimize exposure of personnel handling the body. In this case, the body shall be buried instead of cremated.
    d. Wound drainage and needle puncture holes shall be disinfected and dressed with impermeable material.
    e. Wrap the body with cloth and place it in the airtight cadaver bag that is leak-proof and zip or close tightly with tapes and bandage strips. For patients with Islamic faith, double cadaver bags with thickness of not less than 150 pm shall be used.
    f. Decontaminate surface of the bag with hypochlorite solution (50-100 ppm) or one-in-four diluted household bleach (mixing | part of 5.25% bleach with 4 parts of water).
    g. If the family of the patient wishes to view the body after removal from the isolation room or area, they may be allowed for as long as standard precautions are strictly followed.
    h. Ensure that the body is fully sealed in an impermeable airtight cadaver bag before being removed from the isolation room or area and before transfer to mortuary or crematorium, to avoid leakage of body fluid.
    i. Properly dispose of the PPE used and wash hands with liquid soap and water immediately.

2. Removal of Body of Suspect, Probable, and Confirmed Monkeypox Cases who were Quarantined in a Non-Healthcare Facility
    a. The relative of the deceased shall coordinate with the local government for the proper disposal of the remains who are quarantined in a non-healthcare facility (e.g. home).
    b. Only authorized personnel (e.g. health personnel and support staff, LGU team for management of the dead and missing persons, funeral parlor workers) shall be allowed to handle the human remains.
    c. All must wear appropriate PPE before handling the human remains.
    d. All attached apparatuses, if any, such as tubes, drains, catheters on the human remains, should be removed with extreme caution and placed in a leak-proof

f. The body should be wrapped with cloth, or robust and leak-proof transparent plastic bag, and placed in the airtight cadaver bag that is leak-proof and shall be zipped or closed tightly with tapes and bandagestrips and properly labeled.
g. The outside or surface of the cadaver bag should be decontaminated with hypochlorite solution (50-100 ppm) or one-in-four diluted household bleach (mixing | part of 5.25% bleach with 4 parts of water) and allow the air to dry.
h. Ensure that the human remains are fully sealed in an impermeable airtight cadaver bag before being removed from the room or area and before transfer to the mortuary, to avoid leakage of body fluids.
i. When properly packed, the body can be safely removed from storage in the mortuary and transported to the crematorium,or placed in a coffin for burial.
j. At no instance shall unzipping the cadaver bag of the body and removal of the body be permitted.
k. The accredited/identified funeral establishment shall provide transport. If not available, the LGU shall provide transportation to the burial site/crematorium.
l. The household shall be advised to clean and disinfect the room occupied by the deceased immediately after the body was removed.
m. All soiled linens and fabrics by the deceased shall be properly washed and disinfected.

3. Transfer to Funeral Home/Crematorium
   a. The accredited/identified funeral establishment/crematorium shall provide proper transport. Otherwise, the concerned Local Government Unit (LGU)shall assist in securing the services of a funeral establishment which will transport the remains to the burial site/crematorium.
   b. The body shall be fully sealed in a cadaver bag and decontaminated as not to pose additional risk to the staff transporting the dead body.
   c. At no instance shall unzipping the cadaver bag of the body and removal of the body be permitted.
   d. Embalming and hygienic preparation, such as cleaning of the body, tidying of hair, trimming of nails and shaving shall not be allowed.
   e. The personnel handling the body shall wear at the minimum a mask, gloves, water-resistant gown/apron, and goggles as protection if there be splashes.
   f. The vehicle used for transport shall be disinfected immediately following proper disinfection protocol.
   g. Dispose properly the PPE used and wash hands with liquid soap and water immediately.

4. Procedures for Burial and Cremation
   a. The procedures for burial and cremation shall be done within 12 hours after death. However, burial of remains should be in accordance with the person's religion and culturally-acceptable norms, to the most possible extent (e.g. in Islamic rites, cremation is forbidden or "haram").
   b. The staff should practice hand hygiene, use of masks, gloves, goggles and water-resistant gown/apron as standard precautions.
   c. Transportation shall be provided by the funeral home to the burial site.
   d. Large gatherings at the crematorium/ burial ground should be avoided.
   e. For those that will be buried:

3. LEADERSHIP & MANAGEMENT-No Entry

4. HUMAN RESOURCE MANAGEMENT-No entry

5. INFORMATION MANAGEMENT

GUIDELINES IN ADOPTING PROOF OF SUBMISSION TO THE NATIONAL DATABASE HUMAN RESOURCES FOR HEALTH INFORMATION (NDHRHIS) BY DOH REGULATED HEALTH FACILITIES

The LGU specifically will adopt Department Circular 2022—0492 in order to strengthen the data collection system concerning human health resources and be used as reliable database to guide RHU personnel

STRENGHTENING OF THE IMPLEMENTATION AND MONITORING OF THE INTEGRATED CLINIC INFORMATION SYSTEM (iClinicSys)

The LGU shall adopt the iClinicSys is an advanced electronic medical record (EMR) system utilized by the Department of Health. It is a comprehensive and efficient software solution designed to streamline and enhance the management of medical records and patient information in healthcare facilities. iClinicSys offers a wide range of features and functionalities that facilitate the seamless storage, retrieval, and analysis of patient data.

With iClinicSys, healthcare professionals can securely store and access patient records, including medical history, diagnosis, treatment plans, and test results. The system ensures data accuracy and integrity, reducing the risk of errors and enabling healthcare providers to make informed decisions based on reliable information. It also allows for easy collaboration and communication among healthcare teams, promoting efficient and coordinated care.

One of the key advantages of iClinicSys is its user-friendly interface, which simplifies the process of documenting patient encounters, ordering tests, and generating reports. The system supports customization, enabling healthcare organizations to adapt it to their specific workflows and requirements.

Furthermore, iClinicSys incorporates robust security measures to protect patient confidentiality and comply with data privacy regulations. It employs encryption, access controls, and audit trails to safeguard sensitive information, providing peace of mind to both patients and healthcare providers.

In summary, iClinicSys serves as a valuable tool for the Department of Health, enabling healthcare professionals to efficiently manage and access patient records, enhance communication and collaboration, and ultimately deliver high-quality care.

GUIDELINE ON ADOPTION OF ICLINICSYS FOR FHSIS REPORTING

The LGU shall adopt the use of FHSIS on iClinicsys in order to digitize inorder to have patients records accessible throughout province wide

GUIDELINES IN ADOPTING THE NATIONAL ARCHIVES OF THE PHILIPPINES CIRCULAR NO.2 ENTITLED "GUIDELINES ON THE DISPOSAL OF VALUELESS RECORDS IN GOVERNMENT, RECORDS DISPOSITION SCHEDULES AND TEMPLATES

1. Purpose The purpose of this policy is to outline the adoption and implementation of the National Archives of the Philippines (NAP) Circular No. 2 on the Disposal of Value Less Records within RHU. This policy aims to establish guidelines and procedures for the efficient and systematic disposal of records that no longer hold any significant value, while ensuring compliance with legal and regulatory requirements.
2. Scope This policy applies to all departments, divisions, units, and employees of RHU] who handle or manage records in any format, including but not limited to physical documents, electronic files, audiovisual materials, and other relevant media.
3. Definitions
   3.1. National Archives of the Philippines (NAP): The national agency responsible for the preservation, management, and disposal of public records in the Philippines.

   3.2. Disposal: The process of removing records from the active files and determining their a appropriate disposition, which may include destruction, transfer, or permanent preservation.

   3.3. Value Less Records: Records that have no enduring administrative, legal, fiscal, research, or historical value, as determined by the NAP guidelines.

4. Policy Statement
   4.1. [Organization Name] recognizes the importance of efficient records management and acknowledges the authority and expertise of the National Archives of the Philippines in matters related to the disposal of value less records.

   4.2. RHU shall adopt and adhere to the guidelines outlined in the National Archives of the Philippines Circular No. 2 on the Disposal of Value Less Records for all records under its custody.

   4.3. All departments and employees of RHU shall cooperate and comply with the procedures established by the NAP for the disposal of value less records.
5. Responsibilities
   5.1. National Archives of the Philippines (NAP)
   5.1.1. The NAP shall provide guidance, training, and support to [Organization Name] in implementing the Circular No. 2 on the Disposal of Value Less Records.
   5.1.2. The NAP shall periodically update its guidelines and provide necessary notifications to [RHU] regarding any changes or amendments.

   5.2. RHU
   5.2.1. The designated Records Management Officer or department shall oversee the implementation of the NAP Circular No. 2 within RHU.
   5.2.2. The Records Management Officer shall coordinate with the NAP and ensure that all employees are aware of and trained on the guidelines for the disposal of value less records.
   5.2.3. Each department and employee shall be responsible for identifying, segregating, and submitting value less records to the Records Management Officer for proper disposal in accordance with the NAP guidelines.

6. Procedures

6.1. Identification of Value Less Records

6.1.1. Each department shall regularly assess their records and identify those that have no enduring administrative, legal, fiscal, research, or historical value.

6.1.2. The Records Management Officer shall provide guidance and training to department heads and employees on identifying value less records.

6.2. Segregation and Submission

6.2.1. Departments shall segregate the identified value less records from active files and ensure they are properly labeled or tagged for disposal.

6.2.2. The Records Management Officer shall establish a centralized location for the collection and temporary storage of value less records.

6.3. Disposal Methods

6.3.1. Destruction: Value less records shall be securely destroyed through appropriate methods, such as shredding, pulping, or incineration,

GUIDELINES ON THE DISPOSAL OF VALUELESS RECORDS IN GOVERNMENT AGENCIES

ARTICLE I
COVERAGE

Rule 1.

This circular prescribes uniform standards or guidelines to be followed by government agencies in the disposal or destruction of their valueless records.

These guidelines on the Disposal of Valueless Records in Government Agencies consist of six (6) parts: (1) Coverage, (2) Definition of Terms, (3) General Requirements on the Disposal of Valueless Records, (4) Records Disposal Procedures, (5) Offenses and Penalties, and (6) Miscellaneous Provisions.

Attached to these guidelines is the General Records Disposition Schedule (GRDS) common to ALL GOVERNMENT AGENCIES.

ARTICLE II
DEFINITION OF TERMS

Rule 2. Definition

Administrative Value – refers to the usefulness of records to the originating or succeeding agency in the conduct of current business;

Agency – refers to any agency other than the National Archives of the Philippines;

Agency Personnel Concerned – refers to Agency Records Officer/Archivist/Records Custodian;

Appraisal – refers to the study of records, their relationships and contents, to determine their utility values as to administrative, fiscal, legal, and archival value and time values whether temporary or permanent;

Authorized Representative – refers to official/employee given the right to act as witness in the disposal of valueless records;

Authority – refers to a conclusive statement leading to an official decision;

Authority to Dispose of Records – refers to written permission issued by the Executive Director of the National Archives of the Philippines (NAP) to government agencies for the destruction of valueless records;

Disposal – refers to the act of selling, landfill/ burying, or any other way of discarding valueless records in accordance with the provision of R.A. 9470;

Disposal Procedures – refer to series of steps in the disposal of valueless records;

Economical Disposal – refers to management ways of discarding valueless records that will generate savings in terms of space, equipment, manpower and other source of income;

Evaluation – refers to the act of examining disposable records in order to assess their value, quality, importance and extent of physical condition;

Examination – refers to the process of looking at and considering something carefully;

Executive Director – refers to the head of the National Archives of the Philippines;

Financial Records – refer to records created and maintained by the agency about their financial transactions and obligations;

Fiscal Value – refers to the relative worth or usefulness of records pertaining to financial transactions and obligation of agencies and organization;

General Records Disposition Schedule – refers to a records control schedule governing the disposition of specified recurring records series common to all government agencies issued by National Archives of the Philippines;

Inventory – refers to a descriptive listing of the records holding by record series indicating its specific location, inclusive dates and volume in cubic meters; conduct of related activities to locate, identify,

describe, count, and measure all records in the office and storage area including all loose and bound papers, microfilms, optical disks, and magnetic tapes and disks;

Legal Value – refers to the value of records containing evidence of legally enforceable rights or obligations of government and/or private person;

Letter of Availment – refers to letter of agencies availing the services of the NAP official buyers of valueless records;

Mode of Disposal – refers to destruction of valueless records by Sale, Landfill/ Burying or any other ways;

Permanent Records – refer to records which usefulness are worthy of preservation because of their administrative, legal and/ or archival (historical and research) significance;

Public Records – refer to records or classes of records, in any form, in whole or in part, created or received, whether before or after the effectivity of R.A. 9470, by a government agency in the conduct of its affairs, and have been retained by that government agency or its successors as evidence or because of the information contained therein;

Records – refer to information, whether in its original form or otherwise, including documents, signatures, seals, texts, images, sounds, speeches, or data compiled, recorded, or stored, as the case may be:

(1) in written form on any material; or

(2) on film, negative, tape, or other medium so as to be capable of being reproduced; or

(3) by means of any recording device or process, computer, or other electronic device or process;

Records Disposition – refers to the systematic transfer of non-current records from office to storage area, identification and preservation of archival records and the destruction of valueless records;

Records Disposition Schedule – refers to a listing of records series by organization showing, for each records series the period of time it is to remain in the office area, in the storage (inactive) area and its preservation or destruction;

Records Series – refer to a group of related records arranged under a single unit or kept together as a unit because they deal with a particular subject, result from the same activity or have a special form;

Request for Authority to Dispose of Records – refers to NAP Form No. 3 used in the disposal of valueless records;

Requesting Agency – refers to any agency other than the National Archives of the Philippines who have filed a request for authority to dispose of records;

Retention Period – refers to the specific period of time established and approved by the National Archives of the Philippines as the life span of records, after which they are deemed ready for permanent storage or destruction;

Temporary Records – refer to records that already serve the purpose for which they had been created;

Valueless Records – refer to all records that have reached the prescribed retention periods and outlived the usefulness to the agency or the government as a whole;

Volume of Records – refers to quantity of records in terms of cubic meter.

ARTICLE III

GENERAL REQUIREMENTS ON DISPOSAL OF VALUELESS RECORDS

Rule 3. General Requirements

3.1. Use the General Records Disposition Schedule (GRDS), Agency Records Disposition Schedule (RDS) and/or specific laws and regulations in determining public records for disposal.

3.2. Ensure that only records with a Disposal Schedule are destroyed after the completion of its period for storage.

3.3 Ensure that records to be disposed have a number and subject/title as in the Agency Records Disposition Schedule and General Records Disposition Schedule.

3.4. Conduct periodic examination of agency files at least once a year to identify valueless records that can be requested for disposal.

3.5. Separate the records for disposal from those for further retention as suggested by the National Archives of the Philippines.

3.6. Do not dispose any public records under their administration and control without authority from the National Archives of the Philippines.

3.7. Do not dispose public records that are involved in any case until they are finally decided upon or settled.

3.8. Do not dispose financial records that are subject of audit by the Commission on Audit until they are post-audited and finally settled.

ARTICLE IV

DISPOSAL PROCEDURES

Rule 4. Determination of Valueless Records for Disposal

4.1. Agency personnel concerned shall determine the valueless records by checking their specific and authorized retention periods using the agency's RDS, GRDS and/or specific laws and regulations as the legal basis.

4.2. Agency personnel concerned shall estimate the volume of the valueless records to determine and facilitate economical disposal.

Rule 5. Request for Authority to Dispose

5.1 Agency personnel concerned shall accomplish the Request for Authority to Dispose of Records (NAP Form No. 3) in three (3) copies and properly fill-up the specific record series, period covered, volume and authorized retention periods in the Agency RDS, GRDS and/or specific laws and regulations are complied with such as:

5.1.1. financial records that are subject of audit by the Commission on Audit (COA) were post-audited and finally settled, and

5.1.2. the records involved in a case or investigation were finally decided upon or settled.

5.2. Upon completion of Request for Authority to Dispose of Records and the agency officials concerned have approved and signed the request, agency personnel concerned shall submit the same to NAP.

Rule 6. Evaluation of Disposable Records

6.1. Upon receipt of the Request for Authority to Dispose of Records, the same shall be forwarded to the Chief of Records Management Services Division (RMSD) for NCR and Luzon requests; Head of Cebu Regional Archival Network (RAN) for Visayas requests and Head of Davao Regional Archival Network (RAN) for Mindanao requests.

6.2. The Chief of RMSD/Cebu RAN/Davao RAN concerned shall assign a division staff to evaluate the valueless records requested for disposal who shall then prepare and submit an analysis report based on his/her evaluation and/or examination.

Rule 7. Authority to Dispose

7.1. The Executive Director, upon the recommendation of the Chief of RMSD and based upon his/her final evaluation and judgment shall issue the Authority to Dispose of records indicating therein the mode of disposal.

Rule 8. Notification of Actual Disposal

8.1 Upon approval of the Request for Authority to Dispose of Records, the requesting agency shall be notified on its approval.

8.1.1. In case the mode of disposal is by Sale, the guidelines on Government Procurement shall be followed in the selection of contracted buyer. A copy of the contract shall be submitted to NAP prior to the actual disposal. For agencies that opted to avail the services of NAP official buyer, a letter of availment shall be submitted to NAP.

8.2 The Chief of RMSD/Cebu RAN/Davao RAN concerned shall inform the requesting agency on the actual date of disposal, who in turn will notify its Resident Auditor on the date of actual disposal.

Rule 9. Segregation and Custody of Valueless Records

9.1 The Records Officer/Archivist/Records Custodian of the agency shall supervise the segregation of valueless records and be responsible for their safekeeping until their actual disposal.

Rule 10. Actual Disposal

10.1. Actual disposal shall be witnessed by Authorized Representatives from the requesting agency, NAP and COA to ensure that the records to be disposed of are the same records that were authorized for disposal.

10.2. Witnessing of actual disposal by NAP authorized representative shall be dispensed with for those agencies that have been compliant with all the government recordkeeping requirements as ascertained by NAP or in instances deemed appropriate and expedient by the Executive Director based on economy, nature of records series involved and track records of the agency.

Rule 11. Certificate of Disposal

11.1. A Certificate of Disposal shall be prepared in three (3) copies by the NAP authorized representative who will witness the actual disposal of records and ensure that all pertinent data are complete.

11.2. In cases where the witnessing by NAP authorized representative is dispensed with, Records Officer/ Archivist/records Custodian of the agency shall prepare the said Certificate of Disposal in three (3) copies.

11.3. The distribution of copies shall be as follows: Requesting Agency – Original Copy; NAP – 2nd Copy and COA – 3rd Copy.

Rule 12. Proceeds of Sale

12.1 All proceeds realized from the sale of valueless records shall be remitted either to the National Fund, Local Government Fund, Revolving or Trust Fund.

Rule 13. Disposal of Damaged Public Records

13.1. Disposal of damaged permanent public records and damaged public records that have not yet passed their prescribed retention periods shall be considered for authorized disposal only upon submission to NAP of the following requirements:

13.1.1. Official Report pertaining to the non-usability and extent of damage done to the records, causes of the damage to the public records; photo documentation and information on what other agency records series can the data or information of the damaged public records be found;

13.1.2. Request for Authority to Dispose of Records (NAP Form No. 3) in three (3) copies and properly filled-up with the specific records series, period covered and volume of the damaged public

NAP Form No. 3
Revised 2012

Accomplish in 3 copies

NATIONAL ARCHIVES OF THE PHILIPPINES
Pambansang Sinupan ng Pilipinas

REQUEST FOR AUTHORITY TO DISPOSE OF RECORDS

AGENCY NAME:		
ADDRESS:		
DATE	**TELEPHONE NUMBER:**	**EMAIL ADDRESS:**

GRDS/ RDS ITEM NO.	RECORD SERIES TITLE AND DESCRIPTION	PERIOD COVERED	RETENTION PERIOD AND PROVISIONS/S COMPLIED (*if Any*)

LOCATION OF RECORDS:	**VOLUME IN CUBIC METER:**
PREPARED BY: (Name & Signature)	**POSITION:**

CERTIFIED AND APPROVED BY:

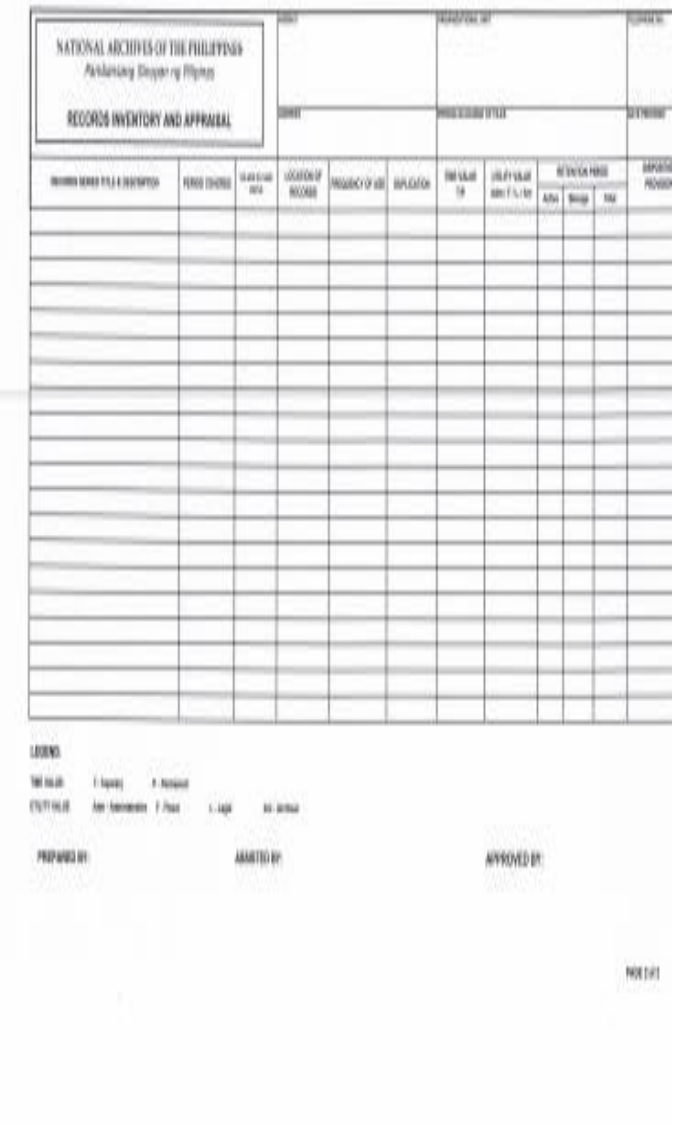
This is to certify that the above-mentioned records are no longer needed and not involved nor connected in any administrative or judicial cases.

Name and Signature of Agency Head
or Duly Authorized Representative

NATIONAL ARCHIVES OF THE PHILIPPINES
Pambansang Sinupan ng Pilipinas

RECORDS INVENTORY AND APPRAISAL

LEGEND:



NATIONAL ARCHIVES OF THE PHILIPPINES
Pambansang Sinupan ng Pilipinas

RECORDS INVENTORY AND APPRAISAL

LEGEND:

PREPARED BY: ATTESTED BY: APPROVED BY:

NAP Form No. 2
2008

NATIONAL ARCHIVES OF THE PHILIPPINES
Pambansang Sinupan ng Pilipinas
RECORDS DISPOSITION SCHEDULE

1. AGENCY NAME: **DEPARTMENT OF HEALTH**
2. ADDRESS: San Lazaro Compound, Sta. Cruz, Manila
3. SCHEDULE NO.: 2 (Revision)
4. DATE PREPARED: January 12, 2016

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	ADMINISTRATIVE SERVICE RECORDS				
1	ACKNOWLEDGEMENT RECEIPT FOR EQUIPMENT	3 years		3 years	After issuance of clearance/after property had been returned
2	ADMINISTRATIVE SERVICE MANUAL OF PROCEDURES	PERMANENT			
3	REQUESTS Job Order Overtime Vehicle	2 years		2 years	After acted upon
	BUREAU OF INTERNATIONAL HEALTH COOPERATION RECORDS				
4	FOREIGN ASSISTED PROJECT RECORDS	5 years		5 years	After submission of project completion report
5	LEGAL RECORDS Bilateral Agreements Memorandum of Agreement/Understanding Memoire	PERMANENT			
6	PROGRAM RECORDS Exchange Visitor Sector Development	PERMANENT			If implemented, otherwise, dispose five (5) years from the date of record
7	PROJECT COMPLETION REPORT	PERMANENT			
	BUREAU OF LOCAL HEALTH SYSTEMS DEVELOPMENT (BLHSD) RECORDS				
8	MANUALS Barangay Health Workers Inter-local Health Zone	PERMANENT			
9	PLANS Annual Operational Investment	2 years	3 years	5 years	

NATIONAL ARCHIVES OF THE PHILIPPINES
RELEASED
TR No.: BY:

IMPORTANT: Pursuant to Section 18, Article III, RA 9470 s. 2007, "No government department, bureau, agency and instrumentality shall dispose of, destroy or authorize the disposal or destruction of any public records, which are in the custody or under its control except with the prior written authority of the executive director."

2008

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	CENTER FOR DEVICE REGULATION, RADIATION HEALTH AND RESEARCH (CDRRHR) RECORDS				
10	CERTIFICATES INCLUDING APPLICATIONS AND REQUIREMENTS Certificate of Compliance for X-ray Facility Certificate of Product Registration for Water and Water Treatment Magnetic Resonance Imaging (MRI) Registration Power Lines	1 year 3 years 1 year PERMANENT		1 year 3 years 1 year	From the date of expiration From the date of expiration From the date of expiration
11	CLEARANCES Custom Release (CFCR) Non-Radiating Emitting	1 year		1 year	From the date of expiration
12	PERMIT TO OPERATE LINEAR ACCELERATOR INCLUDING APPLICATION AND REQUIREMENTS	1 year		1 year	From the date of expiration
13	REPORTS Performance/Conformance Testing Quarterly Submitted Film Badges Radiation Protection Survey & Evaluation (RPSE) Radiofrequency Radiation (RFR) Evaluation Radiofrequency Radiation (RFR) Measurement	PERMANENT 2 years 2 years PERMANENT PERMANENT		2 years 2 years	After superseded
	DISEASE PREVENTION AND CONTROL BUREAU (DPCB) RECORDS				
14	GANTT CHART OF ACTIVITIES PER PROGRAM	2 years		2 years	After superseded
15	HEALTH MONITORING TOOLS	2 years		2 years	
16	HEALTH SURVEY FILES Questionnaires Result/Summary	1 year PERMANENT		1 year	After evaluated
17	LISTS Event-Based Surveillance and Response Special/Big Events	2 years		2 years	After updated
18	LOGBOOKS OF MEDICINES ISSUED	2 years		2 years	After date of last entry
19	PROGRAM BRIEFER	PERMANENT			
20	REPORTS Inception Monitoring Program Assessment	2 years		2 years	

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4. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	EPIDEMIOLOGY BUREAU (EB) RECORDS				
21	EMERGING DISEASES RECORDS	PERMANENT			
22	FIELD HEALTH SERVICE INFORMATION SYSTEM RECORDS	PERMANENT			
23	INTEGRATED HUMAN BEHAVIOR SEROLOGIC FILES Data Set Injecting Drug User (IDU) Female Sex Worker (FSW) Freelance Female Sex Worker (FFSW) Male Sex with Male Registered Female Sex Worker (RFSW) Raw Data Set	PERMANENT			
24	MASTERLISTS OF CERTIFIED MEDICAL CODERS (ICD-10)	PERMANENT			
25	REPORTS Annual Field Health Service Information System FHSIS Executive Summary Results Global Adult/Youth Tobacco Survey Integrated Human Behavior Serologic Post Activity Report Response Report Philippine Health Statistics Preliminary Blood Transfusion Sentinel Sexually Transmitted Infection Serologic Results Technical Assistance Visit Vaccination Vaccine Preventable Disease Progress	PERMANENT			
	Disease Surveillance	2 years	3 years	5 years	
	Etiologic Surveillance System	2 years	3 years	5 years	
	Event-Based Surveillance & Response	2 years	3 years	5 years	
26	TRAINING PROGRAM RECORDS Field Epidemiology Field Management	PERMANENT			
	FINANCE SERVICE (FS) RECORDS				
	ACCOUNTING				
27	AUDIT OBSERVATION MEMORANDA	2 years	5 years	7 years	After acted upon and cleared by COA
28	BANK RECONCILIATION STATEMENT	3 years	7 years	10 years	

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4. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
29	BUDGET UTILIZATION REQUEST	3 years		3 years	
30	DAILY CASH FLOW	4 years		4 years	
31	DETAILED BREAKDOWN OF DISBURSEMENTS	2 years	5 years	7 years	
32	GENERAL LEDGER BALANCES	PERMANENT			
33	LIST OF EMPLOYEES WITH HOLD/ RELEASE OF SALARY AND OTHER BENEFITS	1 year		1 year	After updated
34	REPORTS Collection and Deposit Disbursement Liquidation	5 years	5 years	10 years	Provided post-audited and finally settled
35	TAX REMITTANCE ADVICE	5 years	5 years	10 years	
	BUDGET				
36	AGENCY BUDGET MATRIX	2 years	3 years	5 years	
37	ANNUAL BUDGET PROPOSAL	3 years		3 years	
38	CERTIFICATION OF AVAILABILITY OF FUNDS	3 years		3 years	
39	NOTICE OF TRANSFER OF CASH ALLOCATION	3 years		3 years	
40	OBLIGATION REQUEST	5 years	5 years	10 years	
41	REGISTRY OF ALLOTMENT	5 years	5 years	10 years	
42	STATEMENT OF ALLOTMENT AND OBLIGATION	5 years	5 years	10 years	
43	SUB-ALLOTMENT ADVICE	5 years		5 years	
44	WORK AND FINANCIAL PLAN	3 years		3 years	
	CASHIER				
45	ADVICE OF CHECKS ISSUED AND CANCELLED	4 years		4 years	
46	BANK SLIPS	5 years	5 years	10 years	
47	NOTICE OF CASH ALLOCATION	3 years		3 years	
48	OFFICIAL RECEIPTS	5 years	5 years	10 years	Provide post-audited and finally settled

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4. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
49	ORDER OF PAYMENT	5 years	5 years	10 years	
50	REPORTS Accountabilities for Accountable Forms Cash Disbursement Petty Cash Replenishment	3 years 5 years 5 years	5 years 5 years	3 years 10 years 10 years	After cash had been examined Provided post-audited and finally settled Provided post-audited and finally settled
	HEALTH EMERGENCY MANAGEMENT BUREAU (HEMB) RECORDS				
51	HOSPITAL EMERGENCY PREPAREDNESS RESPONSE AND RECOVERY PLANS	PERMANENT			
52	REPORTS Final Reports of Events (Major and Minor) Flash Reports Health Emergency Alert Reporting System (HEARS) Medical Post Team Monitoring and Evaluation Post-Incidents Evaluation Surveillance in Post Extreme and Disaster (SPEED)	PERMANENT			
	HEALTH FACILITY DEVELOPMENT BUREAU (HFDB) RECORDS				
53	DIRECTORY OF PARTICIPANTS	2 years		2 years	After updated
54	HEALTH FACILITY DEVELOPMENT MANUALS	PERMANENT			
55	PLANS Drawing (Schematic) Mastersite Development	PERMANENT			
56	REPORTS Assessment and Monitoring Bi-Annual Nursing Service Evaluation Hospital Statistical Integrated Hospital Operations and Management Program Monitoring Medical Social Services	3 years 4 years 5 years 3 years 3 years 3 years		3 years 4 years 5 years 3 years 3 years 3 years	
57	RESEARCHES	PERMANENT			Except for working papers, which can be dispose of one (1) year from the date of publication

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5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	HEALTH FACILITIES AND SERVICES REGULATORY BUREAU (HFSRB) RECORDS				
58	APPEALS/COMPLAINTS	5 years		5 years	After settled. Resolutions are Permanent
59	CERTIFICATES INCLUDING APPLICATIONS AND REQUIREMENTS Certificate of Accreditation (COA) Certificate of Need (CON) to Construct a Hospital Certificate of Recognition as Certifying Body	2 years		2 years	After the date of expiration, except for Certificate of Registration which is Permanent
60	HEALTH ASSESSMENT TOOLS	2 years		2 years	
61	HEALTH SURVEY FILES Questionnaires Result/Summary	1 year	PERMANENT	1 year	After evaluated
62	LICENSE TO OPERATE INCLUDING APPLICATIONS AND REQUIREMENTS	2 years		2 years	After the date of expiration
63	LOGSHEETS/LOGBOOKS FOR HEALTH FACILITIES	5 years		5 years	After date of last entry
64	MASTERLISTS Certificate of Need (CON) to Construct a Hospital with CON Numbers Regulated Health Facilities	PERMANENT			
65	PERMIT TO CONSTRUCT INCLUDING APPLICATIONS AND REQUIREMENTS	5 years		5 years	After issuance of License to Operate (LTO)
	HEALTH HUMAN RESOURCE DEVELOPMENT BUREAU (HHRDB) RECORDS				
66	LICENSE CERTIFICATES Embalmers Massage Therapists	PERMANENT			
67	SCHOLARSHIP FILES INCLUDING APPLICATION REQUIREMENTS AND SERVICE CONTRACT Foreign Local (Pinoy MD, Midwives and Masteral/ Bachelor in Public Administration) Graduate Scholars who rendered service obligation Graduate Scholars who have yet to render service Scholars who were not able to graduate	3 years		3 years	After completion of service obligation/settlement
68	SERVICE CARDS	PERMANENT			

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5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	HEALTH PROMOTION AND COMMUNICATION SERVICE (HPCS) RECORDS				
69	CLEARANCE ON STANDARD SPECIFICATIONS OF INFORMATION EDUCATION COMMUNICATION (IEC) MATERIALS	1 year		1 year	After delivery had been accepted
70	HEALTH PLANS	2 years	3 years	5 years	
71	INFORMATION EDUCATION COMMUNICATION RECORDS (Flip Charts/Flyers/Pamphlets/Posters)	1 year		1 year	After updated. Retain one (1) copy for reference
72	MEDIA PLACEMENT MONITORING REPORTS	2 years		2 years	
73	PUBLICATIONS Health Beat Philippine Health Advisories	PERMANENT			Record set
	HEALTH POLICY DEVELOPMENT AND PLANNING BUREAU (HPDPB) RECORDS				
74	ANNUAL HEALTH REPORTS	PERMANENT			Except for working papers which can be dispose of five (5) years after incorporated in the Annual Report
75	HEALTH SYSTEM RESEARCH MANAGEMENT FILES Health Policy Notes Health Research Agenda Research Dissemination and Utilization Research Forum Proceedings	PERMANENT			
76	MASTERLISTS OF HEALTH RESEARCH PROJECTS	PERMANENT			
77	MINUTES OF MEETINGS ExeCom National Staff Meeting Research Hub Minutes	PERMANENT 3 years 3 years	4 years 4 years	7 years 7 years	
	INTERNAL AUDIT SERVICE (IAS) RECORDS				
78	REPORTS Audit/Monitoring Audit Working Papers Financial and Operational Audit Fact Finding Investigation Special Audit	5 years	5 years	10 years PERMANENT PERMANENT	

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5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	KNOWLEDGEMENT MANAGEMENT AND INFORMATION TECHNOLOGY SERVICE (KMITS) RECORDS				
79	CERTIFICATE OF USER'S ACCEPTANCE	PERMANENT			
80	HEALTH FACILITY FILES				
	Profile	2 years		2 years	After updated
	Survey	1 year		1 year	After evaluated
81	HEALTH PROGRAM RECORDS	PERMANENT			If implemented, otherwise, dispose of five (5) years from date of record
82	HEALTH RESEARCHES	PERMANENT			Except for working papers, which can be dispose of one (1) year from the date of publication
83	MAILING FILES Certificate of Mailing Daily Statement & Report of Mailing Mailing Request with Attachments Summary of Mail Processed	3 years		3 years	After settled
84	MANUALS ISO OPERATIONS	PERMANENT			
85	MASTERLIST OF PUBLISHED ADMINISTRATIVE ISSUANCES	PERMANENT			
86	NON-DISCLOSURE AGREEMENT	5 years		5 years	After terminated
87	PERSONNEL FOLDERS (201 FILES) OF VIP's	PERMANENT			
88	REPORTS ON INFORMATION COMMUNICATION TECHNOLOGY	2 years		2 years	
89	REQUESTS	2 years		2 years	After acted upon
90	RESOLUTIONS Inter-Agency ExeCom	PERMANENT			
91	TERMS OF REFERENCE (TOR) WITH CLEARANCE REPORT	PERMANENT			

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5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD: Active	Storage	Total	8. REMARKS
	LEGAL SERVICE (LS) RECORDS				
92	CASES Administrative Civil Civil Service Commission Consumer Court of Appeals Supreme Court	7 years		7 years	After the case has been adjudicated except for decisions which are permanent
93	CERTIFICATE OF NO PENDING CASE	2 years		2 years	
94	LEGAL OPINION	PERMANENT			
95	MEMORANDUM RELATIVE TO CONTRACT	5 years		5 years	
96	ORDER/RESOLUTION	PERMANENT			
	PUBLIC ASSISTANCE UNIT (PAU) RECORDS				
97	GUARANTEE LETTER WITH REQUIREMENTS Abstract/Clinical Records Certificate of Indigency Request Letter Prescription of Medicine	2 years		2 years	After acted upon
	PHILIPPINE NATIONAL AIDS COUNCIL (PNAC) SECRETARIAT RECORDS				
98	AIDS GAZETTE	PERMANENT			
99	CHARTS (PNAC ORGANOGRAM)	PERMANENT			
100	MASTERLIST Consultants Participants	PERMANENT			
101	POSITION PAPER	PERMANENT			
102	PRESS RELEASE	PERMANENT			
103	REPORTS AIDS Medium Term Plan (AMTP) Investment Plan Midterm/Endterm Review Strategic Plan Annual ASEAN Getting to Zero Global AIDS Response Progress National Country	PERMANENT			

NAP Form No. 2
2008

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD: Active	Storage	Total	8. REMARKS
104	TECHNICAL COMMITTEE MEETING FILES Attendance/Confirmation Sheets Minutes of Meeting Photo Documentation Resolutions with attachments	2 years PERMANENT PERMANENT PERMANENT		2 years	
105	TERMS OF REFERENCE OF PNAC TECHNICAL COMMITTEES	PERMANENT			
106	WORKSHOP/TRAINING FILES Attendance/Confirmation Sheets Course Design/Outline/Syllabus Photo Documentation Workshop Proceedings	2 years 1 year PERMANENT PERMANENT		2 years 1 year	After superseded
	PROCUREMENT SERVICE (PS) RECORDS				
107	BIDS AND AWARDS COMMITTEE RECORDS Alternative Modes Public Bidding	5 years		5 years	After contract of winner has been terminated/settled
108	PROCUREMENT PACKAGES WITH PENDING CASES RECORDS	5 years		5 years	After settled/resolved

6. SAFE PRACTICE AND ENVIRONMENT

ADOPTION OF GUIDELINES FOR INCLUSION OF CORONA VIRUS ON THE LIST OF NOTIFIABLE DISEASES FOR MANDATORY REPORTING TO DOH

V. GENERAL GUIDELINES

A. Coronavirus Disease 2019 (COVID-19) is a notifiable disease as per Administrative Order No. 2020-0012 dated March 17, 2020 and its reporting shall be mandatory.

B. The COVID-19 Surveillance shall utilize existing surveillance systems, such as the ILI and SARI surveillance systems and the Event-based Surveillance and Response System, for detection of COVID-19 cases.

C. All DOH hospitals and level three (3) private hospitals and medical centers and health offices of highly urbanized cities shall serve as the sentinel reporting sites for COVID-19 surveillance. Cases seen at non-sentinel hospitals and health centers and results of COVID-19 tests done at laboratory facilities shall also be mandatorily reported.

D. Case definitions for COVID-19 shall be used to ensure proper classification and appropriate management of cases.

E. Laboratory confirmation for COVID-19 remains essential in determining the true burden of this disease.

VI. SPECIFIC GUIDELINES

A. COVID-19 Surveillance System

1. The Epidemiology Bureau (EB) of the Department of Health shall lead in establishing and implementing the **COVID-19 Surveillance System** and cases will be detected through the following:

1.1. Expanded SARI Sentinel Surveillance System

The COVID-19 surveillance shall utilize existing SARI sentinel sites as well as the additional sentinel sites to be identified, including DOH and Level III hospitals and medical centers, as sites for sentinel-based notification of COVID-19 cases.

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1.2. Enhanced ILI Sentinel Surveillance System

The COVID-19 surveillance shall utilize existing ILI sentinel sites as well as the additional sentinels to be identified, prioritizing inclusion of highly urbanized cities, as sites for sentinel-based notification of COVID-19 cases as well as reporting of aggregate ILI data.

1.3. Notification from Health Facilities and Laboratory Facilities

Health facilities, such as hospitals and health centers, shall record and report consultations and/or admissions who fit any of the COVID-19 case definitions. Also, laboratory facilities conducting testing for COVID-19 shall notify DOH, through the set notification system, of individuals who underwent testing for COVID-19 and their results.

1.4. Event-based Surveillance and Response

Clustering or sudden increase of ILI and SARI cases and deaths of unknown etiology shall be reported through the ESR system

2. **Case definitions** for notification shall be based on the current information available and shall be updated accordingly. This amendment shall define the transition from reporting individuals as Patients Under Investigation (PUI) and Persons Under Monitoring (PUM) ***(See Annex A)*** to Suspect, Probable, and Confirmed COVID-19 cases.

   2.1. Suspect case – is a person who is presenting with any of the conditions below.

   a. All SARI cases where NO other etiology fully explains the clinical presentation.

   b. ILI cases with any one of the following:

      ii. with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in an area that reported local transmission of COVID-19 disease during the 14 days prior to symptom onset OR

      iii. with contact to a confirmed or probable case of COVID-19 in the two days prior to onset of illness of the probable/confirmed COVID-19 case until the time the probable/confirmed COVID-19

a. Suspect case whom testing for COVID-19 is inconclusive
b. Suspect who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory or officially accredited laboratory for COVID-19 confirmatory testing

2.3. Confirmed case – any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-certified laboratory testing facility.

i. Case Detection

3.1. SARI and ILI Sites and Other Health Facilities, Providers, and Institutions

The identified SARI and ILI surveillance sites shall detect COVID-19 cases among its consultations and admission using the set case definitions. Other health facilities and providers and other institutions, including hospitals, health centers, and clinics, shall also detect COVID-19 cases among its consultations and admission using the set case definitions.

The ILI sites and identified health offices in highly urbanized cities shall submit weekly aggregate data on total consultations of ILI disaggregated as to age, sex, date of onset of illness, and place of residence.

Case investigation of detected and/or reported suspect, probable, and confirmed COVID-19 cases shall be undertaken by designated or trained disease surveillance officers (DSO) at these facilities using a standard case investigation form ***(See Annex B)***. In the absence of a designated or trained DSO at the facility, personnel of the Infection Control Unit or a similar office, shall conduct the case investigation. In the absence of any personnel capable of conducting case investigations at these facilities, the higher level office shall supervise and provide technical guidance or take the lead. Provincial Epidemiology and Surveillance Units (PESU) shall supervise or take lead for health facilities, providers, and offices and institutions at the municipal and component city and the Regional Epidemiology and Surveillance Unit (RESU) for those in highly urbanized cities and PESU, if latter has limited capability to supervise or lead. The investigation shall include but is not limited to the following: review of medical records, case interview, and laboratory sample collection and its results.

Officials and staff of health facilities and providers and concerned institutions shall comply with the request for access to patient and laboratory records for the purpose of this case investigation.

The health facility where any of these suspect, probable, or confirmed COVID-19 cases are admitted shall conduct daily monitoring of cases as to their status

and consolidate hospital census related to COVID-19 using the set template ***(See Annex C)***. Identified deaths among these cases shall be profiled using the set format.

Confirmed COVID-19 cases assessed as asymptomatic or clinically recovered by their attending physician shall be tested and will be discharged after at least one negative result. Confirmed COVID-19 cases who have clinically recovered or are well with negative results on repeat testing shall be reported as RECOVERED. If said discharged cases develop new signs or symptoms or progression from mild to more serious signs and symptoms, he/she shall be re-admitted once more to isolation and re-testing done. This guideline shall be reviewed and revised accordingly.

3.2. Laboratory Facilities

ALL Laboratory facilities conducting testing for COVID-19 shall notify DOH daily of official results of individuals tested for COVID-19, regardless of the test result.

Laboratory confirmation for COVID-19 shall be performed by the Research Institute for Tropical Medicine (RITM), five (5) sub-national laboratories (SNL) following the Regional Zoning of Services of National Reference and Subnational Laboratories for SARI ***(See Annex D)***, and officially accredited laboratory facilities. Note that this zoning may be updated in subsequent issuances. The RITM and DOH will work to improve the capabilities of these laboratories.

Current available laboratory confirmation for COVID-19 is done through real time/conventional Reverse Transcriptase-Polymerase Chain Reaction (RT-PCR). This may be updated as additional, officially recognized laboratory confirmatory testing becomes available.

Laboratory testing facilities should fulfill the following for it to be officially accredited by RITM as a COVID-19 laboratory confirmation testing facility:

a. Submit a self-assessment to RITM
b. Undergo and pass Proficiency Testing
c. Have five positive samples pass RITM external quality assessment.

If the laboratory does not pass all three criteria, result of any test conducted at their facility shall not be recognized as a laboratory confirmation test but shall still be submitted to DOH.

3.3. Event-based Surveillance and Response System

Local health authorities through the local epidemiology and surveillance units (LESU) shall report all health events, to include rumors of clustering or sudden increase of cases of ILI and SARI and deaths of unknown etiology.

c. Health workers assessed as with high risk of exposure, even in the absence of any sign or symptom
d. Clusters of ILI or SARI

The collection, storage, and transport of specimens from reporting health facility or office to the laboratory shall be facilitated by the designated disease surveillance officer. Laboratory collection shall be done by a trained health staff in the health facility where case was detected and submitted to designated and official laboratory testing facilities. Staff who conduct laboratory sample collection shall be equipped with appropriate and complete personal protective equipment (PPE) during collection of specimens. All cases with laboratory specimens collected shall be coordinated with the RESU.

All collected specimens shall be transported within 48 to 72 hours upon collection and stored at 2 °C to 8 °C. If specimens will not be transported within 72 hours, store the specimen in the freezer.

A laboratory quality assurance of DOH SNL shall be implemented by RITM through its Molecular Biology Laboratory (MBL). The MBL should ensure that a Biosafety, Biosecurity, and Laboratory Quality Assurance team shall be deployed to all DOH SNL.

Other hospitals with existing capacity for laboratory confirmatory testing for COVID-19 shall provide RITM with aliquots of their samples for re-testing as part of Laboratory Quality Assurance.

C. Recording and Notification System

Health authorities from the government and private sectors, including health facilities, laboratory testing facilities, offices, institutions, and individuals, are mandated to report suspect, probable, and confirmed cases of COVID-19 and results of COVID-19 testing done within 24 hours of identification or completion of testing.

1. Designation of a Dedicated COVID-19 Coordinator

All public and private health facilities and providers that admit and give consultations to suspect, probable, and confirmed COVID-19 cases and/or laboratory facilities that conduct testing for COVID-19 must identify and designate a COVID-19 coordinator and his/her alternate. The COVID-19 Coordinator shall ideally be the head of or point person for the concerned epidemiology and surveillance unit, ICC, or laboratory facility, whichever is applicable. The COVID-19 coordinator shall:

a. Serve as the main liaison between the DOH and the health facility, health provider, or laboratory facility for all communication on COVID-19 concerns including but not limited to data requests, validation, and follow-up;
b. Continuously coordinate with the EB COVID-19 surveillance team to facilitate immediate and timely accommodation of all surveillance, laboratory data submission, and contact tracing activities such as but not

limited to: reviewing patient records, interviewing patients, relatives, and other health care providers and other concerned personnel of the facility, and immediate submission of laboratory results;

c. Promptly and correctly update the DOH COVID-19 Information System.

All public and private health facilities, health providers, and laboratory facilities shall provide the DOH with the following details of their assigned COVID-19 coordinator and alternate:

a. Name
b. Position
c. Cell phone number
d. E-mail Address

Details shall be submitted to the EB COVID-19 surveillance team covidcontacttracing.eb@gmail.com with the subject header "[COVID-19] Coordinator for <name of facility>".

2. Case Notification and Monitoring

2.1. Case Notification and Submission of COVID-19 Laboratory Test Results

Information on suspect, probable, and confirmed COVID-19 cases shall be recorded using the COVID-19 Case Investigation Form or CIF ***(See Annex B)*** and reported within 24 hours using a set notification system ***(See Annex F)***. The health facility or provider or concerned institution, shall submit within 24 hours of detection the accomplished CIF to RESU, who shall in turn submit this to EB.

For reported clustering or sudden increase of ILI and SARI cases or deaths of unknown etiology, these shall be reported through the ESR system also within 24 hours. The health facility or provider or concerned institution shall inform the RESU of identified suspect cases and health events. The RESU shall in turn notify EB immediately. However, upon detection of a probable or confirmed COVID-19 case, the reporting unit shall immediately notify the EB and RESU, simultaneously.

Laboratory results from the national reference laboratory, subnational referral laboratory, and laboratory testing facilities shall be submitted to DOH within 24 hours of completion of test using the same notification system. However, if the result was equivocal or positive, this report should be submitted immediately. Laboratories should diligently accomplish the lab reporting form in **Annex G.**

A transmittal of laboratory results shall be released by RITM following the protocol for releasing laboratory results. The transmittal shall be shared to designated officials after vetting of their Head of Office. This transmittal shall be considered official. Signed individual laboratory results shall be shared as soon as available. These transmittal and individual laboratory results shall be released by RITM to the Office

hospitals, EB, and the concerned RESU. The RESU will inform their regional director (RD) and assistant regional director (ARD), who in turn inform the concerned LGU.

For subnational reference laboratories and other testing facilities, laboratory results shall be immediately sent by their heads of offices to the DOH Executive Committee, EB, RITM, RESU, and the Infection Control Committee (ICC) head or point person of requesting hospitals. An official transmittal shall be sent immediately but signed individual laboratory results should follow. The RESU in turn informs their respective RD and ARD, who in turn inform the concerned LGU.

2.2. Case Monitoring

A template shall be submitted daily by **5 PM** which will include status of admitted suspect, probable, or confirmed COVID-19 cases ***(See Annex B)***. If any of these became a fatality, this should be immediately reported to RESU using the set format, who shall in turn immediately notify EB. The following information shall be updated:

a. Medical Status (of condition, as of time of update), including current signs and symptoms
b. Laboratory Status
c. For fatalities:
    i. Date and Time of Death
    ii. Cause of Death
    iii. Comorbidities
d. Disposition
e. Remarks: any other relevant notes from the patient chart; indicate especially if the patient is using a ventilator.

The COVID-19 coordinator shall provide detailed information on the death listed above, as well as other pertinent information from patient records.

For health facilities and providers and laboratory facilities with capability to set-up and use the COVID-19 Information System, the EB COVID-19 surveillance team shall assist the assigned COVID-19 coordinators in setting up their accounts to access the COVID-19 Information System website. This shall serve as the main data repository of COVID-19 data from all health facilities.

Confirmed COVID-19 cases who are currently isolated at home or in a non-health facility, the LESU shall be responsible in monitoring the clinical status of the patients and collect sample for repeat testing at the end of the 14-day isolation period.

2.3. Utilizing the COVID-19 Information System

admitted or have consulted at the facility using this system. In turn, laboratory facilities conducting COVID-19 testing shall input case information and upload the official transmittal and laboratory result.

The COVID-19 coordinator ***must*** update the COVID-19 Information System website sheets **daily** without need for prompting by **5:00 PM.** The COVID-19 coordinator must pay special attention to *ensure that the following variables are updated*:

a. Medical Status (of condition, as of time of update), including current signs and symptoms
b. Laboratory Status
c. For fatalities:
    i. Date and Time of Death
    ii. Cause of Death
    iii. Comorbidities
d. Disposition
e. Remarks: any other relevant notes from the patient chart; indicate especially if the patient is using a ventilator.

The RESU will review the data after submission. They may call the COVID-19 coordinator to follow-up for updates or clarify certain data entries. Likewise, the COVID-19 coordinator may contact the RESU for any questions or clarification with regards to the reporting forms. The EB Data Managers shall coordinate with the RESU for data requiring further verification.

Designated disease surveillance staff in these sentinel sites and disease reporting units shall implement and exercise zero reporting and notify the RESU, who shall in turn notify EB.

VII. ROLES AND RESPONSIBILITIES

A. The Epidemiology Bureau shall:

1. Lead in the establishment and implementation of the COVID-19 Surveillance System.
2. Draft and issue required policies and guidance in relation to this surveillance system.
3. Conduct training, orientation, and/or technical assistance to ensure that disease reporting units and concerned stakeholders will know how to implement the system.
4. Shall be the process owner of the COVID-19 Information System and as such shall:
    a. Act as the Database Managers for surveillance data
    b. Liaise with the COVID-19 coordinators for the timely turnover of complete data and information
    c. Review and approve updated attribute data which may be submitted by the users
5. Draft and disseminate COVID-19 surveillance report.
6. Assess and coordinate with respective RESUs all reported clustering, sudden increase, and local transmission of COVID-19 within 24 hours upon receipt of detection of clustering, sudden increase, or local transmission.

POLICY ON ADOPTING THE 2008 LIST OF NOTIFIABLE DISEASE, SYNDROME AND HEALTH RELATED EVENTS AND CONDITIONS

The LGU shall adopt the following as per AO no. 2008-0009 specifically on the following:

VI. Implementation Arrangements

The method and urgency of reporting of these diseases and syndromes shall follow the implementing procedures and guidelines prescribed in the Philippine Integrated Disease Surveillance and Response (PIDSR) System **(Administrative Order No. 2007-0036).** These notifiable diseases and syndromes fall into two categories within the PIDSR.

A. Immediately Notifiable Disease/Syndrome/Events and Conditions (Category I)

Immediate notification is required for the epidemic-prone diseases that newly appear in a population or have existed but are rapidly increasing in incidence. This also includes epidemic-prone diseases targeted for eradication and elimination. The Disease Reporting Unit (DRU) shall notify simultaneously the PHO, CHD and NEC within 24 hours of detection by the fastest means possible even a single case of such disease. A case-based investigation report shall be submitted to the above-mentioned offices by facsimile or e-mail. The diseases or syndromes under this category include:

1. Acute Flaccid Paralysis	syndrome
2. Adverse Event Following Immunization (AEFI)	syndrome
3. Anthrax	A22
4. Human Avian Influenza	J10
5. Measles	B05
6. Meningococcal Disease	A39
7. Neonatal Tetanus	A33
8. Paralytic Shellfish Poisoning	T61.2
9. Rabies	A82
10. Severe Acute Respiratory Syndrome (SARS)	UO4.9
11. Outbreaks	
12. Clusters of diseases	
13. Unusual diseases or threats	

B. Weekly Notifiable Disease or Syndrome (Category II)

All cases of notifiable diseases and syndromes that a DRU sees within the week should be reported to the next higher level using case report form. The weekly notifiable diseases or syndromes include:

1.	Acute Bloody Diarrhea	syndrome
2.	Acute Encephalitis Syndrome	syndrome
3.	Acute Hemorrhagic Fever Syndrome	syndrome
4.	Acute Viral Hepatitis	B15-B17
5.	Bacterial Meningitis	A87
6.	Cholera	A00
7.	Dengue	A90-A91
8.	Diphtheria	A36
9.	Influenza-like Illness	J11
10.	Leptospirosis	A27
11.	Malaria	B50-B54
12.	Non-Neonatal Tetanus	A35
13.	Pertussis	A37
14.	Typhoid and Paratyphoid Fever	A01

The data collected are analyzed and the results used to monitor progress towards disease reduction targets, measure achievements of disease prevention activities, and identify hidden outbreaks or problems so that early action can be taken.

Zero-case reporting shall be implemented in all levels. This means reporting of "zero case" when no case has been detected by the reporting unit.

Attached to this directive is a copy of the Case Definitions of Notifiable Diseases/Syndromes for ready reference.

7. IMPROVING PERFORMANCE – No Entry

8. PHYSICAL PLANT – No Entry

9. PUBLIC ACCESS TO PRICE INFORMATION

ADOPTING THE GUIDELINES ON PUBLIC ACCESS TO PRICE INFORMATION OF ALL HEALTH SERVICES AND ITS CURRENT ASSESSMENT TOOLS TO MONITOR FOR COMPLIANCE WITH AO NO. 2021-0008 ON PUBLIC ACCESS TO PRICE INFORMATION OF THE HEALTH SERVICES AND GOODS IN HF

ASSESSMENT TOOL FOR ENSURING PUBLIC ACCESS TO PRICE INFORMATION OF ALL HEALTH SERVICES AND GOODS IN HEALTH FACILITIES IN THE PHILIPPINES

INSTRUCTIONS:

1. To properly fill-out this tool, the Licensing Officer shall make use of: INTERVIEWS, REVIEW OF DOCUMENTS, OBSERVATIONS and VALIDATION of findings.
2. If the corresponding items are present, available or adequate, place (/) on each of the appropriate spaces under the FINDINGS column or space provided alongside each corresponding item. If not, put an (X) instead.
3. The REMARKS column shall document relevant observations.
4. Make sure to fill-in the blanks with the needed information. Do not leave any items blank.
5. The Team Leader shall ensure that all team members write down their printed names, designation and affix their signatures and indicate the date of inspection/monitoring, all at the last page of the tool.
6. The Team Leader shall make sure that the Head of the facility or, when not available, the next most senior or responsible officer likewise affix his/her signature on the same aforementioned pages, to signify that the inspection/monitoring results were discussed during the exit conference and a duplicate copy also received.

GENERAL INFORMATION:

Name of Health Facility: _____

Address: _____
(Number and Street) (Barangay/District) (Municipality/City)

_____
(Province/Region)

Telephone/Fax No. _____ E-mail Address: _____
Initial: _____ Renewal: _____

Existing License No: _____ Date Issued: _____ Expiry Date: _____

Name of Owner or Governing Body (if corporation): _____

Name of Head of Health Facility: _____

Classification:

Ownership: __ Government __ Private

CRITERIA	INDICATOR/EVIDENCE	COMPLIED	REMARKS
1. The price list shall be readily available to the public in a conspicuous area.	**Observe** • Availability of the price list in a conspicuous area, such as, but not limited to, the lobby, reception area, information kiosk and business office. • The price list may be presented in any form, but not limited to, the following: o Printed handout o Menu booklet o Interactive digital form o Posters or tarpaulins		
2. The price list of all health services shall be itemized comprehensively and all fees indicated clearly, including outsourced services, if applicable.	**Document Review** • The price list shall include, but not limited to, the following: o Price per type of accommodation, critical care units and emergency room o Fees for medical and surgical procedures o Price of laboratory tests o Professional fees o Price of drugs, medicines, and medical supplies o Bundle/package price of health services o Corresponding PhilHealth case rate packages and Z-package rates, if applicable o Corresponding Health Maintenance Organization (HMO) rates, if applicable *May be presented in ranges, if deemed appropriate		
3. For health facilities that have official website, the price list shall be readily available and regularly updated	**Observe** • Updated price list is available on the health facility's official website. • The date when the price list was last updated shall be indicated.		

CRITERIA	INDICATOR/EVIDENCE	COMPLIED	REMARKS
4. The health facility shall update the price list at least annually, or as needed.	**Documents Review** • Price list is updated at least annually. • The date when the price list was last updated shall be indicated.		
5. The patient or patient's guardian shall be informed of the price list upon admission or before provision of outpatient services or procedures.	**Documents Review** • Documented proof that the price list, including the No Balance Billing policy for basic accommodation, was presented and explained. • Documented proof that the information was understood and accepted by the patient or patient's guardian.		
6. All health facilities shall submit information regarding its prices and charges for goods and health services, including professional fees to PhilHealth.	**Documents Review** • Proof of submission of data to the information system of DOH and PhilHealth, once the system is fully functional.		